



INDIANA HEALTH COVERAGE PROGRAMS

MANAGED CARE ENTITY POLICIES AND PROCEDURES MANUAL

Indiana Pathways for Aging MCE Policies and Procedures Manual

POLICIES AND PROCEDURES AS OF JUNE 19, 2023
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Preface

The policy and procedure manual is provided to MCEs to provide guidance and clarity as it applies to *Indiana Pathways for Aging* program. The contents of this manual document policies and procedures that are the MCE's responsibility for service delivery and compliance.

It is not intended to modify, contradict, or reinterpret state and federal laws or regulations, FSSA bulletins, banners, guides, modules, or the terms in the *Indiana Pathways for Aging* contract.

The healthcare industry, and managed care in particular, is constantly changing to meet the demands of its patients, providers, and payers. *Indiana Pathways for Aging* is subject to many of these changes. *Indiana Pathways for Aging* is a fluid program striving to meet the needs of its many constituents. The State provides many forums – formal and informal – to address the concerns of *Indiana Pathways for Aging* members and providers. The State Care Programs team will incorporate changes and will publish revisions accordingly.

In addition to complying with the *Indiana Pathways for Aging MCE Policies and Procedures Manual*, the MCE must operate in compliance with applicable FSSA bulletins, banners, modules, all other program manuals, as well as any amendments thereto. It is the MCE's responsibility to stay up to date with any information published after this current manual version. Should any of the aforementioned, or the terms in the *Indiana Pathways for Aging* contract, supersede this policies and procedure manual, the MCE must follow contractual terms.

Future modifications that have a significant impact on the MCE's responsibilities will be made through the contract amendment process.

Note: Sections within this policy and procedure manual mirror those contained in the <i>Indiana Pathways for Aging</i> scope of work; however, subsections contain additional information and may not strictly align with scope of work subsections.
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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and Procedures as of March 31, 2023 Published: March 31, 2023	New Manual	OMPP
2.0	Policies and Procedures as of June 19, 2023 Published: June 19, 2023	Updates as follows: • Updated 2.a, Member Eligibility Requirements, and 5.c, Member Enrollment and MCE Selection, to reflect new language regarding auto-assignment. • Updated 2.d.5, Additional Required Training, to include trainings described in the <i>Indiana Pathways for Aging Care and Service Coordination Manual</i>. • Added SUPDL language to 3.c, Pharmacy and 3.c.4, E-Prescribing. • Updated rebate language in 3.c.1, Drug Rebates. • Updated SUPDL language and included process for neutral drugs in 3.c.2, PDL and Formulary Requirements. • Added MHQAC reporting and mental health drug requirements to 3.c.3, Dispensing, Monitoring, and MHQAC Reporting Requirements. • Updated Member Handbook requirements to include that the following information must be included in the member handbook: ○ how members can obtain information from the State about how to access the services, ○ procedures for obtaining benefits including authorization requirements, family planning services, and supplies from out-of-network providers, ○ how members can access covered behavioral health services and that the materials shall include information about behavioral health conditions that may be treated by a primary care provider (PCP) within their scope of practice, ○ services that are not covered by the MCE because of moral or religious objections, ○ Information on how to report suspected fraud or abuse. • Updated 5.f.1, General Information Review, Approval, and Requirements, to no longer disallow use of contractions in member communications. Additionally, corrected provider website to member website on page 96. • Added language that the MCE cannot require providers to use a specific form to submit an appeal on behalf of the member to 5.l.3, Appeals Processing Requirements.	OMPP

		• Corrected 5.m, Health Needs Screening (HNS), to reflect that the HNS must be conducted within 30 days of the effective date of enrollment. • Corrected 5.m.1, Health Needs Screen Extract, to reflect that the HNS must be conducted within 30 days of the effective date of enrollment. • Corrected 5.n, Comprehensive Health Assessment (CHAT), to reflect correct timeframes for completion. • Updated 6.n, Maintenance of Provider Medical Records, wording to align with 405 IAC 1-1.4-2. • Updated 6.v, Billing and Reimbursement Policies and Procedures and 9.d.3, Claims Payment Timelines, to reflect that the MCE must pay or deny all electronically filed clean claims within 21 calendar days of receipt, with the exception of HCBS claims. The MCE must pay HCBS related electronically filed clean claims within seven calendar days of receipt. With regards to paper claims, the MCE must pay both HCBS related and non-HCBS related clean paper claims within 30 calendar days of receipt. • Corrected 7.a.6, Incentive Programs, to reflect maximum incentive amounts of \$300. • Updated 7.b.4, Special Consideration for Long Term Services and Supports (LTSS) Service Authorization, with information about requirement of providers to sign the service plan. Additionally corrected language describing that the State reserves the right to require the MCE to submit service plans for review and approval.	
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Table of Contents

PREFACE	II
REVISION HISTORY	III
TABLE OF CONTENTS	V
SECTION 1: INTRODUCTION	1
1.a Indiana Pathways for Aging Target Population	2
1.b Program Quality Goals	3
1.b.1 Objectives for <i>Indiana Pathways for Aging</i> Quality Goals	3
1.c Future Areas of Focus	3
1.d MCE Commitment	4
1.e Service Delivery Innovation	4
SECTION 2: PROGRAM ADMINISTRATION	5
2.a Member Eligibility Requirements	5
2.a.1 Eligibility Determination Process	6
2.a.2 Expedited Waiver Eligibility (EWE) Program	7
2.b MCE Licensure and NCQA Accreditation Requirements	8
2.c Administrative and Organizational Structure	9
2.d Staffing Requirements	10
2.d.1 Key Staff	10
2.d.2 Additional Required Staff Positions	12
2.d.3 Staff Training	12
2.d.4 FSSA Email Address and Other State-Owned Accounts	13
2.d.5 Additional Required Training	13
2.e Debarred Individuals	19
2.f State Meeting Requirements	19
2.g Financial Requirements	19
2.g.1 Solvency	19
2.g.2 Insurance	20
2.g.3 Reinsurance	20
2.g.4 Financial Accounting Requirements	21
2.g.5 Reporting Transactions with Parties of Interest	22
2.g.6 Compensation	22
2.g.7 Medical Loss Ratio	22

2.h Supplemental Payments and Direct Payments -----	23
2.h.1 Hospital Assessment Fee (HAF) Payments -----	23
2.h.2 Physician Faculty Access to Care (PFAC) Program -----	24
2.h.3 Nursing Facility Supplemental Payments -----	24
2.h.4 LTSS and HCBS Minimum Fee Schedule -----	24
2.i Subcontracts-----	24
2.i.1 Subcontracting Expectations -----	24
2.i.2 Seeking State Approval for Subcontracting Engagement-----	25
2.j Confidentiality of Members’ Medical Records and Other Information -----	28
2.j.1 Disclosure of Health Records Requiring Member Consent -----	28
2.k Internet Quorum Inquiries -----	28
2.l Material Change to Operations -----	29
2.m Conflict of Interest-----	29
2.n Data Requests -----	29
2.o Maintenance of Records -----	29
2.p Maintenance of Written Policies and Procedures-----	29
2.q Dissemination of Information -----	30
2.r Access to Premises and Information -----	30
2.s Integration and Alignment of Medicare and Medicaid -----	31
2.s.1 Coordination with Medicare -----	31
2.s.2 Dual Eligible Special Needs Plan (D-SNPs) Requirements and Coordination -----	32
SECTION 3: COVERED BENEFITS AND SERVICES -----	34
3.a Indiana Pathways for Aging Covered Services -----	34
3.b Emergency Care -----	37
3.b.1 Inpatient Hospitalization Notification -----	39
3.b.2 Post-Stabilization Services -----	39
3.c Pharmacy-----	39
3.c.1 Drug Rebates-----	40
3.c.2 PDL and Formulary Requirements-----	41
3.c.3 Dispensing, Monitoring, and MHQAC Reporting Requirements -----	42
3.c.4 E-Prescribing-----	44
3.c.5 Carve-Out of Select Drugs -----	44
3.c.6 Other Covered Services and Benefits-----	45
3.c.7 SUPPORT Act Compliance-----	45
3.c.8 Medicare Part D -----	45
3.c.9 PBM Contracting -----	46
3.d Self-Referral Services -----	46

3.e Out-of-Network Services -----	47
3.f Smoking Cessation and Tobacco Dependence Treatment-----	48
3.g Behavioral Health-----	48
3.g.1 Behavioral Healthcare Services -----	49
3.g.2 Behavioral Health Provider Network-----	50
3.g.3 Care Coordination and Service Coordination for Members Receiving Behavioral Health Services ----	50
3.g.4 Behavioral Health Coordination-----	51
3.g.5 Behavioral Health Continuity of Care -----	52
3.g.6 Inpatient Hospitalizations -----	53
3.g.7 Partial Hospitalization Services for Behavioral Health-----	53
3.g.8 Substance Use Disorder and Serious Mental Illness -----	53
3.h Prevention and Wellness Program-----	54
3.i Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) -----	55
3.j 24-Hour Nurse Call Line -----	56
3.k Carve-Outs and Excluded Services-----	56
3.k.1 Carve-outs-----	56
3.k.2 Excluded Services-----	57
3.l State Plan Authority Long Term Services and Supports -----	58
3.l.1 Nursing Facilities -----	58
3.l.2 Home Health-----	60
3.l.3 Hospice-----	63
3.m Home and Community Based Services (HCBS)-----	64
3.n Participant-Directed Attendant Care Services (PDACS) -----	64
3.o Informal Caregiver Support -----	67
3.o.1 Informal Caregiver Training, Education, and Resources-----	67
3.o.2 Informal Caregiver Coaching-----	69
3.o.3 Informal Caregiver Assessments -----	69
3.p Continuity of Care -----	69
3.q Housing -----	71
3.r Medical Equipment -----	72
3.r.1 MCE Service Coordination Requirements with Medical Equipment -----	73
3.s Opioid Treatment Program (OTP)-----	73
3.t Dental Services -----	74
3.u Non-Emergency Medical Transportation Services-----	74
3.u.1 Non-Emergency Medical Transportation Providers and Provider Network -----	75
3.u.2 NEMT Communications -----	76
3.u.3 NEMT Care Coordination-----	77

3.u.4 Community Transportation -----	78
3.u.5 Attendant Care Aide Transportation-----	78
3.v Medication Therapy Management Services-----	79
3.w Enhanced Services-----	81
SECTION 4: CARE COORDINATION -----	82
SECTION 5: MEMBER SERVICES -----	83
5.a Marketing and Outreach -----	83
5.b New Member Materials -----	84
5.b.1 Member Welcome Packet-----	84
5.b.2 Member Handbook-----	84
5.b.3 Member ID Card -----	87
5.c Member Enrollment and MCE Selection -----	87
5.c.1 Enrollment and Practice Discrimination-----	88
5.c.2 Member Enrollment Rosters -----	88
5.c.3 Primary Medical Provider (PMP) Selection -----	90
5.c.4 Provider Network and Provider Directory -----	91
5.c.5 Member Disenrollment from MCE -----	92
5.c.6 Member Information Changes -----	93
5.d Managed Care Entity Member Services Helpline -----	95
5.e Electronic Communications -----	97
5.f Member Information, Outreach Education, and Engagement -----	98
5.f.1 General Information Review, Approval, and Requirements -----	99
5.f.2 Oral Interpretation and Translation Services -----	101
5.f.3 Member Website-----	101
5.f.4 Preventive Care Information -----	102
5.f.5 Advance Directive Information -----	102
5.f.6 Member and Stakeholder Education and Engagement-----	103
5.f.7 Health Equity and Cultural Competency -----	104
5.f.8 Cost and Quality Information -----	105
5.g Member-Provider Communication -----	105
5.g.1 Member and Potential Member Communications Review and Approval-----	106
5.g.2 Member Communications - Returned Mail-----	106
5.h Members' Rights-----	107
5.i Redetermination Assistance-----	107
5.j Additional Information Available Upon Request -----	108
5.k Procedures Regarding Potential Abuse, Neglect, and Exploitation (ANE) of Older Adults -----	109

5.k.1 MCE Responsibility -----	109
5.k.2 Policies and Procedures -----	110
5.k.3 Access to Adult Protective Services (APS) and the State Ombudsman Program -----	110
5.k.4 Examination and Treatment Services -----	111
5.k.5 Adult Protective Services and State Ombudsman Relations -----	111
5.l Member Inquiries, Grievances and Appeals -----	111
5.l.1 Inquiry Processing Requirements -----	112
5.l.2 Grievance Processing Requirements -----	112
5.l.3 Appeals Processing Requirements -----	113
5.l.4 External Review by Independent Review Organization -----	114
5.l.5 State Fair Hearing Process -----	115
5.l.6 Continuation of Benefits Pending Appeal & Reinstatement of Benefits -----	115
5.l.7 Member Notice of Grievance, Appeal and Fair Hearing Procedures -----	116
5.l.8 Ombudsman -----	117
5.l.9 State Member Support Services Contractor -----	117
5.m Health Needs Screening (HNS) -----	117
5.m.1 Health Needs Screen Extract -----	118
5.n Comprehensive Health Assessment (CHAT) -----	118
5.o Member Cost Sharing -----	119
5.p Member Liabilities -----	119
5.p.1 Waiver Liabilities -----	120
5.p.2 Patient Liabilities -----	120
5.p.3 Retroactive Adjustment of Member Liabilities -----	121
5.q Member Medicaid Suspension -----	121
5.r Transfer of Property Penalties -----	121
5.s Managed Care Entity Application Assistance and Distribution to Non-members -----	122
5.t SNAP Alignment Language -----	123

SECTION 6: PROVIDER ENROLLMENT AND NETWORK DEVELOPMENT -----124

6.a Managed Care Entity Enrollment in CoreMMIS -----	124
6.b Managed Care Entity Provider Network Requirements -----	125
6.b.1 Network Development and Management Plan -----	125
6.b.2 Culturally and Linguistically Competent Providers -----	126
6.b.3 Network Composition Requirements -----	127
6.b.4 Acute Care Hospital Facilities -----	131
6.b.5 Preferred Medical Provider (PMP) Requirements -----	131
6.b.6 Specialist and Ancillary Provider Network Requirements -----	133
6.b.7 Pharmacy Services -----	135

6.b.8 Non-Psychiatrist, Non-Substance User Disorder (SUD), and Behavioral Health Providers -----	135
6.b.9 Inpatient Psychiatric Facilities-----	135
6.b.10 Substance Use Disorder (SUD)-----	136
6.b.11 Dental Providers -----	136
6.b.12 Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHCs)-----	136
6.b.13 Indian Healthcare Providers -----	137
6.b.14 County Health Departments -----	138
6.b.15 Urgent Care Clinics-----	138
6.b.16 Dialysis Treatment Centers-----	139
6.b.17 Non-Emergency Medical Transportation Providers-----	139
6.b.18 Physician Extenders -----	139
6.b.19 Skilled Nursing Facilities -----	139
6.b.20 Telehealth Providers-----	139
6.c Workforce Development-----	139
6.d Provider Policies and Procedures Manual -----	140
6.d.1 Provider Accessibility -----	140
6.e Provider Agreements -----	141
6.f Provider Network Participation Requests -----	142
6.f.1 Network Participation Process -----	142
6.f.2 Provider Network Participation Request Forms -----	143
6.f.3 HCBS-Specific Network Participation Requirements -----	144
6.f.4 Network Participation Effective Dates-----	145
6.f.5 Network Participation Provider Welcome Letter -----	147
6.f.6 Provider Network Participation Documentation -----	148
6.f.7 Network Participation Annual Audit -----	149
6.g HCBS LTSS Provider Qualifications and Standards-----	149
6.h Provider Credentialing and Recredentialing Policies and Procedures -----	150
6.h.1 Credentialing Timeframe-----	150
6.h.2 Credentialing Requirements -----	150
6.h.3 Credentialing and Recredentialing Mechanisms -----	151
6.h.4 Credentialing Site Visits (non-HCBS providers)-----	152
6.h.5 Recredentialing (non-HCBS providers)-----	152
6.h.6 Recredentialing Site Visits -----	153
6.h.7 Credentialing for Healthcare Delivery Organizations -----	153
6.h.8 Re-certification for HCBS Providers -----	153
6.h.9 Altering Conditions of Provider Participation -----	153
6.i Provider Enrollment-----	154
6.i.1 IHCP Provider Enrollment-----	154

6.i.2 MCE Pre-Enrollment Provider Education -----	156
6.i.3 Post-Enrollment Provider Education -----	157
6.i.4 Preferred Medical Providers (PMP) Enrollment -----	157
6.i.5 PMP Scope of Practice Changes -----	158
6.j Provider Disenrollment or Treatment Termination -----	159
6.j.1 PMP Provider Disenrollment -----	160
6.k Out of State Providers -----	161
6.l Residency Programs -----	162
6.m Provider Referrals -----	163
6.m.1 Physician Extenders -----	163
6.n Maintenance of Provider Medical Records -----	164
6.o Provider Communications -----	165
6.o.1 LTSS-Specific Provider Communication -----	166
6.o.2 Provider Website -----	166
6.o.3 Provider Newsletters -----	167
6.o.4 Provider Services Helpline -----	167
6.o.5 IHCP Workshops and Seminars -----	168
6.p Provider Dispute Process -----	168
6.q Provider Directory -----	169
6.r Provider Education -----	170
6.s Provider Complaint Resolution -----	170
6.s.1 Complaints Received by MCE -----	171
6.s.2 Complaints Received by the State About an MCE -----	171
6.s.3 MCE Failure to Resolve -----	171
6.t Provider Qualifications and Standards -----	171
6.u Practice Standards -----	172
6.u.1 Additional Standards -----	172
6.v Billing and Reimbursement Policies and Procedures -----	173
6.v.1 Interest Payments to Noncontracted Providers -----	174
6.v.2 Billing and Balance Billing IHCP Enrollees -----	174
6.v.3 Future Recovery Effort Due to Retroactive Medicare Eligibility -----	175
SECTION 7: QUALITY IMPROVEMENT AND UTILIZATION MANAGEMENT -----	176
7.a Quality Improvement -----	176
7.a.1 Quality Program Expectations -----	177
7.a.2 Quality Management and Improvement Program (QMIP) -----	178
7.a.3 QMIP Committee and Peer Review Committee -----	183
7.a.4 Waiver Assurances -----	184

7.a.5 External Quality Review -----	184
7.a.6 Incentive Programs-----	184
7.a.7 Critical Incidents -----	187
7.a.8 Mortality Review Committee -----	187
7.b Utilization Management Program -----	187
7.b.1 Utilization Management Staffing and Training -----	187
7.b.2 Medical Service and Pharmacy Prior Authorization (Non-HCBS Services) -----	188
7.b.3 Mandatory Medical Criteria Hierarchy-----	189
7.b.4 Special Consideration for Long Term Services and Supports (LTSS) Service Authorization -----	190
7.b.5 Established Utilization Management Policy -----	191
7.b.6 Authorization of Service and Notice of Action-----	193
7.b.7 Requirements for Tracking Prior Authorization Requests -----	196
7.b.8 Objection on Moral or Religious Grounds -----	197
7.b.9 Utilization Management Committee -----	197
7.c The Right Choices Program -----	198
SECTION 8: PROGRAM INTEGRITY -----	199
8.a Program Integrity Plan -----	199
8.b Additional Program Integrity Requirements -----	201
8.c Program Integrity Operations -----	201
8.d Program Integrity Reporting -----	202
8.d.1 Reporting Waste, Fraud and Abuse -----	203
8.e Program Integrity Overpayment Recovery -----	204
8.f Auditing Program Integrity Operations -----	205
8.f.1 Provider Audits by MCE -----	205
8.f.2 Provider Payment Suspensions -----	206
8.g Medical Management Standard Compliance-----	207
8.h Long-Term Services and Supports -----	207
8.i Program Integrity Definitions-----	208
SECTION 9: INFORMATION TECHNOLOGY SYSTEMS-----	209
9.a Disaster Recovery Plans -----	209
9.b Member Enrollment, Capitation and Data Exchange -----	210
9.b.1 Capitation Adjustments – Systematic-----	211
9.b.2 Manual Capitation Adjustments -----	211
9.c Rate Information -----	211
9.c.1 IHCP Fee Schedules -----	211
9.d Claim Processing -----	213

9.d.1 Claim-Processing Capability-----	214
9.d.2 Compliance with State and Federal Claim-Processing Regulations -----	214
9.d.3 Claims Payment Timelines-----	215
9.e Encounter Data Submission -----	215
9.e.1 Weekly Batch Submission -----	215
9.e.2 Pre-cycle Edits -----	216
9.e.3 Encounter Claims Quality -----	216
9.e.4 Coordination of Benefits Details -----	217
9.e.5 Encounters Voids for Services Payable as FFS-----	217
9.e.6 Capitated Provider Encounters -----	217
9.e.7 Denied Encounters and Rejected Common Definitions -----	217
9.e.8 HIPAA Adjustment Reason Codes-----	218
9.e.9 Encounter Data Edits and Audits-----	218
9.e.10 Encounter Data Output Documents-----	219
9.e.11 Encounter Submission Summary Report -----	219
9.e.12 Remittance Advice (RA)-----	219
9.e.13 Encounter Data Corrections and Resubmissions-----	220
9.e.14 Encounter Data Adjustments -----	220
9.f Third-Party Liability (TPL) -----	221
9.f.1 Coordination of Benefits-----	221
9.f.2 Third-Party Liability Data Sources -----	223
9.f.3 Managed Care Entity Third-Party Liability Responsibilities – Cost Avoidance and Coordination of Benefits-----	223
9.f.4 Third-Party Liability Collection and Reporting-----	224
9.g Electronic Visit Verification -----	225
9.h Health Information Technology and Data Sharing -----	226
SECTION 10: PERFORMANCE REPORTING-----	229
10.a State Response -----	230
10.b Ad-hoc Reports and Presentations -----	230
10.c Report Listing-----	231
10.c.1 Financial Reports -----	231
10.c.2 Member Service Reports-----	232
10.c.3 Network Development Reports -----	232
10.c.4 Provider Service Reports-----	232
10.c.5 Quality Management Reports -----	232
10.c.6 Utilization and Authorization Reports -----	232
10.c.7 Claims Reports -----	233
10.c.8 Care Coordination and Service Coordination Reporting-----	233

10.c.9 Health Outcomes and Clinical Reporting -----	233
10.c.10 CMS Reporting -----	233
10.c.11 Other Reporting-----	233
APPENDIX A: INDIANA PATHWAYS FOR AGING CAPITATION PAYMENT TRANSACTION CODES -----	A
APPENDIX B: EXTRACTS AND REPORTS -----	B
APPENDIX C: MEMBER FAQ & WHO TO CONTACT -----	C
APPENDIX D: MCE REMITTANCE TO THE STATE-----	D
APPENDIX E: STATE SYSTEMS AND VENDORS -----	E
APPENDIX F: TPL HIERARCHY -----	F

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Section 1: Introduction

The *Indiana Pathways for Aging* MCE Policies and Procedures manual is provided to each managed care entity (MCE) contracting with the State to administer services to *Indiana Pathways for Aging* members. This manual provides additional information regarding MCE responsibilities in the program and the interactions and interfaces among the MCEs, the State, and other contractors. This manual will be periodically amended.

This manual is organized into the following sections:

- *Introduction* outlines the *Indiana Pathways for Aging* program population, goals, objectives, and the MCE's required commitment to the successful execution and delivery of the program.
- *Program Administration* includes information about eligibility requirements for members, the MCE's expected role in the *Indiana Pathways for Aging* program, and staffing requirements.
- *Covered Services* describes the services and benefits that are covered, excluded, and carved out of the various programs under the managed care umbrella. Information regarding in-network versus out-of-network services, self-referral services, Long Term Services and Supports (LTSS), and Home and Community Based Services (HCBS) are also included.
- *Care Coordination* defines care coordination and service coordination and directs MCEs to the separate *Indiana Pathways for Aging* Care and Service Coordination Manual.
- *Member Services* describes the regulations and general program expectations relating to member education and enrollment, member helpline, grievance and appeals, and member-provider communication information. Guidance for member liabilities and transfer of property penalties is also included.
- *Provider Enrollment and Network Development* details the requirements and processes with respect to MCE provider education and communication, network development, credentialing processes, and provider related reports.
- *Quality Improvement and Utilization Management* is a critical aspect of managed care and outlines expectations, incentive programs, compliance, monitoring, and reporting for *Indiana Pathways for Aging*. Information about critical incidents and mandatory reporting is also detailed in this section.
- *Program Integrity* includes information about the MCEs requirements to safeguard funds against improper, unnecessary, or inappropriate use of Medicaid. This section details information regarding what is necessary to support the prevention of fraud, waste, and abuse.
- *Information Technology Systems* details the functionality required for claims processing, data sharing and reporting requirements of the MCEs in reference to encounter data, third-party liability (TPL), and general financial reporting.
- *Performance Reporting* lists reports which are required to support the State in monitoring MCE performance. The *MCE Reporting Manual* is another resource that provides details and instructions for MCE reporting.

In addition to these sections, appendices provide information about capitation payment transaction codes, extracts, and additional resources applicable to the *Indiana Pathways for Aging* program.

1.a Indiana Pathways for Aging Target Population

Indiana Pathways for Aging is a statewide managed care program for Indiana's Medicaid enrollees who are 60 years of age and older, are eligible for Medicaid based on age, blindness, or disability, and have limited income and resources.

Members will have eligibility in full-benefit Medicaid categories such as MA-A, MA-B, MA-D, MA-DI, MA-DW, MA-SI. Furthermore, members may be *full-benefit dually-eligible* (QMB-also, SLMB-also, and FBDE). Therefore, members *may*, in addition to the aforementioned full-benefit Medicaid categories, have eligibility in categories such as MA-L or MA-J.

Enrollees are members who meet the age and eligibility requirements and include those who have a full Medicare benefit (dually eligible), are in a nursing facility, are receiving hospice services, and those who are receiving long-term services and supports (LTSS) in a home or community-based setting (to include those served on the Aged and Disabled Waiver).

All individuals who are 60 years of age or older in the target eligibility categories will be included *unless* they meet one of the following exclusions:

- Individuals who are only partial benefit dually-eligible (QMB-**only**, SLMB-**only**, QI, or QDWI)
- Individuals who are DDRS waiver recipients
- Program of All Inclusive Care for the Elderly (PACE) members
- Room and Board (RCAP) members
- End Stage Renal Disease (ESRD) 1115 members
- Breast and cervical cancer (MA-12) eligible members
- Individuals who are TBI waiver recipients
- TBI out of state placements
- IDD residents of intermediate care facilities (ICF) (i.e., group homes)
- Emergency services only (ESO) members
- Family planning only members
- Members with MAGI eligibility in HIP or HHW
- Individuals who are hospice recipients prior to age 60 will remain in FFS unless they choose to opt-in to *Indiana Pathways for Aging*
- Individuals who are registered members of a federally recognized Tribe that are eligible for HIP but have opted out into non-HIP, Fee for Service (FFS) coverage (MANA).
 - Individuals who are in the American Indian/Alaskan Native population and in an *Indiana Pathways for Aging* eligible category may voluntarily enroll in *Indiana Pathways to Aging*. If they do not choose to opt-in, these enrollees will remain in FFS.
- Anyone 59 years of age or younger (including those on the Aged & Disabled Waiver)
 - Eligible Medicaid enrollees that are age 59 and under, who are on the Aged & Disabled Waiver, will receive waiver services by Department of Disability and Rehabilitative Services (DDRS) in conjunction with Fee for Service (FFS); for information on DDRS, visit <https://www.in.gov/fssa/ddrs/>.

1.b Program Quality Goals

The MCE is required to help lead the transformation of the Medicaid LTSS delivery system and to collaborate with the State and other *Indiana Pathways for Aging* MCEs to achieve this mission. The MCEs must abide by the requirements further detailed in [Quality Improvement](#). The State has established three overarching quality goals for the *Indiana Pathways for Aging* program:

Indiana Pathways for Aging Program Quality Goals

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

Goal 2: Ensuring Smooth Transitions – Ensure continuity of care and seamless experiences for members as they transition into the *Indiana Pathways for Aging* program and ongoing as transitions occur between providers, settings, or coverage types.

Goal 3: Access to Services (Member Choice) – Assure timely access to appropriate services and supports to enable members to live in their setting of choice and promote their well-being and quality of life.

The State believes that achieving these goals will be advantageous for all parties involved in the following respects:

- *Members* will have increased choice and access to services as well as increased control over their services and supports,
- *Providers* will have clear, consistent messaging about program priorities, technical assistance, and training to help them deliver services to enhance the member experience, and
- *MCEs* will, through collaborative and aligned efforts, be able to effectively support care for members and support providers to achieve optimal outcomes.

1.b.1 Objectives for *Indiana Pathways for Aging* Quality Goals

To actively support the *Indiana Pathways for Aging* Program Quality Goals, the State will establish focus areas, objectives, and performance targets which will evolve over time to reflect the maturation of the *Indiana Pathways for Aging* program and managed care entities. The MCEs will be expected to develop and accomplish annual workplans and make investments toward improved outcomes. Certain measurable objectives and performance targets, which MCEs will be required to meet, have been designated as Pay for Outcomes (P4O) measures for which incentive payments will be available to MCEs that attain target goals; see Exhibit 2, *Contract Compliance and Pay for Outcomes*.

The initial focus areas and objectives were designed to build infrastructure that will enable the State to effectively monitor member outcomes and manage positive member experiences. Thus, the initial objectives largely rely on the establishment of structural and process measures that are reliant on successful State and MCE collaboration.

1.c Future Areas of Focus

MCE quality of services is an important component of the member experience. Below are examples of future areas of focus to support the *Indiana Pathways for Aging* Quality Goals.

Indiana Pathways for Aging Possible Future Focus Areas

Goal 1: Person-Centered Services and Supports – Coordination between Medicaid MCE and D-SNPs/other Medicare plans; member goal attainment (LTSS and non-LTSS); advance care planning and palliative care.

Goal 2: Ensuring Smooth Transitions – Favorable transitions among settings (Hospital, NF, HCBS); continuity of care transitions between MCEs/Medicare health plans; members newly eligible for Medicare; transitions from nursing facility to HCBS (when chosen by the member); Use of an event notification system; Medicare-Medicaid care coordination; completeness and accuracy of options counseling (transitions into LTSS).

Goal 3: Access to Services (Member Choice) – Direct service worker workforce initiatives; home health nursing workforce initiatives; timely member access to HCBS; availability of informal caregiver supports; connections with social determinants of health (SDOH) and closed-loop referrals; HCBS utilization; potentially preventable events and/or adult core measures (as an indicator of access to preventive care); primary care visits; community inclusion; Healthy Days at home; loneliness initiatives.

1.d MCE Commitment

The MCE must ensure that all staff are committed and competent to the successful implementation and delivery of the *Indiana Pathways for Aging* program. The MCEs are expected to preserve and promote values that will best serve this targeted population. A vested partnership with the State is critical and must demonstrate dedication in supporting and promoting the health and well-being of older Hoosiers and their caretakers.

1.e Service Delivery Innovation

The MCE must promote innovation in the *Indiana Pathways for Aging* service delivery system.

Indiana's focus includes continuous system improvements to build a more cohesive and effective health care system by reducing fragmentation, coordinating dually eligible Medicare benefits, structuring provider reimbursements to further quality outcomes, leveraging health information technology, and working with private sector partners. The MCE shall collaborate and demonstrate innovative initiatives to promote positive member outcomes in, but not limited to, the following concepts:

- Person-centered service planning and delivery to optimize member choice
- Whole person care for care coordination
- Health equity to allow members to attain their highest level of care
- Care coordination and integration to support care team concept
- Housing access and modifications to allow member choice
- Employment opportunities for members
- Direct Service Workforce innovation to support all LTSS services
- Telehealth services to accommodate member location and mobility needs
- Public/private partnerships to benefit program population
- [Electronic visit verification](#) (EVV) for tracking and documentation
- Emergency triage, treat, and transport (ET3) to address emergency care needs
- Payment modernization to ensure timely provider payments
- Health information technology (HIT) for interoperability opportunities
- Justice system transitions to minimize barriers
- Transportation for member access and equity support
- Trauma informed care to identify unique needs

Section 2: Program Administration

Each MCE will have an assigned Contract Compliance Officer (CCO) to facilitate communication between the MCE and the State's Office of Medicaid Policy and Planning (OMPP). Compliance matters and questions regarding the MCE policy and procedure manual should be directed to the MCE's assigned CCO.

2.a Member Eligibility Requirements

The State has sole authority for determining whether individuals meet the eligibility criteria for the *Indiana Pathways for Aging* program. The FSSA's Division of Family Resources (DFR) makes eligibility determinations based on federal and state policy, as interpreted by the State. Nursing Facility Level of Care (NFLOC) – the functional standard that indicates nursing facility placement and can be reimbursed under Medicaid – is determined based on state law and administrative rule.

- **Age Group, Target Group, and Medicaid Eligibility**

- To be eligible to enroll with an MCE, an individual must be in the age and target groups, and not subject to exception; see [Indiana Pathways for Aging Target Population](#).

- **Functional Eligibility**

- Functional Eligibility is determined using the InterRAI assessment. The InterRAI is person centered, evidence based, holds a focus on home care, and gives data which can be compared across institutional and HCBS populations.
- To meet functional eligibility for Long-Term Services and Supports, an otherwise eligible individual must have NFLOC, as determined by the InterRAI assessment, and meet the requirements under *Indiana Code 12-10-11.5-4*. The LOC will be completed by an Enrollment Contractor selected by the State. MCEs will not determine the member's level of care (LOC).
- For nursing facility admittance, if the individual is reasonably expected to no longer meet NFLOC (time period of 30, 60, 90, or 120 days) the NFLOC must be reassessed in the respective time period.
- For members receiving LTSS, the NFLOC must be reassessed at least annually.

- **Residency**

- To be eligible for *Indiana Pathways for Aging*, an otherwise eligible individual must be a resident of Indiana, as determined by DFR rules found in the Indiana Health Coverage Program Policy Manual.

- **MCE Assignment**

- For individuals who come into the program with no current Medicaid coverage, MCE assignment will be effective on the date of eligibility approval. Medicaid coverage *may* be effective up to three months retroactively from their application date. Retroactive coverage will be in the [fee for service \(FFS\)](#) program. **Managed care assignment will not be retroactive.**
- For individuals transitioning from an existing Medicaid managed care program or FFS, MCE assignment will be effective the first day of the month following the notice of change in eligibility.
- Plan selection can be made while pending enrollment in Pathways. The enrollment broker will be responsible for providing outreach to members on plan selection and choice counseling to the member. If an individual does not select a plan while pending Pathways enrollment there will be an assignment process in place directed by the State. The member's enrollment in the selected or assigned Pathways plan will be effective the 1st day of the month of eligibility determination. Plan assignment will favor plan alignment between Medicare and Medicaid to the greatest extent allowable. Other factors may be considered such as the residential provider of the member (if

applicable). Individuals will have the chance to change a health plan at the frequencies described in [Member Disenrollment from MCE](#).

- **Medicare Election**

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

2.a.1 Eligibility Determination Process

- **Eligibility Determination Prior to Initial Enrollment**

- The MCE must ensure separation from the State's initial eligibility determination and enrollment counseling functions. The separation shall meet criteria established by the State in accordance with applicable federal and state guidelines.
- MCEs may market directly to members, or potential members, only in accordance with a marketing plan that has been approved by the State and may use only marketing materials that have been approved by the State.

- **Functional Eligibility Re-determination**

- Once enrolled, the MCE is responsible for assuring that all members have a current and accurate level of care (LOC) as determined by the InterRAI. This includes, at minimum, an annual re-determination of LOC. It may also include a post-enrollment re-determination shortly after enrollment or a re-determination necessitated by a change in the member's condition. The MCE must not complete the LOC determination, but rather work with the Enrollment Services Vendor and MCE member to have the LOC determined annually and when any change in the member's condition occurs.

- **Supporting Members to Maintain Medicaid Eligibility**

- The MCE is responsible for supporting members with maintaining their Medicaid eligibility. This responsibility includes, but is not limited to:
 - Reminding members of the required annual Medicaid recertification procedure and coordinating member transportation to any needed DFR appointments,
 - Educating members on any applicable Medicaid income and asset limits and, as appropriate and needed, supporting members to meet verification requirements,
 - Educating members on any deductible, cost share, patient or waiver liability obligation, or transfer penalty period they may need to meet to maintain Medicaid eligibility,
 - If appropriate and needed, supporting members to obtain a representative payee or legal decision maker, and
 - Referring and connecting members, as needed, to other available resources in the community that may assist them in obtaining or maintaining eligibility (i.e., elder and disability benefits specialists and advocacy organizations).

- **Providing Information that May Affect Eligibility**

- Members have a responsibility to report certain changes in circumstances, that may affect Medicaid eligibility, to DFR within 10 calendar days of the change. The MCE is expected to be knowledgeable of eligibility criteria and educate members in reporting known changes to the DFR. [Member Information Changes](#)

- **Medicare Coverage Elections**

- The MCE must have essential staff, knowledge, and resources to support members enrollment in Medicare services/plans to avoid unintended misalignment or even potential disenrollment from the program. This includes understanding Medicare coverage choices: traditional Medicare, Medicare Advantage (non-special needs plans), and Special Needs Plans (SNPs) as well as all relevant Medicare enrollment periods, including the Open Enrollment Period (OEP) and Special Enrollment Periods (SEPs).

- **Waiver or Patient Liability**

- Members may be required to pay a monthly waiver or patient liability to be eligible for program support. *Liability* is the term applied to the monetary amount that IHCP members in long-term care (HCBS or nursing facility) must contribute toward their monthly care. [Member Liabilities](#).
- The MCE is responsible for the ongoing monitoring of the waiver or patient liability amounts of its members. The MCE is to receive and monitor medical claim amounts and apply allowable costs against the liability to ensure member responsibility is met and to cover allowable costs after the liability is met.

- **Transfer of Property Penalties**

- DFR will determine if an applicant or member for LTSS Medicaid has inappropriately transferred assets without adequate consideration to qualify for Medicaid, as specified in 405 IAC 2-3-1.1. The dates of any penalty period will be communicated to the MCE from the CoreMMIS system. Provider portal and eligibility-checking systems must indicate the start and end dates of member ineligibility due to transfer of property penalty to providers. [Transfer of Property Penalties](#).

2.a.2 Expedited Waiver Eligibility (EWE) Program

The State has sole authority for determining eligibility of the Expedited Waiver Eligibility (EWE) program. The FSSA's Division of Family Resources (DFR) makes eligibility determinations based on federal and state policy. The Nursing Facility Level of Care (NFLOC) is determined based on state law and administrative rule.

- **Age and Target Group**

- Eligibility for the EWE route to *Indiana Pathways for Aging* enrollment into an MCE is met by meeting the below age and target group criteria.

- **Medicaid Eligibility**

- The population for the EWE route to *Indiana Pathways for Aging* is individuals 65 and older who have income that does not exceed the Special Income Limit (300% of the current year's Maximum Federal Benefit Rate for Supplemental Security Insurance recipients); spousal income is not included. Individuals must have less than \$2000 in countable assets; assets held only by the spouse of the applicant are not included, and assets held jointly with a spouse are counted at 50% of their value. Applicants must meet the functional criteria for the initial level of care:
 - Must be an Indiana resident and have a citizenship status which allows for full coverage Medicaid
 - Individuals 65 years of age and older who meet the Nursing Facility Level of Care (NFLOC)
 - Individuals who do not have active Medicaid coverage in a full benefit category and are not known to have high income or extensive assets
 - Individuals who are open only in the following limited benefit categories may apply for and be approved for EWE if otherwise eligible:
 - HPE, PEPW, PEPA, PEPF (Presumptive Eligibility)
 - Family Planning Services (FPS)

- HIP Bridge
- QMB-Only (Qualified Medicare Beneficiary Only)
- SLMB-Only (Specified Medicare Beneficiary Only)
- QI (Qualified Individual)
- QDW (Qualified Working Disabled Individuals)

- **Functional Eligibility**

- Functional Eligibility is determined using the InterRAI questions. To be functionally eligible for the Expedited Waiver Eligibility route to *Indiana Pathways for Aging*, an otherwise eligible individual must have a NFLOC as determined by the InterRAI questions and meet the requirements under IC 12-10-11.5-4. This level of care will be completed by an Enrollment Services Vendor selected by the State. MCEs will not determine the EWE member's initial level of care but will be responsible for completing the full-service plan after EWE approval.

- **Residency**

- To be eligible for the EWE route to *Indiana Pathways for Aging*, an otherwise eligible individual must be an Indiana resident, as determined by DFR using rules found in the *Indiana Health Coverage Policy & Program Manual*. (<http://www.in.gov/fssa/ompp/forms-documents-and-tools2/medicaid-eligibility-policy-manual/>).

- **Approved Expedited Waiver Eligibility Applicants**

- Individuals approved through the EWE Eligibility process will have a Medicaid effective date back to the first day of the month of the application. The initial level of care is approved on the same day the application is submitted.
- Approved applicants will show in the MMIS system with the aid category "MEE" (Medicaid Expedited Eligibility) and benefits package "WEE" (Waiver Expedited Eligibility) until their full Medicaid is evaluated and approved or denied by the DFR. If approved, the MEE will be replaced with a standard Medicaid Category such as MA-A (Medicaid for the Aged).
- The Enrollment Services Vendor will contact the Enrollment Broker while the member and/or their authorized representative is present to choose an MCE to provide long-term support and services. MCEs will receive records of the Expedited Waiver Eligibility approved applicants along with an indicator that shows if the member is at an urgent risk of nursing home admission. The state strongly encourages MCEs to prioritize urgent applicants for the completion of a full-service plan to avoid a potentially more expensive and/or less desired (by the member) nursing home placement. However, the Service Level Agreements (SLAs) for the Expedited Waiver Eligibility group are the same as for other waiver applicants.
- Once the full-service plan has been completed and the standard Aged & Disabled waiver level of care has been received by CoreMMIS, the end date the WEE benefit will be determined and replaced with the full waiver benefit package. The procedures for completing and reporting the level of care will be identical to that of other Medicaid members.

- **MCE Assignment**

- The MCE assignment for EWE is the same process applicable to non-EWE members.

2.b MCE Licensure and NCQA Accreditation Requirements

Managed care entities (MCEs) must comply with the following to participate in the *Indiana Pathways for Aging* program:

- Be an Indiana-licensed accident or sickness insurer, or an Indiana-licensed health maintenance organization (HMO).

- Be fully authorized under Indiana law to arrange or administer the full range and scope of services required under a procurement process undertaken by the State.
- Contract with the State on a prepaid, capitated basis to arrange, administer, and pay for the delivery of healthcare services to its members.
- As required by *IC 12-15-12-21*, the MCE must be Health Plan accredited by the National Committee for Quality Assurance (NCQA), on or before the contract start date. MCEs must have NCQA LTSS Distinction of Health Plans as part of their accreditation. If an MCE does not have NCQA Health Plan Accreditation and/or NCQA LTSS Distinction of Health Plans by the start date of the agreement, both must be obtained no later than the end of the second full calendar year of operation. MCEs must maintain NCQA accreditation with LTSS Distinction status throughout the course of the contract. If at any point during the contract period, MCE fails to maintain accreditation or is deemed a Provisional status they must inform the State within 10 business days of notification. In addition, the following data must be submitted annually:
 - detailed report of NCQA Health Plan Rating
 - final HEDIS rates
 - final CAHPS scores
- Per *42 CFR 438.332(b)(1)-(3)*, the MCE must authorize NCQA to provide the State a copy of its most recent accreditation review including:
 - its accreditation status, survey type, and level (as applicable),
 - recommended actions or improvements, corrective action plans, and summaries of findings, and
 - the expiration date of the accreditation.
 - Acceptable documents include NCQA certificate, preliminary results/findings, final results/scoring and corrective action plans.

2.c Administrative and Organizational Structure

The MCE must have sufficient administrative and clinical staff to support and comply with all *Indiana Pathways for Aging* program requirements and standards. The MCE's infrastructure must demonstrate functional linkage of major operational areas:

- Administrative and fiscal management
- Member services
- Provider enrollment and services
- Care Coordination
- Marketing
- Network development and management
- Quality management and improvement
- Utilization management
- Clinical assessment, prevention and wellness program(s), care coordination, complex case management, and service coordination
- Special investigations and waste, fraud, and abuse detection
- Behavioral and physical health
- Information systems

- Performance data reporting and encounter claims submission
- Claims payments
- Grievances and appeals
- Medicare and Medicaid coordination

This infrastructure shall be scrutinized by the State during MCE Readiness Review and on-going onsite audits. The MCE shall maintain a detailed implementation plan, pre-approved by the State, which identifies the MCE's functional components of staff responsibilities, timelines and processes that will be used to ensure contracted services are able to begin upon the contract effective date. Additionally, internal MCE policies and procedures are required to serve as compliance tools and conformation of contractual responsibilities.

2.d Staffing Requirements

The MCE must ensure qualified staff in each major operational area has appropriate and ongoing training (e.g., orientation, cultural sensitivity, program updates, clinical protocols, policies and procedures compliance, computer systems, and so forth), education, skills, knowledge, and experience with the unique aspects of geriatrics, LTSS populations and services, home and community-based services (HCBS) coordination, as well as the coordination of Medicare and Medicaid. Prior LTSS experience or experience serving the program population across staff is highly preferred. Staff must be culturally competent and aware of MCE's equity plan.

The MCE must develop job descriptions for all positions discussed in this section. The descriptions must include the responsibilities and qualifications for the position. Qualifications include, but must not be limited to, educational degree(s), professional credentials, direct work experience, and membership in professional or community associations.

The MCE must institute mechanisms to maintain a high level of performance and program data monitoring, regardless of staff vacancies or turnover. The MCE must also have an effective method to mitigate the effects of staff turnover (e.g., cross-training, use of temporary staff or consultants, etc.). Processes must be in place to solicit feedback from MCEs' staff members to improve the work environment. These processes will be verified during the readiness reviews and subject to onsite audits. The MCE must maintain personnel records to document and prove completion of training including, but no limit to, curriculum, training schedules, and attendance.

2.d.1 Key Staff

The State requires the MCE to have key staff members dedicated to its *Indiana Pathways for Aging* program. The MCE must have an office within 10 miles of the mile square of downtown Indianapolis, Indiana where key staff members physically perform majority of their daily duties and responsibilities, and where a major portion of the plan's operations take place. Should the MCE plan to re-locate the physical location of established office, the MCE is required to notify the State. All information which contains the MCE office address must be updated with the new address and sent to the State for approval. Upon State approval, MCE shall communicate to all members, providers, and other individuals required to know the address. The MCE will follow guidelines for approval of communications.

For all functions conducted outside the state of Indiana, the MCE must ensure a seamless integration of its operations. The MCE is responsible for ensuring all staff functions conducted outside the state of Indiana are always readily reportable to the State's request for information. Key staff must maintain a full understanding of the operations conducted outside Indiana and must be prepared to discuss these operations upon request, including during unannounced State site visits.

The MCE must employ specific key staff dedicated as a full-time equivalent (FTE). The State reserves the right to interview prospective candidates and approve or deny the individuals filling these positions.

The MCE must develop a complete job description for each position, based on stipulations contained in the contract listing of key staff members. The key staff members are as follows:

- Chief Executive Officer or Executive Director
- Chief Financial Officer
- Compliance Officer
- Chief Information Officer (CIO) or Information Technology (IT) Director
- Medical Director
- Staff Geriatrician or Physician with 10 Years of Clinical Practice with Older Adults
- Member Services Manager
- Provider Services Manager
- Special Investigation Unit (SUI) Manager
- Long-Term Services and Supports (LTSS) Program Manager
- Quality Management Manager
- Utilization Management Manager
- Care Coordination Manager
- Service Coordination Administrator.
- Behavioral Health Manager
- Dental Manager
- Data Compliance Manager
- Pharmacy Director
- Transition Coordinator
- Member Advocate/Non-Discrimination Coordinator
- Grievance and Appeals Manager
- Claims Manager
- Nutritionist
- Equity Officer
- Housing Coordinator
- Workforce Development Administrator
- Non-Emergent Medical Transportation (NEMT) Manager

Except in circumstances of unforeseeable loss of a key staff member's service, the MCE must provide written notification, to the MCE's assigned State contract compliance officer, of anticipated key staff vacancies within five business days of receiving the key staff person's notice to terminate employment or five business days before the vacancy occurs, whichever occurs first. At that time, the MCE must present an interim plan to cover the responsibilities created by the key staff vacancy. Likewise, the MCE must notify the State's contract compliance officer, in writing, within five business days after a candidate's acceptance to fill a key staff position or five business days prior to the candidate's start date, whichever occurs first. All key staff must be accessible to the State and its program subcontractors for verbal communication and responsive email. The MCE must submit updated contact information for key staff as changes occur. Additionally, MCEs are required to review and complete a contact sheet on a quarterly basis.

2.d.2 Additional Required Staff Positions

The MCE is responsible for ensuring adequate staffing to meet the requirements outlined in the scope of work and the delivery of high quality, operationally efficient services. The State may set required staffing levels for MCEs. The State may require additional staffing for MCEs who fail to maintain compliance with the performance metrics of the *Indiana Pathways for Aging* scope of work. The MCE shall adhere to the State approved staffing plan. In addition to the [Key Staff](#) positions, the MCE is required to employ the following:

- Part-time, or on-call, board certified psychiatrist and addiction specialist
- A member liaison
- Quality management staff
- Case management supervisor(s)
- Grievance and appeals staff
- Technical support services staff
- Utilization and medical management staff
- Care coordinators
- Service coordinators
- Transition coordination staff
- Member service representatives
- Member marketing and outreach staff
- Special investigation unit staff
- Compliance staff
- Provider representatives
- Claims processors
- Member and provider education/outreach staff
- Website staff
- A housing coordinator
- Provider Claims Educator(s)
- A minimum of two staff members who are certified through the Learning Community's train-the-trainer program

2.d.3 Staff Training

The MCE must ensure that each staff person, including those of a subcontractor, has appropriate education, skills, and experience to fulfill the requirements of their position, as well as ongoing training (for example, orientation, cultural sensitivity, program updates, clinical protocols, policies and procedures understanding, management information systems, and training on fraud and abuse). The MCE must ensure that all staff members receive training on major components of the *Indiana Pathways for Aging* program. Staff training shall include, but is not limited to:

1. An overview of the *Indiana Pathways for Aging* program, associated policies and procedures, and quality goals including updates whenever changes occur,

2. *Indiana Pathways for Aging* program services and supports including covered benefits and how to access within the MCE's network
3. D-SNP program services and supports
4. Review of the *Indiana Pathways for Aging* policy and procedure manual (shall be provided to the MCE's entire staff and any subcontractors providing services under the contract),
5. Comprehensive education on person-centered service delivery,
6. Contractual requirements and state and federal requirements specific to job functions,
7. Training on the MCE's responsibilities to provide advance directive support (in accordance with 42 CFR 422.128),
8. Initial and ongoing training on identifying and handling quality of care concerns,
9. Cultural competency and health equity training, performed or created in conjunction with disability and aging advocacy organizations,
10. Training on fraud and abuse and the *False Claims Act*,
11. *Health Insurance Portability and Accountability Act* (HIPAA) training,
12. Management of IT systems and expectations, and
13. Education to understand and recognize abuse, neglect, exploitation, and prevention including the detection, reporting, investigation, and remediation requirements.

The MCE must also ensure all applicable subcontractors provide any such training to their respective staff.

The MCE must update its training materials on a regular basis to reflect program changes. The MCE must maintain documentation to confirm internal staff training, curricula, schedules, and attendance and must provide this information to the State upon request and during regular audit activity. MCEs must ensure that all trainings are approved by the State.

2.d.4 FSSA Email Address and Other State-Owned Accounts

Any staff member given a FSSA email must complete all FSSA required trainings. Unless an alternative deadline is identified by FSSA for a specific training, all FSSA required trainings must be completed by its respective due date. The MCE may request additional time to complete the trainings, but the State is under no obligation to grant extensions. Each FSSA required training that is past due, without an approved extension, will be documented on the MCE Quarterly Scorecard. If the MCE is noticing issues accessing FSSA required trainings, the MCE shall communicate with their respective State contract compliance officer to discuss solutions.

The MCE shall ensure that any MCE staff member given a FSSA email or access to another State-owned application (i.e., *CoreMMIS*) complies with privacy and security protocols. FSSA emails and other State-owned accounts, in which access has been granted, shall be utilized **exclusively** for official business of State and MCE operations. Account and password sharing is **prohibited**. Violations of this policy are subject to corrective action and/or monetary penalties.

2.d.5 Additional Required Training

Certain positions will require detailed training in additional areas beyond the training detailed in [Staff Training](#); this includes, but is not limited to:

- **Clinical Staff**
 - clinical protocol and triage training.
- **Call Center Staff (Member Services, Provider Services, 24-Hour Nurse Line, etc.)**
 - program refresher training; completed annually, at minimum.

• Transportation (Driver) Staff

- cultural competency training as part of onboarding and annually thereafter,
- first aid training as frequently as needed to keep certification current, and
- cardiopulmonary resuscitation (CPR) training as frequently as needed to keep certification current.

• Transportation, Prior Authorization and Member Services Staff

- training on the geography of the state and location of network service providers to facilitate the approval of services and recommended providers in the most geographically appropriate location.

• Utilization Management Staff

- ongoing training regarding interpretation and application of the MCE's utilization management guidelines. The ongoing training must be conducted, at a minimum, on a quarterly basis and as utilization management guideline changes occur.

• Care Coordinators

- New hire orientation, new hire training, and continuous education:
 - information as detailed in staff training.
 - Medicaid as it relates to service delivery.
 - quality assurance measures.
 - quality improvement standards.
 - the continuum of LTSS services, including available service delivery options, placement settings and service restrictions/limitations.
 - evidence-based assessment processes, person-centered care planning, and care plan development. Updates and population specific training relevant to the populations enrolled in the *Indiana Pathways for Aging* program.
 - member rights and responsibilities.
 - the federal regulations for the security and privacy of protected health information found in *45 CFR Part 164* (HIPAA) and for the confidentiality of substance use disorder patient records found in *42 CFR Part 2*.
 - member self-direction of health care tasks.
 - coordination of care for dually eligible members, including D-SNP-Aligned and D-SNP Unaligned members.
 - critical incident reporting.
 - cultural competency performed or created in conjunction with disability and aging advocacy organizations.
 - housing and employment services.
 - responsibilities related to recognizing, screening, monitoring for, and reporting of quality-of-care concerns, including, but not limited to, suspected abuse, neglect, self-neglect, and/or exploitation as defined in *455 IAC 2-4-2*; *455 IAC 1-2-2(g-h)* and in alignment with *Indiana Pathways for Aging* requirements in Section 5.13 of the scope of work.
 - individualized care plan development processes, timeliness requirements, and 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 MCE'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.
- understanding and application of population health elements.
- behavioral health information, including identification of member's behavioral health needs, covered behavioral health services, how to access those services within the MCE's network, the requirements for initial and quarterly behavioral health consultations, processes for making referrals for serious mental illness (SMI) determinations, and standards for the provision of services for members determined to have an SMI.
- the use of tools and protocols for critical transitions:
 - hospital discharge planning and post care plan,
 - nursing facility assessment - Pre-Admission Screening and Resident Review (PASRR), and
 - nursing facility to community transitions service coordination.
- grievance, hearing, and appeals processes.
- the 4Ms (Mentation, Mobility, Medications, and What Matters) of Age Friendly Health Systems.
- an introduction to all Indiana Medicaid services, including covered physical and behavioral health services and long-term services and supports (LTSS), processes for authorizing such services, as applicable; expectations for the integration of LTSS service coordinators with the Interdisciplinary Care Team and LTSS service planning with the care planning and delivery for individuals enrolled in *Indiana Pathways for Aging* and the care coordinator's role and responsibility in facilitating access to other Indiana Medicaid covered benefits.
- an introduction to Medicare services, including those provided by the MCE's aligned D-SNP, the aligned D-SNP's State Medicaid Agency Contract (SMAC) and Model of Care (MOC), and the coordination of care for dually eligible members.
- Housing needs assessment and resource identification, including legal and financial resources.
- Awareness of current national and industry developments to topics relevant to the populations served.
- training and education on systems of support provided through Area Agencies on Aging (AAAs), care management providers (including independent care management (ICM) providers), and Aging and Disability Resource Centers (ADCRs), such as programs for older adults, people with disabilities, caregivers, veterans, and member families.
- training on applicable Care Management tools and protocols.
- "Person Centered Thinking" training through The Learning Community for Person Centered Practices (also referred to as "Learning Community"):
 - Training must be completed within 12 months of *Indiana Pathways for Aging* implementation, or
 - Prior to serving *Indiana Pathways for Aging* members, if after the initial 12 months from implementation date.

- Re-training in areas found deficient through the MCE's internal monitoring process.

- **Service Coordinators**

- New hire orientation, new hire training, and ongoing training:
 - information as detailed in staff training.
 - Medicaid as it relates to service delivery and coordination.
 - service definitions included in Indiana's 1915(c) waiver.
 - case management expectations and protocols.
 - level of care of basic and skilled needs.
 - level of care activities of daily living.
 - quality assurance measures.
 - quality improvement standards.
 - the continuum of LTSS services, including available service delivery options, placement settings and service restrictions/limitations.
 - evidence-based assessment processes, person-centered care planning, and care plan development. Updates and population specific training relevant to the populations enrolled in the *Indiana Pathways for Aging* program.
 - member rights and responsibilities.
 - the federal regulations for the security and privacy of protected health information found in *45 CFR Part 164* (HIPAA) and for the confidentiality of substance use disorder patient records found in *42 CFR Part 2*.
 - consumer direction concept of eligible HCBS.
 - member self-direction of health care tasks.
 - coordination of care for dually eligible members.
 - how to identify and address service gaps timely to the welfare of the member.
 - critical incident reporting.
 - cultural competency performed or created in conjunction with disability and aging advocacy organizations.
 - housing and employment services.
 - supportive technologies that allow members to remain in their home and/or maintain independence.
 - responsibilities related to recognizing, screening, monitoring for, and reporting of quality-of-care concerns, including, but not limited to, suspected abuse, neglect, self-neglect, and/or exploitation as defined in *455 IAC 2-4-2*; *455 IAC 1-2-2(g-h)* and in alignment with *Indiana Pathways for Aging* requirements in Section 5.13 of the scope of work.
 - the principle of most integrated, least restrictive settings for member placement.
 - the HCBS settings rule *42 CFR 441.301(c)*.
 - development and implementation of back-up plans in the event of informal caregiver inability.
 - risk assessment and incorporating identified risk and risk mitigation strategies into the member's plan of care.

- end of life person centered planning, Advance Directives, 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 MCE'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.
- understanding and application of population health elements.
- behavioral health information, including identification of member's behavioral health needs, covered behavioral health services, how to access those services within the MCE's network, the requirements for initial and quarterly behavioral health consultations, processes for making referrals for serious mental illness (SMI) determinations, and standards for the provision of services for members determined to have an SMI.
- the use of tools and protocols for critical transitions:
 - hospital discharge planning and post care plan,
 - nursing facility assessment - Pre-Admission Screening and Resident Review (PASRR), and
 - nursing facility to community transitions service coordination.
- grievances, hearing and appeals.
- training around self-direction including Participant-Directed Attendant Care Services (PDACS), future iterations of the program, and the roles and responsibilities including financial administration and brokerage functions (fiscal intermediary).
- evidence-based assessment processes.
- person-centered care planning.
- population specific training relevant to members enrolled in the *Indiana Pathways for Aging* program.
- housing needs assessment and resource identification, including legal and financial resources.
- "Person Centered Thinking" training through The Learning Community for Person Centered Practices (also referred to as "Learning Community") or certified trainer.
 - training must be completed within 90 days of hire date
- awareness of current national and industry developments to topics relevant to the populations served.
- training specific to how to immediately identify and address service gaps.
- training and education on systems of support provided through Area Agencies on Aging (AAAs), care management providers (including independent care management (ICM) providers), and Aging and Disability Resource Centers (ADCRs), such as programs for older adults, people with disabilities caregivers, veterans, and member families.
- training on applicable Care Management tools and protocols.
- re-training in areas found deficient through the MCE's internal monitoring process.

2.e Debarred Individuals

In accordance with 42 CFR 438.610, the MCE must not knowingly have a relationship with the following:

- An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described previously.

The relationships include directors, officers, or partners of the MCE; persons with beneficial ownership of 5% or more of the MCE's equity; or persons with an employment, consulting, or other arrangement with the MCE for the provision of items and services that are significant and material to the MCE's obligations under the contract.

In accordance with 42 CFR 438.610, if the State finds that the MCE is in violation of this regulation, the State will notify the Secretary of noncompliance and determine if the contract will continue.

The MCE shall have policies and procedures in place to routinely monitor staff positions and subcontractors for individuals debarred or excluded.

The MCE is required to disclose to the OMPP Program Integrity (PI) section information required by 42 CFR 455.106 regarding the MCE's staff and persons with an ownership/controlling interest in the MCE that have been convicted of a criminal offense related to that person's involvement in Medicare/Medicaid or Title IX programs. [Program Integrity](#).

2.f State Meeting Requirements

The State conducts meetings and collaborative workgroups for the *Indiana Pathways for Aging* program. The MCE must comply with all the meeting requirements established by the State and/or its contractors including in-person (physical location) meetings. The MCE shall cooperate with the State in preparing for and participating in these meetings which may require subcontractor engagement and/or attendance at no cost to the State. The State reserves the right to cancel any regularly scheduled meetings, change the meeting frequency or format, or add meetings as it deems necessary.

The State reserves the right to meet at least annually with the MCE's executive leadership to review the MCE's performance, discuss the MCE's outstanding or commendable contributions, identify areas for improvement and outline upcoming issues that may impact the MCE or the *Indiana Pathways for Aging* program. Engagement of key staff is expected during meetings of readiness review and ongoing onsite audits.

2.g Financial Requirements

The State and the Indiana Department of Insurance (IDOI) monitor the MCE's financial performance and require submission of quarterly financial reports. The State includes IDOI findings on monitoring activities. The MCE must copy the State on required filings with IDOI and the required filings must break out financial information on the *Indiana Pathways for Aging* lines of business separately.

2.g.1 Solvency

The MCE must maintain a fiscally solvent operation per federal regulations and must meet IDOI requirements for minimum net worth, set reserve amount and risk-based capital surplus. The MCE must have a process in place to review and authorize contracts established for reinsurance and third-party liability, if applicable.

The MCE must comply with federal requirements for protection against insolvency (pursuant to 42 CFR 438.116), which require a non-federally qualified MCE to:

- Provide assurances satisfactory to the State that its provision against the risk of insolvency is adequate to ensure that its enrollees would not be liable for the MCE's debts if the MCE became insolvent.
- Meet the solvency standards established by the State for private health maintenance organizations or be licensed or certified by the State as a risk-bearing entity.

2.g.2 Insurance

The MCE must comply with all applicable insurance laws of Indiana and of the federal government throughout the term of the contract. No fewer than 90 calendar days before delivering services under the contract, the MCE will obtain Fidelity Bond or Fidelity Insurance from an insurance company authorized to do business in the State of Indiana.

The insurance coverage must be maintained throughout the term of the contract. No fewer than 30 calendar days before each policy's renewal effective date, the MCE must submit its certificate of insurance to the State for approval. The MCE must submit the certificate of insurance through the State-established document review process. Policy renewals must be submitted at least annually. Insurer coverage or policy amendments must be submitted as they occur.

2.g.3 Reinsurance

The MCE must purchase reinsurance from a commercial reinsurer and establish reinsurance agreements. The reinsurance agreement shall be maintained for duration of State contract. The MCE must submit new policies, renewals, or amendments to the State for review and approval at least 120 calendar days before becoming effective. The MCE must submit through the State-established document review process.

• Agreements and Coverage

- The MCE must adhere to and provide all agreements and proof of coverages listed as follows:
- The attachment point must be equal to or less than \$500,000 and must apply to all services, unless otherwise approved by the State. The MCE electing to establish commercial reinsurance agreements with an attachment point greater than \$500,000 must provide a justification in its proposal or submit justification to the State in writing at least 120 calendar days prior to the policy renewal date or date of the proposed change. The MCE must receive approval from the State before changing the attachment point.
- The MCE's co-insurance responsibilities above the attachment point shall be no greater than 20%.
- Reinsurance agreements must transfer risk from the MCE to the reinsurer.
- The reinsurer's payment to the MCE must depend on and vary directly with the amount and timing of claims settled under the reinsured contract. Contractual features that delay timely reimbursement are not acceptable.
- The MCE must obtain continuation of coverage insurance (insolvency insurance) to continue plan benefits for members until the end of the period for which premiums are paid. This coverage must extend to the members in acute care hospitals or nursing facility settings when the MCE's insolvency occurs during the member's inpatient stay. The MCE must continue to reimburse for its members' care under those circumstances until the member is discharged from the acute care setting or nursing facility.

• Requirement for Reinsurance Companies

- The MCE must submit documentation that the reinsurer follows the National Association of Insurance Commissioners' (NAIC) Reinsurance Accounting Standards.
- The MCE is required to obtain reinsurance from insurance organizations that have a Standard and Poor's claims-paying ability ratings of "AA" or higher and a Moody's bond rating of "A1" or higher, unless otherwise approved by the State.

- **Subcontractor Insurance**

- Subcontractors' reinsurance coverage requirements must be clearly defined in the reinsurance agreement.
- Subcontractors are encouraged to obtain their own stop-loss coverage with the previously mentioned terms.
- If subcontractors do not obtain reinsurance on their own, the MCE is required to forward appropriate recoveries from stop-loss coverage to applicable subcontractors.

2.g.4 Financial Accounting Requirements

The MCE must maintain separate accounting records for *Indiana Pathways for Aging*. These records must incorporate performance and financial data of subcontractors, particularly risk-bearing subcontractors. The MCE must maintain accounting records in accordance with IDOI standards and provide proof on compliant IDOI documentation upon request of the State. If the MCE does not provide *Indiana Pathways for Aging* specific information, the State may terminate the MCE contract.

In accordance with 42 CFR 455.100-104, the MCE must notify the State of any person or corporation with 5% or more ownership or controlling interest in the MCE and must submit financial statements for these individuals or corporations. Additionally, annual audits must include an annual actuarial opinion of the MCE's incurred but not received claims (IBNR) specific to the *Indiana Pathways for Aging* program.

Copies of any accounting records pertaining to the contract must be made available by the MCE within 10 calendar days of receiving written request from the State. If such original documentation is not made available as requested, the MCE must provide transportation, lodging, and subsistence at no cost, for all state and/or federal representatives to carry out their audit functions at the principal offices of the MCE or where such records are located. The FSSA, the IDOI, and other state and federal agencies (and their respective authorized representatives or agents) must have access to all accounting and financial records of any individual, partnership, firm, or corporation, as the records relate to transactions with any department, board, commission, institution, or other state or federal agency connected with the contract.

The MCE must maintain financial records pertaining to the contract, including all claims records, for three years following the end of the federal fiscal year during which the contract is terminated, or when all state and federal audits of the contract have been completed, whichever is later (in accordance with 45 CFR 74.53). Financial records must address matters of ownership, organization, and operation of the MCE's financial, medical, and other record keeping systems. However, accounting records pertaining to the contract shall be retained until final resolution of all pending audit questions and for one year following the termination of any litigation relating to the contract (if the litigation has not terminated within the three-year period). In addition, the State requires the MCE to produce the following financial information upon request:

- tangible net equity (TNE) or risk based capital at balance sheet date.
- cash and cash equivalents.
- claims payment, IBNR, reimbursement, fee for service claims, provider contracts by line of business.
- appropriate insurance coverage for medical malpractice, general liability, property, workers' compensation and fidelity bond, in conformance with state and federal regulations.
- revenue sufficiency by line of business/group.
- renewal rates or proposed rates by line of business.
- corrective action plan documentation and implementation.
- financial, cash flow, and medical expense projections by line of business.
- underwriting plan and policy by line of business.
- premium receivable analysis by line of business.

- affiliate and inter-company receivables.
- current liability payables by line of business.
- medical liabilities by line of business.
- copies of any correspondence to and from the IDOI.

2.g.5 Reporting Transactions with Parties of Interest

The MCE, if not federally qualified, must disclose to the State information on certain types of transactions it has with a *Party of Interest*, as defined in the *Public Health Service Act* (see §1903(m)(2)(A)(viii) and 1903(m)(4) of the *Social Security Act*).

As defined in §1318(b) of the *Public Health Service Act*, a *Party of Interest* is:

- Any director, officer, partner, or employee responsible for management or administration of an HMO,
- Any person who is directly or indirectly the beneficial owner of more than 5% of the equity of the HMO,
- Any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5% of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law,
- Any organization in which a staff member who is a director, officer or partner has directly or indirectly a beneficial interest of more than 5% of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than 5% of the assets of the HMO,
- Any person directly or indirectly controlling, controlled by, or under common control with an HMO, or
- Any spouse, child, or parent of an individual described within this bulleted list.

Disclosures shall be made pursuant to stipulations within contract. Given this initial contract with the State, if the MCE has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed within 30 days of contract execution. The business transactions that must be reported are not limited to transactions related to serving the Medicaid enrollment. All the MCEs' business transactions must be reported.

2.g.6 Compensation

The method of compensation under the contract is *capitation payments* and payments from liable third parties, as specified and defined within the contract, appropriate laws, regulations, and policies. Final capitation rates are identified and developed, and payment is made in accordance with 42 CFR 438.3(c). For additional information see Exhibit 5, *Capitation Rates*.

2.g.7 Medical Loss Ratio

The MCE shall maintain, at minimum, a Medical Loss Ratio (MLR) of 93% for the *Indiana Pathways for Aging* line of business. The State shall recoup excess capitation paid to the MCE in the event the MCE's MLR, as calculated by the State on an annual basis, is less than 93%. In addition, the MCE is required to submit MLR reporting as described in the MCE Reporting Manual.

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

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

- The MLR calculation shall be performed separately for each program. The MLR for the *Indiana Pathways for Aging* program shall be calculated separately from other managed care programs.
 - Expenses shall be appropriately pro-rated among expense types, programs and populations and allocated as required in 42 CFR 438.8(g). The state will provide guidance on allowable quality expenses, such as care management and service coordination, which the MCE shall follow.
- For each MLR reporting year, a preliminary calculation will be performed with six months of incurred claims run-out, and a final calculation will be performed within the months of run-out specified in the contract.
- Incurred claims reported in the MLR should relate only to members who were enrolled with the MCE on the dates of service, based on data and information available on the reporting date (claims for members who were retroactively disenrolled should be recouped from providers and excluded from MLR reporting).
- Under sub-capitated or sub-contracted arrangements, the MCE may only include amounts actually paid to providers for covered services and supplies as incurred claims. The non-benefit portion of sub-capitated and sub-contracted payments should be excluded from incurred claims. The MCE should ensure all subcontracts provide for sufficient transparency to allow for this required reporting.

2.h Supplemental Payments and Direct Payments

2.h.1 Hospital Assessment Fee (HAF) Payments

Hospital Assessment Fee (HAF) payments will be integrated into capitation rates. MCEs are required to pay HAF hospitals at the enhanced Medicaid rates for HAF eligible services detailed below:

- **HAF eligible hospitals**

- *Contracted providers*

- MCEs shall pay one 100% of the enhanced HAF rates which is:
 - 100% of the fee schedule rate multiplied by the HAF factor, or
 - 100% of the Inpatient APR DRG rate multiplied by the HAF factor.

- *Non-contracted providers*

- MCEs shall pay 98% of the enhanced HAF rates which is:
 - 98% of the fee schedule rate multiplied by the HAF factor, or
 - 98% of the Inpatient APR DRG rate multiplied by the HAF factor.

- **Non-HAF eligible hospitals**

- *Contracted providers*

- MCEs shall pay the amount negotiated with the contracted provider:
 - 100% of the Medicaid APR DRG rates for Inpatient, and
 - 100% of the Medicaid OP Fee Schedule.

- *Non-contracted providers*

- MCEs shall pay:
 - 98% of the Medicaid APR DRG rates for Inpatient, and
 - 98% of the Medicaid OP Fee Schedule.

2.h.2 Physician Faculty Access to Care (PFAC) Program

Enhanced reimbursement is authorized under the Indiana Physician Faculty Access to Care (PFAC) program. Payments for the PFAC program will be integrated into capitation rates; see Section 2.8.2 of *Indiana Pathways for Aging* scope of work for additional information.

2.h.3 Nursing Facility Supplemental Payments

The State administers a *supplemental reimbursement program* for nursing facilities which is referred to as the “Upper Payment Limit” or “UPL” program. In aggregate, the UPL payments represent the difference between Medicare reimbursement rates and State reimbursement rates.

Supplemental payments must be made to nursing facilities or their owners / operators on a quarterly basis. An annual true up of supplemental payments must be performed for each fiscal year which would result in either an additional payment to or a recoupment from each owner / operator or nursing facility.

Each quarter, the State will send the MCE the nursing facility supplemental payments associated with their members along with a list of how those payments must be allocated between approximately 40-50 owner / operators and nursing facilities.

The MCE must demonstrate the capability to accept the aggregate payment from the State and to pay the designated portion of the supplemental payment to each provider on the quarterly list on a timely basis.

Similarly, the annual UPL settlement process will result in a combination of payments and recoupments that the MCE must be able to process. The State will provide the MCE with the net funding for the annual settlement and a list of payments / recoupments by owner / operator or nursing facility. The MCE must complete the recoupments / payments on a timely basis.

The MCE must develop policies and procedures for administering the Nursing Facility Supplemental Payments and provide documentation to the State showing the individual payments and recoupments as well as the date paid / recouped.

2.h.4 LTSS and HCBS Minimum Fee Schedule

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

If a member is admitted to a nursing facility for hospice services, in addition to the routine or continuous care hospice reimbursement amount, the hospice agency must also be paid a room-and-board payment that is equivalent to 95% of the nursing facility’s daily rate. These payments are required to ensure compliance with 405 IAC 1-16-4.

2.i Subcontracts

A *subcontract* is a legal agreement entered into by the MCE with any other organization or person who agrees to perform any administrative function or service for the MCE specifically related to the MCE’s obligations of under the terms of the contract. Any delegated function within the MCE’s state contract is considered a subcontract. This includes healthcare providers or other ancillary medical providers, another prepaid health plan, or physician hospital organization. Additionally, MCE may engage with administrative entities not involved in the actual delivery of medical care. **The MCE is accountable for any functions and responsibilities that it delegates.** Legal agreements with subcontractors must include parameters set forth in the MCE’s State contract.

2.i.1 Subcontracting Expectations

The State encourages the MCE to subcontract with entities located in Indiana. **Subcontracts with entities that are located outside of the United States are prohibited.** This requirement also mandates that work

performed under contractual obligations must occur within the boundaries of the United States and/or its territories.

In the spirit of member care coordination and service delivery, MCE direct care subcontractors shall meet the same expectations as the MCE regarding the extent of LTSS experience with *Indiana Pathways for Aging* targeted population. The MCE shall require subcontractors providing direct services to have quality improvement goals and performance improvement activities specific to the types of services provided by the subcontractors. The MCE will include in their subcontracting approval request of any direct service or care provider a summary of the subcontractor's experience in providing such service and/or care. The MCE shall demonstrate diligent oversight and monitoring activities to ensure subcontractor compliance with these requirements.

The MCE may choose to subcontract claims processing functions, or portions of those functions (after obtaining State approval). The MCE shall demonstrate that the use of such subcontractors is invisible to providers, including out-of-network and self-referral providers, and will not result in confusion to the provider community about where to submit claims for payments.

For Example, the MCE may elect to establish one post office box address for submission of all out-of-network provider claims. If different subcontracting organizations are responsible for processing those claims, it is the MCE's responsibility to ensure that the subcontracting organizations forward claims to the appropriate processing entity. Using this type of method will not extend the timeliness standards for claim processing.

In this example, the definition of "date of receipt" is the date of the claim's receipt at the post office box.

Refer to Section 9.7 of the *Indiana Pathways for Aging* scope of work for full claims processing requirements.

2.i.2 Seeking State Approval for Subcontracting Engagement

The MCE must comply with 42 CFR 438.230, 42 CFR 434.6 and the following subcontracting requirements:

- The MCE must obtain the State's approval before subcontracting any portion of the program's requirements as outlined in *IC 12-15-30-5* and 42 CFR 455.104. The MCE must give the State a written request and submit a draft contract or model provider agreement at least 90 calendar days prior to the use of the subcontractor. The request must include a written plan on continuity of services during any transition of services. If the MCE changes the subcontractor contract, the MCE must submit the amendment for State review and approval 90 calendar days prior to the revised contract effective date. The State has a minimum of 60 days to complete a review and provide an approval or denial on the use of the subcontractor. All subcontracts must be submitted through the State's document review process, using the *Care Programs Subcontract Checklist*. The State will not review a subcontract that is submitted without the checklist attached.
- As stated in *IC 12-15-1-19*, an MCE may contract with community entities for outreach and enrollment, provision of services, and consumer and public health education. The MCE must obtain approval from the State for utilizing vendors for member outreach or to provide direct services, medical or behavioral care to members. The MCE is required to provide a report 60 days after the end of each calendar year listing all such agreements. The report should include method of identifying members for the vendor, services provided, number of members for which each contracted vendor provided services, and standard demographics for the members who received the services.
- The MCE may not advertise or announce the new subcontractor relationship prior to the State's approval of the subcontract. For subcontractors which result in a material change triggering member or provider notice, the 90-day review period for the subcontract, 30-day period for document review, and 30 or 45-day notice requirement may not run concurrently.
- The MCE must evaluate prospective subcontractors' abilities to perform delegated activities prior to contracting with the subcontractor to perform services associated with the *Indiana Pathways for Aging* program. This is similar to the State's readiness review of the MCE as outlined in 42 CFR 438.66(d).

- The MCE must have a written agreement in place that specifies the subcontractor's responsibilities and provides an option for revoking delegation or imposing other sanctions if performance is inadequate (see 42 CFR 422.504(i)). The written agreement must comply with and is subject to all State of Indiana statutes. The subcontract cannot extend beyond the term of the State's contract with the MCE.
- The MCE must collect performance and financial data from its subcontractors; monitor delegated performance on an ongoing basis; and conduct formal, periodic, and random reviews as directed by the State. The MCE must incorporate all subcontractors' data into the MCE's performance and financial data for a comprehensive evaluation of the MCE's performance compliance and, when appropriate, identify areas for its subcontractors' improvement (see 42 CFR 422.504(m)(3) and 42 CFR 438.66). The MCE must take corrective action if deficiencies are identified during the review. The MCE shall provide, to the State, the findings of all subcontractor performance monitoring and reviews upon request.
- The MCE must notify the State any time a subcontractor is placed on a corrective action plan. MCE will provide progress of CAP at the request of the State. CAP closure shall be reported to the State as appropriate.
- All subcontractors must fulfill all state and federal requirements and requirements of the contract (including any amendments) that are appropriate to the services or activities delegated under the subcontract (see 42 CFR 422.504(i)(4)).
- The MCE shall submit a plan to the State on how the subcontractor will be monitored for debarred employees (see 42 CFR 438.610).
- The MCE must submit an MCE oversight and monitoring plan to the State for review and approval during Readiness Review and annually within 60 days of new plan year (see 42 CFR 438.66).
- The MCE shall be responsible for the administration and management of all aspects of the contract, including all subcontracts/subcontractors. The MCE shall ensure that the subcontractor shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the subcontract for purposes of the contract without prior written approval of the MCE. No subcontract, provider agreement, or delegation of responsibility terminates or reduces the legal responsibility of the MCE to the State to ensure that all activities under the contract are carried out in compliance with the contract.
- Should the MCE have a subcontract for utilization management activities for the pharmacy, the MCE must ensure that compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee (see 42 CFR 438.210(e) and 42 CFR 438.3(s)).
- If the MCE subcontracts with an entity specifically to conduct care coordination, care management, or service coordination functions, including comprehensive assessments or reassessments and/or developing or authorizing plans of care (as outlined in 42 CFR 438.208), such subcontractor shall not provide any direct long-term services and supports. This does not preclude nursing facilities or hospitals contracted with the MCE to deliver services from completing and submitting pre-admission evaluations. The care coordinators, care managers, or service coordinators must be in Indiana—The State encourages MCEs who choose to subcontract in this area to consider community-based disability and community-based aging organizations (see IC 12-10-1-6).
- The MCE must provide instruction for all direct services, subcontractors, and providers regarding the MCE's written procedure for the provision of language interpretation and translation services (as defined in IC 16-46-11.1-3) for any member who needs the services, including but not limited to enrollees with Limited English Proficiency. The MCE shall provide instruction to direct service subcontractors and providers on disability access, person-centered thinking, 42 CFR 441.301(c) settings rule compliance, and ADA compliance.
- The MCE and its subcontractors must comply with obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (see 42 CFR 403.812 and Health Information Technology for Economic and Clinical Health Act (HITECH) under the American Recovery and Reinvestment Act of 2009

(ARRA) and 45 CFR 164.524 and their accompanying regulations, as amended). The MCE shall require all its subcontractors to adhere to HIPAA standard transaction requirements.

- The MCE must comply with all subcontract requirements specified in 42 CFR 438.230 and 42 CFR 434.6. All subcontracts, provider contracts, agreements, or other arrangements by which the MCE intends to deliver services required under the contract are subject to review by the State. The State may waive its right to review subcontracts, provider contracts, agreements, or other arrangements. Such waiver does not constitute a waiver of any subcontract requirements nor future waivers.
- The MCE must have policies and procedures addressing auditing and monitoring subcontractors' data, timeliness of data submissions, and performance (see 42 CFR 438.602). The MCE must integrate subcontractors' financial and performance data (as appropriate) into the MCE's information system to report MCE performance and confirm contract compliance accurately and completely. The State reserves the right to audit the MCE's subcontractors' self-reported data and change reporting requirements at any time with reasonable notice (see 42 CFR 438.3(h)). The State may require corrective actions and will assess liquidated damages, as specified in Exhibit 2, *Contract Compliance and Pay for Outcomes* of the contract, for noncompliance with reporting requirements and performance standards (see 42 CFR 422.504(m)(3) and 42 CFR 438.66).
- The MCE is prohibited from subcontracting with providers who have been excluded from the federal government or by the Indiana Health Coverage Program (IHCP) for fraud or abuse. The MCE shall be responsible for checking the lists of providers currently excluded by the state and federal government every 30 days. The MCE must ensure that when the IHCP disenrolls a provider, the MCE also terminates the provider agreement for the *Indiana Pathways for Aging* program (see 42 CFR 438.602 and 42 CFR 438.610).
- If the MCE uses subcontractors, the subcontractors shall meet the same requirements as the MCE including requirements related to experience with LTSS and/or experience with older adults, when noted (see 42 CFR 438.3(o), 42 CFR 438.71(d), and 42 CFR 438.208(c)). The MCE shall demonstrate its oversight and monitoring of the subcontractor's compliance with these requirements (see 42 CFR 438.66). The MCE must require subcontractors providing direct services to have quality improvement goals and performance improvement activities specific to the types of services provided by the subcontractors. The MCE should include in the request for approval of any direct service or care provider a summary of the subcontractor's experience in providing such service and/or care.
- While the MCE may choose to subcontract claim processing functions, or portions of those functions, with a state-approved subcontractor, the MCE must demonstrate that the use of such subcontractors is invisible to providers, including out-of-network and self-referral providers, and will not result in confusion to the provider community about where to submit claims for payments.

For example, the MCE may elect to establish one post office box address for submission of all out-of-network provider claims. If different subcontracting organizations are responsible for processing those claims, it is the MCE's responsibility to ensure that the subcontracting organizations forward claims to the appropriate processing entity. Using this type of method will not extend the timeliness standards for claim processing. *In this example, the definition of date of receipt is the date of the claim's receipt at the post office box.*

- In accordance with 42 CFR 438.3(h) the MCE and its subcontractors shall maintain all books, documents, papers, accounting records, and other evidence pertaining to all costs incurred under the contract. At any time, the MCE must allow duly authorized agents of the State, CMS, the Office of the Inspector General, the Comptroller General (and their designees) to inspect premises, physical facilities, and equipment where Medicaid related activities or work is conducted. The right to audit exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later (see 42 CFR 422.504(d)). Copies shall be furnished, at no cost to the State, if requested.

2.j Confidentiality of Members' Medical Records and Other Information

The MCE must ensure that members' medical records, as well as any other health and enrollment information that contains individually identifiable health information, is only used and disclosed in accordance with the privacy requirements set forth in the *Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule* (see *45 CFR* parts 160 and 164, subparts A and E). The MCE must also comply with all other applicable state and federal privacy and confidentiality requirements.

2.j.1 Disclosure of Health Records Requiring Member Consent

Member consent must be obtained prior to the release of certain health records. Disclosure of health records which necessitate prior member consent include, but are not limited to, the following:

- **Psychotherapy Notes**

- In accordance with *HIPAA*, *45 CFR 164.501*, and *45 CFR 164.508*, *psychotherapy notes* should not be released unless prior member consent is obtained and documented. This includes the disclosure of psychotherapy notes for treatment purposes to a health care provider other than the originator of the notes [*45 CFR 164.508(a)(2)*].

A notable exception exists for disclosures required by other law, such as for mandatory reporting of abuse, and mandatory “duty to warn” situations regarding threats of serious and imminent harm made by the patient.

- The *Privacy Rule* defines *psychotherapy notes* as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the patient's medical record. Psychotherapy notes do not include any information about medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, or results of clinical tests; nor do they include summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. Psychotherapy notes also should not include any information that is maintained in a patient's medical record.

- **Substance Abuse Disorder Treatment**

- In accordance with *42 CFR Part 2*, information about substance use disorder treatment should only be released if member consent has been obtained. *Part 2* protects “records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to substance abuse education prevention, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States.”

- **HIV/AIDS**

- In accordance with *IC 16-41-8-1* and *410 IAC 1-2.5-78*, written member consent should be obtained prior to disclosure of information about HIV/AIDS.

2.k Internet Quorum Inquiries

Internet Quorums (IQs) are communication received by the public on FSSA's website. IQs include managed-care-related questions. FSSA Communications department intakes these messages and assigns a tracking number, which starts with IMA followed by a series of numbers (IMA00532852). IQs are generally official inquiries or concerns from constituents (i.e., members, providers, claim aids, or member representatives). Examples of subject matter include requests for assistance, provider claims disputes, member transportation issues, and legislative inquiries on behalf of a constituent.

IQs are researched by the State to identify relevant member information and respective MCE enrollment. The State will forward an MCE-related concern to the MCE compliance officer. A timeline with response due date is provided and will be strictly enforced. Failure by the MCE to provide a timely and satisfactory response to IQ inquiries will subject the MCE to the liquidated damages set forth in Exhibit 2.

2.1 Material Change to Operations

A *material change to operations* is any change in overall business operations, such as policy, process or protocol which affects, or can reasonably be expected to affect member or provider services. All material changes must be communicated to members and/or providers at least 30 days prior to the effective date of the change. Prior to making a material change, the MCE must submit a request for change to the State for review and approval at least 60 days in advance of proposed change date.

2.m Conflict of Interest

The MCE shall ensure compliance with applicable laws and conflict of interest safeguards in accordance with 42 CFR 438.3(f).

For example, the MCE refers a member to a provider owned by the MCE, the MCE shall notify the member of the conflict of interest. MCEs must uphold conflict of interest standards within their subcontracting services.

2.n Data Requests

MCEs can submit data requests to the State for statistics to help manage their member populations. These data requests are produced by the State Data and Analytics team. The MCEs are not allowed to make data requests to any other State contracted entities, such as the State fiscal agent.

MCEs must submit request for data from the Office of Medicaid Policy and Planning (OMPP) by contacting their State contract compliance officer. The State reviews the data request to determine whether the data will be provided. Data will not be provided for the following scenarios:

- The MCE has access to this data via another mechanism (such as via the *834-enrollment roster*)
- Privacy concerns exists. Data will not be released for non-MCE enrolled members.

If the State approves the data request, the State contract compliance officer will forward the *Data Request Form* to the State Data and Analytics team. If the State denies the data request, the contract compliance officer will notify the MCE representative via email that the requested data will not be produced with explanation.

After the data request is granted, the State Data and Analytics team will send the data to the State contract compliance officer for review. Upon review by contract compliance officer, data will be forwarded to MCE.

2.o Maintenance of Records

The MCE shall adhere to the [FSSA Records Retention and Disposition Schedule](#) including any and all updates.

2.p Maintenance of Written Policies and Procedures

The MCE must develop and maintain written policies and procedures for each functional area in compliance with the Code of Federal Regulations, Indiana Code, Indiana Administrative Code, FSSA Policy and Procedure Manuals and the managed care contract. The policies and procedures must be categorically classified with distinct inventory number. Written guidelines shall be maintained for developing, reviewing, and approving all policies and procedures. The MCE must review all policies and procedures at least annually to ensure they reflect current practice and shall be updated as necessary. Reviewed policies shall be signed and dated by a key staff member. All medical and quality management policies shall be reviewed and

approved by the MCE's Medical Director. The State has the right to review all MCE policies and procedures. Should the State determine an MCE policy requires revision, the MCE shall work with the State to revise within the timeframes specified by the State. If the State determines the MCE lacks a policy or process required to fulfill the terms of the contract, the MCE must adopt a policy or procedure as directed by the State.

2.q Dissemination of Information

Upon request of the State, the MCE must distribute information prepared by the State, its designee, or the Federal Government to its members and/or providers in a time frame designated by the State.

2.r Access to Premises and Information

The MCE will allow duly authorized agents or representatives of the State or federal government, including CMS, the HHS Inspector General, the Comptroller General, or their designees or representatives, at any time, access to the MCE's premises, physical facilities, and equipment, the MCE providers' premises, physical facilities, and equipment or the MCE's subcontractors' premises, physical facilities, and equipment to inspect, audit, monitor, examine, excerpt, transcribe, copy or otherwise evaluate the performance of the MCE's or subcontractors' contractual activities and shall immediately produce all records or documents, including but not limited to financial, member or administrative records, books, contracts, and computer or other electronic systems requested as part of such review or audit.

The State or federal government may inspect and audit any financial, care management, member, administrative or other records of the MCE, its providers, or its subcontractors. There shall be no restrictions on the right of the State or the federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and the reasonableness of their costs or for any purpose the State or federal government deems necessary for administration or operation of the program. When requested by the State or federal government, the MCE must provide access to electronic records in any circumstance when it uses electronic records.

In the event right of access is requested the following shall be made available upon further request to the MCE, provider, or subcontractor:

- staff to assist in the audit or inspection effort,
- adequate space on the premises to reasonably accommodate the State or federal personnel conducting the audit or inspection effort, and
- timely and reasonable access to said party's personnel for the purpose of interview and discussion related to such documents.

The State or federal government may perform off-site audits or inspections to ensure that the MCE is compliant with contract requirements.

All inspections or audits will be conducted in a manner to not unduly interfere with the performance of the MCE's, provider's, or subcontractor's activities. All information so obtained will be accorded confidential treatment as provided under applicable law.

Throughout the duration of the contract, and after termination of the contract, the MCE must provide duly authorized agents of the State or federal government access to all records and material relating to the contract's provision of and reimbursement for activities contemplated under the contract. The rights of access are not limited to the required retention period, but shall last as long as records are retained, if longer. Such access shall include the right to inspect, audit and reproduce all such records and material and to verify reports furnished in compliance with the provisions of the contract. All information so obtained will be accorded confidential treatment as provided under applicable law.

The rights to access, inspect, and audit premises and contract records described in Section 6.10 of the *Indiana Pathways for Aging* scope of work exist for seven years from the final date of the contract period or from the date of completion of any audit, whichever is later. If the State, CMS, or the HHS Inspector General

determines there is a reasonable possibility of fraud or similar risk, these access and audit rights may be exercised at any time.

2.s Integration and Alignment of Medicare and Medicaid

Approximately 80% of *Indiana Pathways for Aging* program's population will be dually eligible for both Medicare and Medicaid. The State has identified the alignment and integration of these two programs in *Indiana Pathways for Aging* as key drivers to remove barriers to care as well as improve outcomes for dually eligible members.

- **Integration** – a delivery system that provides the full array of Medicaid and Medicare benefits to drive increased levels of care coordination and improved health outcomes.
- **Alignment** – the identification and elimination of conflicting requirements, competing incentives, and system gaps between the Medicare and Medicaid programs to reduce administrative burden and streamline policies and operations.

The MCE will maintain an ongoing commitment to work with the State and all relevant Indiana stakeholders to identify and promote the continued integration and alignment of Medicare and Medicaid benefits, processes, and systems for its *Indiana Pathways for Aging* enrollees consistent with program vision and goals.

Indiana Pathways for Aging supports a coordinated and integrated experience from the perspective of dually eligible members, which include, but is not limited to, the assessments and care coordination processes that span Medicaid and Medicare.

The MCE will fully cooperate with all State efforts to streamline the administration of Medicaid and Medicare programs—which may include, but is not limited to:

- **Readiness reviews** - the MCE's demonstrated ability to meet integration expectations
- **Quality and outcomes monitoring** - ensuring positive health outcomes for dually eligible members
- **Member enrollment** - seamless and efficient process for member intake and service delivery
- **Member marketing materials** - effective, targeted marketing for respective population
- **Grievance and appeals processes** - response system to quickly address member and provider related concerns

2.s.1 Coordination with Medicare

The MCE must coordinate all Medicare and Medicaid services for its full-benefit dually eligible members. This must include all reasonable efforts to coordinate care for dually eligible members regardless of Medicare service delivery system or Medicare plan benefit package—including traditional Medicare, unaligned Medicare Advantage plans, Chronic Conditions Special Needs Plans (C-SNPs), and Institutional Special Needs Plans (I-SNPs).

The MCE will ensure that services covered and provided are delivered without charge to members who are dually eligible for Medicare and Medicaid services.

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

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

The MCE must coordinate with all relevant State and social service agencies and community-based organizations to better identify and address both the medical and social needs of the member. The MCE will establish systems and processes to effectively refer and connect members to these agencies.

The MCE must provide continued member, provider, and staff education and assistance to promote the care experience of dually eligible members.

This should include, but is not limited to:

- **Member education and resources, such as:**

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

- **Provider education must cover, at a minimum:**

- Dual eligibility in Indiana for Medicare and Medicaid, and how it relates to specific provider,
- The expected care experience of dually eligible members in Indiana, and
- Coordination of services and benefits for dually eligible members, which should include, but is not limited to, billing and claim submission requirements.

- Care coordinator training as described in [Additional Required Training](#) as it relates to dually eligible members.

The MCE must ensure its systems and business processes support an integrated approach to care coordination and service delivery across Medicare and Medicaid programs. This includes the capacity to receive and load all Medicare claims data, including data from its aligned D-SNP programs, as well as Medicare claims data made available by the State, into its relevant case management systems and processes. This data should be demonstrably accessible for the purposes of care coordination and to support the coordination of applicable member Medicare and Medicaid benefits.

The MCE is required to demonstrate integration of all data and information into relevant systems and processes and accessibility by MCE staff to use that data and information to facilitate effective coordination and alignment goals.

2.s.2 Dual Eligible Special Needs Plan (D-SNPs) Requirements and Coordination

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

The MCE must obtain Centers for Medicare & Medicaid Services (CMS) approval to operate a Dual Eligible Special Needs Plan (D-SNP) in Indiana by or before January 1, 2024, and demonstrate sufficient readiness at *Indiana Pathways for Aging* in Readiness Review activities prior to go-live. The MCE must designate a single point of coordination on the member's Interdisciplinary Care Team (ICT) for its dually eligible members enrolled in its aligned D-SNP to coordinate member care across Medicaid and Medicare.

The MCE will make ongoing efforts to coordinate with its aligned D-SNP to maximize integration of Medicare and Medicaid benefits and to achieve progressively higher levels of administrative alignment and clinical care coordination across all *Indiana Pathways for Aging* MCE and D-SNP processes and systems. This will include alignment and integration of Indiana's SMAC requirements as well as the D-SNP model of care (MOC).

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

The MCE will commit necessary staff and time resources for State-requested meetings with other *Indiana Pathways for Aging* MCEs and aligned D-SNPs, other State agencies, stakeholders, and partners. These meetings will focus on topics such as improving integration and alignment, assessing current performance of the MCE and its aligned D-SNP, fostering program collaboration and innovation, and improving care coordination practices.

Within one year of *Indiana Pathways for Aging* go-live, the MCE must implement a single unified member benefit card for all dually eligible members enrolled in its aligned D-SNP. The single benefit card should provide the dually eligible member with seamless access to all plan benefits regardless of payor source (Medicare or Medicaid).

An MCE seeking D-SNP status for the first time shall be aware of the general timeline for D-SNP implementation as it intersects with the *Indiana Pathways for Aging* program.

CMS continues to develop this timeline therefore it is subject to change without notice to the State. CMS will provide more specific due dates as applicable. The MCE is responsible for monitoring CMS information regarding dates of submission for all necessary D-SNP related documentation. It is also responsible for understanding all State-specific requirements for the SMAC and any other D-SNP related materials.

Section 3: Covered Benefits and Services

This section provides information about the services that are covered and explicitly excluded from the various programs covered by the managed care umbrella. Covered services for *Indiana Pathways for Aging* are identified separately when necessary. Information is also included about in-network versus out-of-network services and self-referral services.

Continuity of care is critical to member outcomes and this section also includes information about members who must transfer to another program due to meeting an exclusion as listed in [Introduction](#).

3.a Indiana Pathways for Aging Covered Services

The services covered by MCEs, for which capitation payments are received, must be provided to the member in an amount, duration, and scope that is no less than the IHCP-covered services detailed in State regulation *405 IAC 5-2-17*. Services excluded from the MCE's scope of responsibility but covered by the Indiana Health Coverage Programs (IHCP) are referred to as *carve-outs* and are addressed later in this section.

In instances where members have both Medicare and Medicaid, Medicare will be the first payer for all Medicare covered services; this applies to those services covered by both Medicare and Medicaid. For services not covered by Medicare, Medicaid may serve as the primary coverage. For additional information, see [Third-Party Liability \(TPL\)](#).

Detailed explanations of Medicaid-covered services and limitations are cited in *405 IAC 5*. The following are broad categories of services provided by the MCE in arrangement with the State:

Table 1 - Indiana Pathways for Aging Covered Services

Service ¹		State Plan Medicaid	State Plan Medicaid plus HCBS	Reference
Physicians' Surgical and Medical Services*	Diagnostic	Covered Service		405 IAC 5-25
	Preventive	Covered Service		
	Therapeutic	Covered Service		
	Rehabilitative	Covered Service		
	Palliative	Covered Service		
Hospital Services*	Inpatient	Covered Service		405 IAC 5-17
	Outpatient	Covered Service		
Laboratory and Radiology Services		Covered Service		405 IAC 5-18 405 IAC 5-27
Home Health Services**	Physical Therapy**	Covered Service Note: also covered outside of home health services		405 IAC 5-16 405 IAC 5-22
	Occupational Therapy**			
	Respiratory Therapy*			
	Speech Pathology*			
	Renal Dialysis	Covered Service		405 IAC 5-16
Medical Supplies and Equipment**	Medical Supplies	Covered Service		405 IAC 5-19
	Durable and Home Medical Equipment	Covered Service		
	Prosthetic Devices	Covered Service		405 IAC 5-19
	Hearing Aids	Covered Service		405 IAC 5-19
	Dentures	Covered Service		405 IAC 5-19
Transportation*	Emergency*	Covered Service		405 IAC 5-30
	Non-emergency Medical	Covered Service		

Service ¹		State Plan Medicaid	State Plan Medicaid plus HCBS	Reference
Nursing Facility Services*	Long-term**	Covered Service, <i>excluding out of state</i>		405 IAC 5-31-1
	Short Term	Covered Service, <i>excluding out of state</i>		
Long Term Acute Care Hospitalization**		Covered Service		405 IAC 5-33
Rehabilitative Unit Services – Inpatient**		Covered Service		405 IAC 5-32
Health Centers	Rural Health Clinics	Covered Service		405 IAC 5-16-5
	Federally Qualified Health Centers (FQHCs)	Covered Service		
Hospice Care**		Covered Service		405 IAC 5-34
Organ Transplants**		Covered Service		405 IAC 5-3-13
Nurse-Midwife Services		Covered Service		405 IAC 5-22-3
Nurse Practitioners		Covered Service		405 IAC 5-22-4
Diabetes Self-management Services*		Covered Service		405 IAC 5-36
Care Conferences		Covered Service		
Dental Services		Covered Service		405 IAC 5-14
Orthodontics**		Covered Service		
Drugs	Legend	Covered Service, <i>Some Carved Out</i>		405 IAC 5-24
	Non-legend	Covered Service		
Smoking Cessation & Tobacco Dependence Treatment		Covered Service		405 IAC 5-37
Residential Substance Use Disorder (SUD) Services*		Covered Service		
Mental Health/ Behavioral Health Services*	Inpatient**	Covered Service		405 IAC 5-20
	Outpatient**	Covered Service		405 IAC 5-20-8
	State Psychiatric Hospital	Carved Out		Carved out service
	Medicaid Rehabilitation Option (MRO) - Community Mental Health Centers	Carved Out		405 IAC 5-21
	Adult Mental Health and Habilitation (AMHH) – 1915(i)	Carved Out		405 IAC 5-21.6
	Behavioral and Primary Healthcare Coordination (BPHC) – 1915(i)	Carved Out		405 IAC 5-21.8
Member Self-Referral Services*	Chiropractors*	Covered Service		405 IAC 5-12
	Immunizations	Covered Service		
	Eye and Vision Care Services	Covered Service		405 IAC 5-23
	Family Planning Services	Covered Service		
	Podiatrist*	Covered Service		405 IAC 5-26
	Routine Dental Services	Covered Service		405 IAC 5-14
	Psychiatric Services	Covered Service		405 IAC 5-20
	Emergency Services	Covered Service		405 IAC 5-17
	Urgent Care Services	Covered Service		
	Diabetes Self-Management Services	Covered Service		405 IAC 5-36
	Behavioral Health Services	Covered Service		405 IAC 5-20

Service ¹		State Plan Medicaid	State Plan Medicaid plus HCBS	Reference
Out-of-State Medical Services*	Emergency Services	Covered Service		405 IAC 5-5
	Acute General Hospital Care**	Covered Service in the following designated cities:		
	Physician Services**	• Louisville, Kentucky		
	Dental Services**	• Cincinnati, Ohio		
	Pharmacy Services**	• Harrison, Ohio		
	Transportation Services**	• Hamilton, Ohio		
	Therapy Services**	• Oxford, Ohio		
	Podiatry Services**	• Sturgis, Michigan		
	Chiropractic Services**	• Watseka, Illinois		
	Durable Medical Equipment**	• Danville, Illinois		
	Medical Supplies**	• Owensboro, Kentucky		
	Diagnostic Services**	And if specific criteria is met for:		
	Hospice Services**	• Chicago, Illinois (42 CFR 456.3)		405 IAC 5-34-3 405 IAC 5-5
	Nursing Facilities	Not Covered		405 IAC 5-5
	ICFs/IID LOC	Not Covered		
	Home Health Services	Not Covered		
Long-Term Care Facilities	Not Covered			
Included HCBS 1915(c) LTSS Waiver Services, for those eligible and with HCBS LOC Determination*	Adult Day Service	Not Covered	Covered Service	405 IAC 5-21.6-8
	Attendant Care	Not Covered	Covered Service	IAC will be provided for services as defined by the State.
	Informal Caregiver Coaching and Behavioral Management	Not Covered	Covered Service	
	Home and Community Assistance	Not Covered	Covered Service	
	Respite	Not Covered	Covered Service	
	Community Home Share Assisted Living	Not Covered	Covered Service	
	Community Transition	Not Covered	Covered Service	
	Home Delivered Meals	Not Covered	Covered Service	
	Home Modification Assessment	Not Covered	Covered Service	
	Home Modifications	Not Covered	Covered Service	
	Integrated Health Care Coordination	Not Covered	Covered Service	
	Nutritional Supplements	Covered Service**	Covered Service	405 IAC 5-24-9
	Participant Directed Attendant Care	Not Covered	Covered Service	IAC will be provided for services as defined by the State.
	Personal Emergency Response System	Not Covered	Covered Service	
	Pest Control	Not Covered	Covered Service	
	Specialized Medical Equipment and Supplies	Not Covered	Covered Service	
	Structured Family Caregiving	Not Covered	Covered Service	
	Vehicle Modifications	Not Covered	Covered Service	
HCBS services are new to the <i>Indiana Pathways for Aging</i> program. IAC will be provided for services as defined by the State.				

¹In Traditional FFS Medicaid benefits and services.

*Prior Approval Required Under Certain Circumstances. | **Prior Approval Always Required.

For Limitations, Coverage, and if services are reimbursed by the MCE see Contract Exhibit 3, *Program Description and Covered Benefits*.

Special provisions for specific types of service, coverage and payment policies apply to some services and providers. These provisions, discussed later in this section, include the following:

- Emergency Services
- Pharmacy
- Self-Referral Services
- Out-of-Network Services
- Behavioral Health Services
- Prevention and Wellness
- Federally Qualified Health Centers (FQHCs) And Rural Health Clinics (RHCS)
- 24-Hour Nurse Call Line
- *Indiana Pathways for Aging* Carve-Outs and Excluded Services
- State Plan Authority Long Term Services and Supports
- Home and Community Based Services (HCBS)
- Participant-Directed Attendant Care Services (PDACS)
- Informal Caregiver Support
- Continuity Of Care

3.b Emergency Care

The MCE must cover emergency services without the need for prior authorization or the existence of a contract with the emergency care provider. Services for treatment of an emergency medical condition, as defined in *42 CFR 438.114*, *IC 12-15-12* (subject to the *prudent layperson* standard) and *405 IAC 5-2-9*, must be available 24 hours a day, seven days a week.

The MCE must contract with urgent care clinics. Urgent care clinics must be made available no less than 11 hours each day Monday through Friday and no less than five hours each day on the weekend.

The MCE must cover the medical screening examination, as defined by the *Emergency Medical Treatment and Active Labor Act (EMTALA)* regulations at *42 CFR 489.24*, provided to a member who presents to an emergency department with an emergency medical condition. The MCE must also comply with all applicable emergency services requirements specified in *IC 12-15-12*. For *Indiana Pathways for Aging*, the MCE must reimburse out-of-network emergency department providers at 100% of the Medicaid rate, unless other payment arrangements are made.

The MCE is required to reimburse for the medical screening examination and facility fee for the screening. The MCE 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 MCE authorized this treatment. The MCE must 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*, the MCE may **not**:

- limit what constitutes an emergency medical condition to those on lists of diagnoses or symptoms.
- 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.
- deny or pay less than the allowed amount for the Current Procedural Terminology (CPT) code on the claim without offering the provider the opportunity for a medical record review.

- refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent's failure to notify the MCE of the member's screening and treatment within 10 calendar days of the presentation for emergency service.
- refuse to cover services if a representative of the MCE instructed the member to seek emergency services.
- hold the member liable for payment concerning the screening and treatment necessary to diagnose and stabilize the condition.
- 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 MCE may not challenge the determination.

The MCE must comply with policies and procedures set forth in [Emergency Services](#) provider reference module regarding emergency department services, IHCP Provider Bulletins regarding emergency room services, additional relevant information and any updates thereto.

If the MCE chooses to use a list of diagnosis codes to initially determine whether a service may be an emergency, the MCE must, at a minimum, use the State's [Emergency Department Autopay List](#), accessible from the [Code Sets page](#). The MCE must check, at a minimum, the diagnosis codes in fields 67 and 67A-E on the UB04 and 21A-F on the CMS 1500 against the emergency department autopay list.

The MCE's provider remittance advices for claims reduced to a screening fee shall include a notice alerting providers:

- where to submit medical records for prudent layperson review.
- that the provider has 120 days to submit medical records for prudent layperson review.
- the location where the provider can find any additional requirements for the submission of medical records for prudent layperson review.

If a prudent layperson review determines the service was not an emergency, the MCE must reimburse for physician services billed on a CMS-1500 claim. The MCE must reimburse for facility charges billed on a UB-04 if a prudent layperson review determines the service was not an emergency.

Note: When the MCE 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 medicine, nursing, or social work. A prudent layperson reviewer would no longer be qualified after an average of 2-3 years spent on the job, due to on-the-job medical training/experience and would require a replacement.

The MCE must have the following mechanisms in place to facilitate payment for emergency services and manage emergency room utilization:

- mechanism in place for a plan provider or MCE representative to respond within one hour to all emergency room providers 24 hours a day, seven days a week. The MCE will be financially responsible for the post-stabilization services if the MCE fails to respond to a call from an emergency room provider within one hour.
- mechanism to track the emergency services notification to the MCE (by the emergency room provider, hospital, fiscal agent, or member's PMP) of a member's presentation for emergency services.
- mechanism to document a member's PMP's referral to the emergency room and pay claims accordingly.
- mechanism in place to document a member's referral to the emergency room by the MCE's 24-Hour Nurse Call Line and pay claims resulting from such referral as emergent.
- mechanism, policies, and procedures for conducting prudent layperson reviews within 30 days of receiving medical records.
- mechanism and process to accept medical records for a prudent layperson review with an initial claim and after a claim has processed. The MCE must, at a minimum, allow a provider to submit medical records for a prudent layperson review within 120 days of a claim's adjudication.

3.b.1 Inpatient Hospitalization Notification

With appropriate consent, the MCE shall notify a member's physician when a member is hospitalized or receives Emergency treatment. This notice must be provided within five calendar days of the hospital inpatient admission or Emergency treatment. The MCE must maintain strategies to receive hospital notification of inpatient admissions to facilitate meeting this requirement. An example is offering incentives to encourage notifications.

3.b.2 Post-Stabilization Services

As described in 42 CFR 438.114(e), 42 CFR 422.113(c), and IC 12-15-12-17, the MCE must cover services related to an Emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or, to improve or resolve the member's condition. The MCE must demonstrate to the State that it has a mechanism in place to respond to requests for authorization to continue post-stabilization care. MCEs must respond to these requests within one hour, 24 hours per day, seven days per week.

The MCE is financially responsible for:

- services obtained within or outside the network that are pre-approved by a plan provider or MCE representative.
- post-stabilization services that are not pre-approved but administered to a member to maintain the stabilized condition within one hour of the request to the MCE for pre-approval of further post-stabilization services.
- reimbursement for post-stabilization services when:
 - MCE does not respond within one hour to a request for pre-approval,
 - MCE cannot be contacted, or
 - MCE and treating physician cannot reach an agreement concerning the members' care and an MCE provider is not available for consultation.
 - In this situation, the MCE must give the treating provider the opportunity to consult with a plan provider and the treating provider may continue with the care of the patient until a plan provider is reached or one of the following conditions is met:
 - A plan provider with privileges at the treating hospital assumes responsibility for the member's care,
 - A plan provider assumes responsibility for the member's care through transfer,
 - An MCE representative and the treating provider reach an agreement concerning the member's care, or
 - The member is discharged.

3.c Pharmacy

Prescription drugs including injections and infusions, certain over the counter drugs, and pharmacy supplements are benefits to be covered by the MCE in *Indiana Pathways for Aging* program.

In the first year of the program, the MCE must provide 120 days of continuity of care for all pre-existing drug regimens for enrolled members. Beginning in year two, MCE must provide 90 days of continuity of care for all pre-existing drug regimens for all new members. This will allow time for the PBM to work with the prescribing provider to negotiate future drug regimens.

Pursuant to 405 IAC 1-14.6-10, all over the counter, legend and non-legend drugs will not be included in the established rate and will be reimbursed separately by the pharmacy benefit. Physician-administered drugs which are administered in a long-term care (LTC) setting (to include LTSS received in a member's home) will also be covered under the pharmacy benefit.

Covered drugs may be subject to utilization management that is no stricter than Fee for Service (FFS) in amount, duration, and scope.

The MCE must ensure all claims (including emergency claims) from a non-IHCP pharmacy will reject. In addition, all claims (except emergency claims) from a non-IHCP prescribing provider will reject.

The MCE must abide by *42 CFR 438.3(s)*, *CMS- 2390-F* and *P.L. 115-27*. The MCE must support the State in promptly responding to public and legislative inquiries involving the design and management of the MCE's pharmacy benefit. If the MCE elects to subcontract with a PBM, the MCE shall ensure compliance with all subcontracting requirements, including but not limited to conducting regular audits and monitoring of the subcontractor's data and performance, as well as requiring their PBM to conduct regular audits of their pharmacy provider networks.

MCEs will follow a Statewide Uniform Preferred drug list (SUPDL) for drugs listed in the classes on the fee-for-service (FFS) preferred drug list. Unification of the PDL includes prior authorization (PA), step edit, and utilization edit criteria. For drugs not in the SUPDL, the MCE must provide the utilization edit criteria to the State for approval. The utilization edit criteria will be reviewed by the State Pharmacy Team. The edit criteria must not be more restrictive to FFS utilization edit criteria.

The MCE may only set a Maximum Allowable Cost (MAC) rate on a multiple source drug available from at least two manufacturers. The MAC rate may not be applied when the brand product is preferred over available generics on the SUPDL.

If directed as such by the State, the MCE shall discontinue use of a commercial discount and commercial rebate agreements with pharmaceutical manufacturers for IHCP member pharmacy benefits or consolidate the pharmacy benefit under the FFS program.

The MCE shall develop an escalation process for specified unique review processes and requests submitted by state or federal legislative authority, news media, and/or of a controversial nature.

3.c.1 Drug Rebates

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

The MCE must comply with the requirements under *Section 1927* of the *Social Security Act*. In accordance with the *Affordable Care Act*, manufacturers that participate in the Medicaid drug rebate program are required to pay rebates for drugs dispensed to individuals enrolled with a Medicaid Managed Care Organization. To facilitate collection of these rebates, the State shall include all MCE utilization data of *Indiana Pathways for Aging* when requesting quarterly rebates from manufacturers as well as in quarterly utilization reports to CMS. The MCE must completely, timely, and accurately submit their outpatient drug encounter data to the State. The MCE must comply with all file layout requirements including, but not limited to format and naming conventions and submission of paid amounts. The State intends to use and share the MCE paid amount information on the State's outpatient drug claim extracts for rebate purposes.

Requirements for outpatient encounter claims are outlined in *Section 9.8* of the *Indiana Pathways for Aging* scope of work. For information on reporting, refer to [Performance Reporting](#), *Section 10.0* of the *Indiana Pathways for Aging* scope of work, and the *MCE Reporting Manual*.

The MCE must comply with *42 USC 256B* and *340B*-related State policies and any updates thereto. The MCE must monitor claims for provider compliance with federal and state billing requirements pertaining to *340B*-sourced drugs. The MCE is responsible for providing provider education regarding correct billing (for example: Qty, HCPCS conversion factor and NDCs). The MCE must collaborate with all necessary parties to prevent duplicate discounts.

The MCE must require providers to use *340B* claim modifiers to accurately access rebates. The MCE must ensure that all *340B* claims contain modifiers and that *340B* claims submitted by contract pharmacies are identified for accuracy. *340B* claim modifiers are listed in the following table.

340B Claim Modifiers

Pharmacy Claims	Physician-Administered Claims
NCPDP field number 420-DK, SCC of "20", indicates product dispensed on the claim was a 340B product; and/or NCPDP field number 423-DN, BCD code of "08", indicates cost of claim is based on 340B pricing (AAC)	JG - Drug or biological acquired with 340B drug pricing program discount; and/or TB - Drug or biological acquired with 340B drug pricing program discount, reported for informational purpose
Contract pharmacies are permitted if a mechanism is in place to identify 340B claims	

The MCE must have procedures in place to exclude utilization data for drugs subject to discounts under the 340B Drug Pricing Program from the utilization reports submitted to the State. Specific plans for excluding utilization data should be detailed and agreed upon between the MCE and the State and may use tools including, but not limited to, modifiers, billing instructions, and processes to correctly identify a 340B patient.

The MCE must, on an ongoing basis, monitor claims for provider compliance with federal and state billing requirements pertaining to 340B-sourced drugs. The MCE is fully responsible for ensuring that its providers bill for 340B drugs completely in compliance with federal and state requirements, such as prevention of duplicate discounts. The MCE must maintain records that are clear and auditable that include billing instructions and methods by which 340B claims are excluded from Medicaid reimbursement. The MCE shall allow the State access to any data upon its request to records related to 340B purchased drugs, exclusion from Medicaid reimbursement, and utilization reports.

Additionally, the MCE must assist the State, or the State's PBM Contractor, in resolving drug rebate disputes with the manufacturer. The MCE will work with the State to require resubmission and correction of claims from providers pursuant to billing errors or manufacturer rebate disputes in a timeframe designated by the State. In the event that a duplicate discount, diversion, or other impermissible utilization of drugs obtained through the 340B program derived from MCE utilization is substantiated through appropriate means, the MCE will be responsible for repayment of the duplicate discount and any sanction resulting therefrom. The State will not be responsible for payment for duplicate discounts.

3.c.2 PDL and Formulary Requirements

The MCE must follow the State's Unified Preferred Drug List (SUPDL) and maintain a State approved PDL (for drugs not on the SUPDL) for the MCE's *Indiana Pathways for Aging* packages. The MCE must use the SUPDL as its formulary and may not develop and use its own PDL for any therapeutic categories that are part of the SUPDL. Secondary claims paid by the MCE must follow the SUPDL. The State will provide the Contractor with at least 30 calendar days' notice of any change to the SUPDL, except those changes resulting from a drug shortage, recall or discontinuation, and the MCE will have an additional 15 calendar days to implement the change, including any system change. A drug that is on the SUPDL must have the same criteria and forms as the FFS PDL even if it is reimbursed as a medical claim.

The formulary and non-formulary covered drug lists must support the coverage and non-coverage requirements for legend and non-legend drugs by Indiana Medicaid. More information can be found in 405 IAC 5-24-3, 405 IAC 5-24-4, 405 IAC 5-24-5 and 407 IAC 3-10-1. In accordance with CMS-2390-F, the MCE must demonstrate prescription drug coverage consistent with the amount, duration, and scope of the fee-for-service program. The MCE must follow the SUPDL prior authorization criteria for SUPDL drug classes.

The MCE must submit any changes to the contents of the approved non-formulary drug list and any changes to prior authorization or medical necessity criteria applied to the non-formulary drug list to the State at least 60 days prior to the intended implementation date. The State may disapprove or modify the proposed changes within 30 days of receipt.

The MCE must utilize a Pharmacy and Therapeutics Committee which must meet regularly to make recommendations for changes to non-formulary covered outpatient drugs.

The SUPDL and non-formulary covered drug lists must be made readily available to providers in the MCE's network and to the MCE's members. The SUPDL and non-formulary covered drug lists must be updated to reflect all changes in the status of a drug or addition of new drugs.

Consistent with the requirements of *Indiana Pathways for Aging* scope of work Section 6.11, the MCE must develop provider education and outreach aimed at educating providers about the *Indiana Pathways for Aging* SUPDL and non-formulary covered drug lists to ensure appropriate prescribing for members based on the member's benefit plan.

3.c.3 Dispensing, Monitoring, and MHQAC Reporting Requirements

The MCE must administer pharmacy benefits in accordance with State pharmacy policy and all applicable state and federal laws and regulations. The MCE must comply with the requirements of *IC 12-15-35.5-3* in establishing prescribing limits to mental health drugs. For any drugs which require prior authorization, the MCE will provide a response by telephone or other telecommunication device within 24 hours of a request for prior authorization. Additionally, the MCE must provide for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency as required under *42 U.S.C 1396r-8(d)(5)(B)*. The MCE must employ an automated system for approval of a 72-hour emergency supply of a restricted drug. The automated system shall allow the pharmacist to dispense the 72-hour supply and then follow-up with the MCE or provider the next business day.

For the SUPDL drug classes, the MCE's quantity limits and age edits must follow the SUPDL unless otherwise reviewed and prior approved by the State. The MCE shall comply with the requirements of *IC 12-15-35.5-3* in establishing prescribing limits to mental health drugs.

The MCE implementing a SUPDL must implement the prior authorizations approved for all plans, by the DUR Board. For non-SUPDL formulary covered drug classes, the MCE may require prior authorization requirements (e.g., general member information, a justification of need for drug related to the medical needs of the member and a planned course of treatment, as related to the number drug provided and duration of treatment, etc.).

The MCE is required to have a process in place to allow drugs that are medically necessary, but not included on the formulary or non-formulary lists in the SUPDL, to be accessed by members. The MCE shall utilize the prior authorization hierarchy, depicted below, when making prior authorization decisions.

Figure 1- Prior Authorization Hierarchy Pyramid

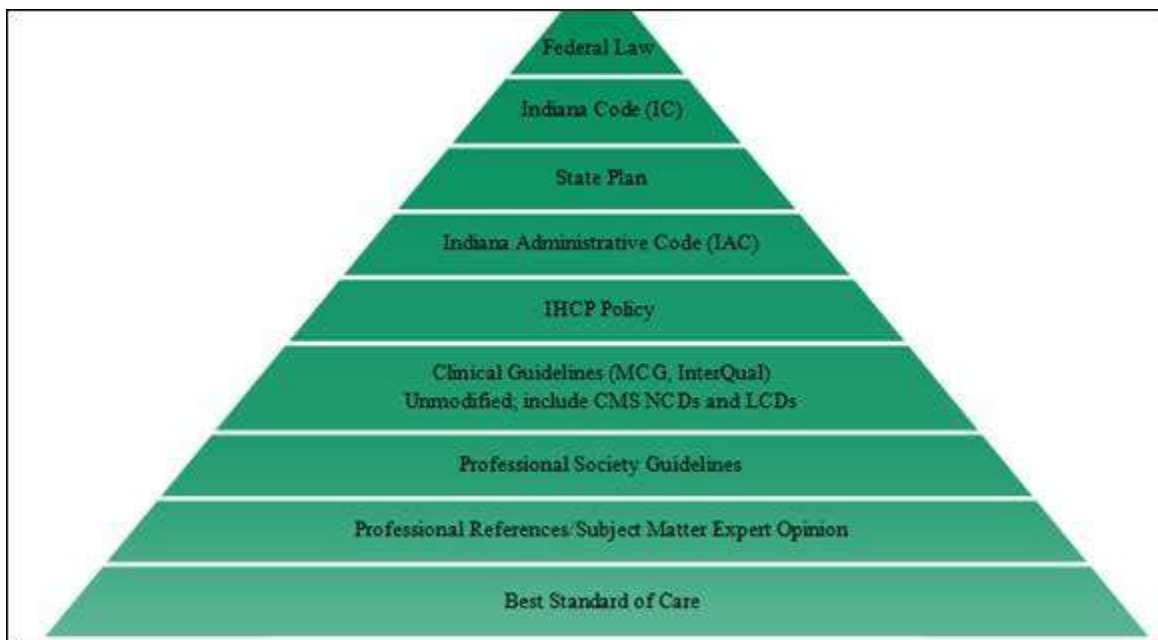


Image Alt Text: Figure 1 - Prior Authorization Hierarchy Pyramid (from top to bottom): 1. Federal Law, 2. Indiana Code (IC), 3. State Plan, 4. Indiana Administrative Code (IAC), 5. IHCP Policy, 6. Clinical Guidelines (MCG, InterQual) Unmodified; include CMS NCDs and LCDs, 7. Professional Society Guidelines, 8. Professional References/Subject matter Expert Opinion, 9. Best Standard of Care (End of list).

The MCE is required to accept prior authorization requests in various formats:

- via telephone,
- via fax,
- via web-based system, or
- in writing

To conform to 42 CFR 437-438.3(s) and CMS-2390-F, the MCE's criteria must be consistent with the amount, duration, and scope of the universal medically necessary prior authorization criteria for access to a prescription drug and may not be more stringent.

The MCE must provide online and real-time rules-based point-of-sale (POS) claims processing for pharmacy benefits. The MCE will maintain prospective drug utilization review edits and apply these edits at the POS. Independently developed and implemented PA criteria will be displayed, in a common format, alongside fee for service and other MCE criteria.

Additionally, the MCE must implement retrospective drug use review to identify patterns of fraud, abuse, overuse, or inappropriate or medically unnecessary care among physicians, pharmacists and individuals receiving benefits, or associated with specific drugs or groups of drugs.

- Administration of all criteria, common or independent, shall be performed by the MCE or its subcontracted PBM. The MCE shall regularly report findings on audits performed and outcomes completed by the PBM on providers.
- The MCE shall regularly report findings of audits performed, and outcomes completed by the MCE on its PBM.
- The MCE shall immediately report to the State claims processing errors and outages experienced by the MCE and/or its PBM and is required to provide a root cause analysis of the outage to the State in a timely manner.
- The MCE shall immediately report to the State claims processing errors and is required to provide a root cause analysis of the claims processing error to the State in a timely manner.

The MCE will monitor their PBM and report to the State when the PBM does not meet the following Service Levels:

- Escalation of requests to the appropriate contact within one business day
- Notification to the requestor of all escalations within one business day
- Provide call logs requested by the MCE within one business day
- Answer at least 90% of all calls within 30 seconds
 - "Answered" meaning the call is picked up by a qualified staff person
- Average hold time shall not exceed 30 seconds
- Resolve all PA requests within 24 hours
- Resolve 95% of all call queries with the first call
- Notify the MCE of call breaches or system downtimes within one hour

MHQAC Reporting Requirements

In accordance with IC 12-15-35-48, the DUR Board will review the prescription drug programs of the MCE at least one time per year. This review will include, but is not limited to, review of the following for non-formulary (i.e., non-SUPDL) covered drug list drug categories:

1. An analysis of the single source drugs requiring prior authorization in comparison to other MCE's prescription drug programs in the *Indiana Pathways for Aging* program.
2. A determination and analysis of the number and the type of drugs subject to a restriction.
3. A review of the rationale for the prior authorization of a drug and a restriction on a drug.

The DUR Board review shall include, but is not limited to, review of the following for all categories, including SUPDL drug categories:

1. A review of the number of requests an MCE received for prior authorization, including the number of times prior authorization was approved and disapproved.
2. A review of patient and provider satisfaction survey reports and pharmacy-related grievance data for a 12-month period.

The MCE must provide to the State information necessary for the DUR Board to conduct this review in the timeframe and format specified by the State. The State may identify therapeutic drug classes or specific drug products for which the MCE may be required to bring certain agents identified by the State to the DUR Board for review prior to the implementation of any changes in coverage or utilization management criteria.

The MCE must comply with any reporting requests required for submission to the DUR Board and the Mental Health Quality Advisory Committee (MHQAC). All mental health drugs described in *IC 12-15-35.5* are considered preferred and included on the SUPDL. The MCE must comply with all SUPDL requirements pertaining to mental health drugs.

The MCE must supply, on a quarterly basis, a report to the State and DUR Board of the number of member days of missed therapy due to prior authorization. The format of this report will be agreed upon by the MCE, the State, and the DUR Board. In addition, the MCE must comply with any additional reporting requests required for submission to the DUR Board. Please refer to the *MCE Reporting Manual* for more information on pharmacy reporting requirements.

The MCE must provide the DUR Board statistics at the DUR Board's monthly meetings. These statistics may include information on drug utilization or prior authorization reports as requested by the State.

3.c.4 E-Prescribing

The MCE must support e-Prescribing technologies to communicate the SUPDL and non-formulary covered drug lists to prescribers through electronic medical records (EMRs) and e-Prescribing applications. Much of the e-Prescribing activity is supported by prescribing providers through web and office-based applications or certified electronic health record (EHR) systems to communicate with the pharmacies. When EHR systems are used, the MCE must supply the EHR systems with information about member eligibility, patient history, and applicable PDL or drug formulary.

The MCE should consider an automated PA process using a rules-based clinical editing algorithm that integrates paid medical and pharmacy claims.

The MCE must develop provider education and outreach aimed at educating providers about the utilization of e-Prescribing technologies to ensure appropriate prescribing for members based on the member's benefit plan.

The MCE will work with the State and the fee for service PBM to transition the pharmacy benefit back to the FFS PBM if the State decides to implement the FFS pharmacy benefit for *Indiana Pathways for Aging* members.

3.c.5 Carve-Out of Select Drugs

Drugs and agents excluded from the MCE's capitation rate payment for an MCE's enrolled *Indiana Pathways for Aging* membership but included in the managed care benefit package are called *carved-out drugs*. The State's fiscal agent pays claims for carved-out drugs on a fee-for-service basis for the MCE's members. While these drugs are not the financial responsibility of the MCE, the MCE must ensure coordination of all Medicaid covered drugs and implement strategies to prevent duplication and fragmentation of care across the healthcare delivery system.

The following drugs are carved out of the *Indiana Pathways for Aging* program (full rating period):

- Hepatitis C drugs (GPI 125350 or 123599)
- Hemophilia Agents (GPI 8510)
- Spinal Muscular Atrophy Treatments (GPI 7470)
- Muscular Dystrophy Treatments (GPI 7460)
- CAR-T Therapies (GPI 21651010 and 21651075)
- Durable Genetic Therapy (GPI 8637)
- Cystic Fibrosis Agents (GPI 453020 and 453099)
- Sickle Cell Agents (GPI 828050 and 828070)

3.c.6 Other Covered Services and Benefits

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

3.c.7 SUPPORT Act Compliance

In accordance with the federal *Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities* (SUPPORT) Act, the MCE must implement and maintain the following processes and standards:

- Safety edits and claims review automated process for the State-approved maximum daily morphine limitation
- Safety edits and claims review automated process for the State-approved maximum daily morphine equivalent for treatment of chronic pain
- Claims review automated process that monitors when a client is concurrently prescribed opioids and benzodiazepines, or is concurrently prescribed opioids and antipsychotics
- Process that identifies potential fraud or abuse of controlled substances by Medicaid clients, enrolled prescribers, and enrolled dispensing pharmacies

Members in exempt categories shall continue to have appropriate access to opioid treatment. The exempt populations include individuals receiving hospice care, palliative care, cancer treatment, and residents of long-term care facility described in 42 USC 1396a(o)(3)(A)(ii).

3.c.8 Medicare Part D

The *Medicare Modernization Act of 2003* (MMA) created the Medicare Part D prescription drug benefit for individuals enrolled in Medicare Part A and Medicare Part B coverages. Medicare Part D drug benefit plans cover prescription drugs as approved by CMS. For full benefit dual eligible members, Indiana Medicaid covers medically necessary, federally and state reimbursable prescription drugs that are excluded from coverage by CMS under Medicare Part D benefit plans. MCE's coverage of CMS Medicare Part D excluded drugs are covered if the drug is medically necessary and federally reimbursable, when:

1. Ordered by a Primary Care Physician, attending physician, dentist or other authorized prescribing clinician; and
2. Dispensed by a pharmacist or a pharmacy intern acting under the direct supervision of a pharmacist in accordance with Indiana Board of Pharmacy Rules and Regulations.

Prescription drugs and therapeutic classes that are covered by a Medicare Part D drug benefit plan, but are not specifically listed in the Medicare Part D Drug List, are covered by the Medicare Part D drug benefit plan and are not covered by Indiana Medicaid. **Drugs eligible for coverage under Medicare Part D will not be covered under Medicaid if the member refuses Part D coverage.**

3.c.9 PBM Contracting

If the MCE elects to subcontract with a PBM, the MCE shall ensure compliance with all [subcontracts](#) requirements.

If the MCE enters into a contract or agreement with a Pharmacy Benefit Manager (PBM) for the provision and administration of pharmacy services, the contract or agreement shall be developed as a pass-through pricing model as defined below:

1. All monies related to services provided for the MCE are passed through to the MCE, including but not limited to, dispensing fees and ingredient costs paid to pharmacies, and all revenue received, including but not limited to pricing discounts paid to the PBM, rebates (including manufacturer fees and administration fees for rebating), inflationary payments, and supplemental or commercial rebates;
2. All payment streams, including any financial benefits such as rebates, discounts, credits, clawbacks, fees, grants, reimbursements, or other payments that the PBM receives related to services provided for the MCE are fully disclosed to the MCE, and provided to the State upon request; and
3. The PBM is paid an administrative fee which covers the cost of providing the PBM services as described in the PBM contract or agreement as well as margin.

The payment model for the PBM's administrative fee shall be made available to the State. The State reserves the right to request pharmacy claims-level payment information at any time. If concerns are identified, the State reserves the right to request any changes be made to the payment mode.

3.d Self-Referral Services

In accordance with state and federal requirements, the *Indiana Pathways for Aging* program includes some benefits and that are available to members on a self-referral basis. These self-referral services do not require a referral from the member's PMP or authorization from the MCE.

The MCE must include self-referral providers in its contracted network. The MCE and its PMPs may direct members to seek the services of the self-referral providers contracted in the MCE's network. The MCE cannot require that the member receive such services from network providers, unless otherwise noted.

Indiana Pathways for Aging members may self-refer to any IHCP provider qualified to provide the service(s). When *Indiana Pathways for Aging* members choose to receive self-referral services from IHCP-enrolled-self-referral providers who do not have a contractual relationship with the MCE, the MCE is responsible for payment to these providers up to the applicable benefit limits and at 98% of Indiana Medicaid FFS rates, except for certain situations described in the scope of work.

Members may not self-refer to a provider who is not enrolled in IHCP.

Services considered to be self-referral services are listed as such in [Table 1 - Indiana Pathways for Aging Covered Services](#) and are detailed further in 405 IAC.

The following services are considered self-referral services and therefore do not require a PMP referral:

- Chiropractic services may be provided by a licensed chiropractor, enrolled as an Indiana Medicaid provider, when rendered within the scope of the practice of chiropractic as defined in IC 25-10-1-1 and 846 IAC 1-1.
- Eye care services, except surgical services, may be provided by any provider licensed under IC 25-22.5 (Doctor of Medicine or doctor of osteopathy) or IC 25-24 (Optometrist).
- Routine Dental services may be provided by any in-network licensed dental provider IC 25-13 (Dental Hygienist) or IC 25-14 (Dentist).

- Podiatric services may be provided by any provider licensed under IC 25-22.5 (doctor of medicine or doctor of osteopathy) or IC 25-29 (doctor of podiatric medicine).
- Psychiatric services may be provided by any provider licensed under IC 25-22.5.
- Family planning services under federal regulation 42 CFR 431.51(b)(2) require a freedom of choice of providers and access to family planning services and supplies. Family planning services are those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. Family planning services also include sexually transmitted disease testing. Abortions and abortifacients are not covered family planning services, except as allowable under the federal Hyde Amendment. Members may self-refer to any IHCP provider qualified to provide the family planning service(s), including providers that are not in the MCE's network. Members may not be restricted in choice of a family planning service provider, so long as the provider is an IHCP provider. The [Family Planning Services](#) provider reference module provides a complete and current list of family planning services.
- Emergency services are covered without the need for prior authorization or the existence of an MCE contract with the emergency care provider. Emergency services shall be available 24 hours a day, seven days a week subject to the "prudent layperson" standard of an emergency medical condition, as defined in 42 CFR 438.114 and IC 12-15-12.
- Urgent care services.
- Immunizations are self-referral to any IHCP enrolled provider. Immunizations are covered regardless of where they are received.
- Diabetes self-management services are self-referral if rendered by an IHCP enrolled DSMT provider.
- Behavioral health services are self-referral if rendered by an in-network provider. Members may self-refer, within the MCE's network, for behavioral health services not provided by a psychiatrist, including mental health, substance abuse and chemical dependency services rendered by mental health specialty providers. The mental health providers to which the member may self-refer within network are:
 - Outpatient mental health clinics
 - Community mental health center (CMHC)
 - Psychologists
 - Licensed psychologists
 - Health services providers in psychology (HSPPs)
 - Licensed social workers (LSW)
 - Licensed clinical social workers (LCSW)
 - Psychiatric nurses
 - Independent practice school psychologists
 - Advanced practice nurses (APN) under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
 - Persons holding a degree in social work, marital and family therapy or mental health counseling (under the Clinic Option)

3.e Out-of-Network Services

With the exception of certain self-referral services, emergency medical care, and the requirements to allow continuity of care, the MCE may limit its coverage to services provided by in-network providers after the MCE has met the network access standards set forth in [Provider Education and Outreach](#). However, in accordance with 42 CFR 438.206(b)(4) the MCE must authorize and pay for out-of-network care if the MCE is unable to provide necessary covered medical services within the required time, distance (30 miles of the member's residence for primary care and 60 miles of the member's residence for specialty care by the MCE') and access standards by the MCE's provider network. In addition, after at least 30 days advance notice, the State may require the MCE to begin providing out-of-network care if the MCE is unable to provide necessary

covered medical services within the MCE's provider network within specified timeliness standards defined by the State.

The MCE must authorize these out-of-network services in the established timeframes and must adequately cover the service for as long as the MCE is unable to provide the covered services in-network. The MCE must require out-of-network providers to coordinate with the MCE with respect to payment. Per *42 CFR 438.206(b)(5)*, the cost to the member for out-of-network services shall be no greater than it would be if the services were furnished in-network.

The MCE may require providers not contracted in the MCE's network to obtain prior authorization from the MCE to render any non-self-referral or non-emergent services to MCE members. If the out-of-network provider has not obtained such prior authorization, the MCE may deny payment to that out-of-network provider. The MCE shall cover and reimburse for all authorized, routine care provided to its members by out-of-network providers.

MCEs must make Advanced Nurse Practitioner and Physician Assistant services available to members per BT 201584 and BT 201743.

The MCE must reimburse any out-of-network provider's claim for authorized services at a negotiated rate, or in the absence of a negotiated rate, an amount equal to or higher than 98% of the Medicaid fee-for-service (FFS) rate, except for in certain situations described in the scope of work (e.g., hospital assessment fees, physician faculty access to care (PFAC) program, nursing facility supplemental payments and LTSS and HCBS providers).

The MCE may not require an out-of-network provider to acquire an MCE-assigned provider number for reimbursement. An NPI number is sufficient for out-of-network provider reimbursement.

3.f Smoking Cessation and Tobacco Dependence Treatment

The MCE must cover, at minimum, Smoking Cessation and Tobacco Dependence Treatment as set forth in *405 IAC 5-37*. Counseling services, in addition to services available with the Indiana Quitline, can be performed by licensed practitioners as outlined in this code.

Drug coverage shall be consistent with the fee-for-service program (refer to Section 3.5 of the *Indiana Pathways for Aging* scope of work) as well as the SUPDL. In certain circumstances a prior authorization may be required (i.e., in instances where members treatment with the SUPDL has been tried and unsuccessful and non-preferred agents are requested). Providers may prescribe one or more methods of treatment and must include counseling as part of treatment.

Additionally, the MCE shall provide each member identified as using tobacco or tobacco related products, information about the Indiana Quitline. The Indiana Quitline is a telephone-based cessation service designed to help all Indiana tobacco users. Visit QuitNowIndiana.com/providers for additional information.

The MCE shall create and implement (after receiving approval from the State) a physician incentive program specific to tobacco dependence counseling. The MCE shall utilize a State approved promotional strategy for tobacco cessation medications.

3.g Behavioral Health

Behavioral health services are underutilized services for individuals transitioning from the A&D Waiver into *Indiana Pathways for Aging*.

For example, Indiana has over 5,000 HCBS waiver members residing in waiver certified assisted living facilities. 85% of those 5,000 individuals have a diagnosis of serious mental illness (SMI), and while these individuals may receive medication to treat the illness, there is little-to-no ongoing mental health counseling or life skills training provided to these individuals.

Without appropriate mental health treatment, members who meet nursing facility level of care are more likely to cycle through daily home care providers and staff, because of behavioral issues. It is common to see providers discontinue services for an individual because staff are not equipped to address behavioral health issues. It is not uncommon for a member with an untreated mental health diagnosis and who meets nursing

facility level of care to burn through available providers in areas where there are a lack of providers. When members are without services, they are quick to utilize emergency rooms for care. Incorporating robust behavioral health services has a ripple effect on a member maintaining other daily community supports that are the catalyst for remaining at home.

The MCE must provide behavioral health services, which include mental health and substance use/abuse services, according to the requirements in this section. In doing so, the MCE must ensure behavioral health services are integrated with physical care services, regardless of if the member resides in a facility or the community, and that behavioral health services are provided as part of the treatment continuum of care. Members who receive HCBS waiver benefits may also receive behavioral health services. MRO does not duplicate HCBS waiver benefits.

The MCE must develop protocols to do the following:

- Provide care that addresses the needs of members in an integrated way, with attention to the physical health and chronic disease contributions to behavioral health.
- Provide a written plan and evidence of ongoing, increased communication between the PMP, the MCE, and the behavioral healthcare provider.
- Coordinate management of utilization of behavioral healthcare services with Medicaid Rehabilitation Option (MRO) services and services for physical health.
- Coordinate with 1915(i) services to prevent duplication and fragmentation of services (see [Carve-Outs](#)).
- Ensure information is included in the Member Handbook and other materials to members and providers regarding how to access covered behavioral health services. Materials shall include information about behavioral health conditions that may be treated by a primary care provider (PCP) within their scope of practice.
- Behavioral health providers identify a primary point of abrasion as the denial of authorizations for consistent and ongoing mental health services.

For example, a licensed social worker (LSW) with a community mental health center (CMHC) submits an authorization for weekly counseling for a member, but the MCE denies the request and modifies it to bi-weekly counseling for the member.

In order to remove this type of provider abrasion, MCEs are required to produce transparent utilization management tools and guidelines with specific instructions for how mental health authorizations are determined. This reduces the ambiguity for the provider of how authorization requests are reviewed and determined.

3.g.1 Behavioral Healthcare Services

The MCE must provide all medically necessary community-based, partial hospitalization and inpatient hospitalization behavioral health services as identified in contract Exhibits 2 and 3. MCEs shall pay CMHCs at no less than the Indiana Medicaid FFS rate for any covered non-MRO service that the CMHC provides to members.

The MCE must provide behavioral health services to members in hospitals, offices, clinics, in homes, virtually ([Telehealth](#)), and other locations, as permitted under state and federal law. This also includes congregate settings such as nursing facilities, assisted living facilities, adult family homes and adult day centers. A full continuum of services, including crisis services, as indicated by the behavioral health care needs of members, must be available to members, including partial hospitalization services as described in 405 IAC 5-20-8.

The MCE must provide medically necessary covered court ordered behavioral health services to its members pursuant to court order(s). The MCE must furnish these services in the same manner as services furnished to other members.

Behavioral health services codes billed in a primary care setting must be reviewed for medical necessity and, if appropriate, shall be paid by the MCE.

The MCE must ensure the availability of behavioral health crisis intervention services 24 hours a day, seven days a week.

The MCE must allow members to self-refer to any behavioral health care provider in the MCE's network without a referral from the PMP. Members may also self-refer to any IHCP- enrolled psychiatrist; see [Self-Referral Services](#).

3.g.2 Behavioral Health Provider Network

The State requires MCEs to develop a sufficient network of behavioral health providers to deliver the full range of behavioral health services. The network must include psychiatrists, psychologists, clinical social workers, and other licensed behavioral healthcare providers with experience in serving a geriatric population. In addition, MCEs must provide inpatient care for a full range of mental health and substance abuse diagnoses. All services covered under the clinic option must be delivered by licensed providers and qualified behavioral health professionals working under a licensed behavioral health provider, described in 405 IAC 5-20-8-2 All outpatient mental health services shall be delivered by licensed psychiatrists and HSPPs, or an advanced practice nurse or person holding a master's degree in social work, marital and family therapy or mental health counseling.

The MCE must train its providers to identify and treat members with behavioral health disorders and must train PMPs and specialists on when and how to refer members for health treatment. The MCE shall also train providers in screening and treating individuals who have co-existing mental health and substance use disorders. The MCE must ensure use of standardized validated screening instruments for all adults, related to behavioral health needs. The MCE is responsible for ensuring that its behavioral health network providers are trained in cultural diversity and can respectfully and effectively interact with individuals with varying cultural, racial, ethnic, and linguistic differences. The MCE must provide, to the State, a written training plan, including dates, methods (such as a seminar or web conference), and subject matter for integration and cultural competency training. The MCE must have the information necessary to provide, to the State upon request, information which reflects provider participation in the trainings as well as information from the participants to determine if they found the training helpful.

Members must be able to receive timely access to medically necessary behavioral health services. In urban areas, the MCE must provide at least one behavioral health provider within 30 minutes or 30 miles from the member's home. In rural areas, the MCE must provide at least one behavioral health provider within 45 minutes or 45 miles from the member's home. The MCE must provide assertive outreach to members in rural areas where behavioral health services may be less available and monitor utilization to assure equality of service access and availability.

3.g.3 Care Coordination and Service Coordination for Members Receiving Behavioral Health Services

The MCE must employ or contract with care coordinators and service coordinators with training, expertise, and experience in providing services to older adults receiving behavioral health services. At minimum, the MCE must provide Complex Case Management services for members discharged from an inpatient psychiatric or substance use disorder hospitalization, for no fewer than 90 calendar days following the inpatient hospitalization. The MCE must also provide Complex Case Management services for any member at risk for inpatient psychiatric, drug overdose, or substance abuse re-hospitalization.

Care coordinators and service coordinators are required to regularly collaborate with the MCE's Behavioral Health Manager to address service plans for specific members with a mental health diagnosis on the service coordinator's case load. The service coordinator will document such collaborations and interventions from these collaborations in the member's person-centered service plan and the success of the intervention. This allows for information to be shared in the event of staff turnover in service coordination with the MCE. This person-centered service plan will also be shared with the member's providers, including HCBS providers for understanding about the mental health diagnosis and helpful interventions to implement with the member. The service coordinator will collaborate regularly with the member's providers, including HCBS providers, about the member's mental health diagnosis and updated interventions that may be needed to support the

member. The service coordinator is integral to ensuring a member with a mental health diagnosis has supports that empower the member to remain in the community, which includes the member maintaining a positive relationship with all providers, especially HCBS providers who render daily services.

Care/Service Coordinators must contact members during an inpatient behavioral health hospitalization or immediately when they are notified of a member's inpatient behavioral health hospitalization. Prior to the member discharging from an inpatient stay, the service coordinator must have any additional supports established in the person's home prior to the member returning to the community. The care coordinators must schedule an outpatient follow-up appointment to occur no later than seven calendar days following discharge for the inpatient behavioral health hospitalization. During this visit, the service coordinator will follow up on any new services implemented to support the member as well as address any unmet needs. The MCE must make sure that lack of transportation is not a barrier to the member attending the outpatient follow-up appointment. If a member misses an outpatient follow-up or continuing treatment, the MCE shall ensure that a behavioral health care provider or the MCE's behavioral care coordinator contacts that member within three business days of notification of the missed appointment. *Contact* in this section means utilizing any and all appropriate communication methods for a good faith attempt to reach the member. The expectation of this outreach is to ensure that the member's needs are met and coordinate a new appointment or new intervention to address unmet needs. If a member misses a behavioral health appointment, the MCE is expected to follow up with the member to ensure the member is not in crisis. If the member is in crisis, the MCE is required to support the member through crisis resolution and ongoing care.

The MCE should use the results of health needs screenings, UCLA Loneliness Assessment, and more detailed comprehensive health assessments to identify members in need of behavioral health services and implement interventions to meet mental health needs. The MCE shall also monitor members receiving behavioral health services who are new to the MCE's plan to ensure that the member is expediently linked to an appropriate behavioral health provider. The MCE shall monitor whether the member is receiving appropriate services and whether the member is at risk of over-utilizing or under-utilizing services. MCEs are cautioned to carefully consider over-utilization of a person's mental health services and consider consequences to decreasing those services. If a decrease in mental health supports is required by the MCE, the MCE will document how the member's needs will be met through alternate interventions. This documentation shall be included in the member's person-centered service plan. The State will provide access to its web-based interface *CoreMMIS* to allow the MCE to monitor MRO utilization, which is covered by Medicaid FFS.

3.g.4 Behavioral Health Coordination

The MCE must ensure the coordination of the member's care team across all physical and behavioral health providers treating the member. The MCE must coordinate services for individuals with multiple diagnoses of mental illness, substance use disorder and physical illness. The MCE must have policies and procedures in place to facilitate the reciprocal exchange of health information between physical and behavioral health providers treating the member.

The MCE shall review incident reporting data pertaining to mental health crisis trends and share those results with service coordinators, care coordinators and providers of the MCE. The MCE must share member health data with physical and behavioral health providers and coordinate care for all members receiving both physical and behavioral health services, to the extent permitted by law and in accordance with the member's consent, when required. Disclosure of mental health records by the provider to the MCE, by the MCE to provider, and to the member's physician is permissible under *HIPAA* and *IC 16-39-2-6(a)* without consent of the patient because it is for treatment. However, consent from the patient is necessary for substance use disorder records.

The MCE must contractually mandate:

1. That its behavioral health care network providers notify the MCE within five calendar days of the member's visit, and submit information about the treatment plan, the member's diagnosis, medications, and other pertinent information.

2. Every network provider, including behavioral health providers, to ask and encourage members to sign a consent that permits release of substance use disorder treatment information to the MCE and to the PMP or behavioral health provider, when applicable.
3. The MCE is required to contractually mandate behavioral and physical health providers to document and reciprocally share the following information for each member receiving behavioral health treatment:
 - Primary and secondary diagnoses,
 - Findings from assessments,
 - Medication prescribed,
 - Psychotherapy prescribed, and
 - Other relevant information.

MCEs must, on at least a quarterly basis, send a behavioral health profile to the respective PMP. The behavioral health profile lists the physical and behavioral health treatment received by that member during the previous reporting period.

MCEs must, at a minimum, establish referral agreements and liaisons with both contracted and non-contracted CMHCs, and shall provide physical health and other medical information to the appropriate CMHC for every member.

The MCE must develop additional mechanisms for facilitating communication across the member's integrated care team, including State Plan providers and HCBS providers, to ensure the provision of integrated member care. Incentive programs, case managers, behavioral health profiles, etc. are potential mechanisms to ensure care coordination and the reciprocal exchange of health information between physical, HCBS and behavioral health providers.

Provider agencies, especially HCBS agencies who interact daily with the member, will share behavioral health information with the member's direct service professional and ensure provider staff are educated about mental health conditions in order to best serve the member. The MCE must evaluate and monitor the effectiveness of its policies and procedures regarding physical and behavioral health coordination and develop and implement mechanisms to improve coordination and continuity of care based on monitoring outcomes.

3.g.5 Behavioral Health Continuity of Care

The MCE must utilize care coordinator and service coordinators with experience in behavioral health to monitor the care of members receiving behavioral health services who are new to the MCE or who are transitioning to another MCE or other treatment provider, to ensure that medical records, treatment plans and other pertinent medical information follows each transitioning member. The MCE must notify the receiving MCE or other provider of the member's previous behavioral health treatment and shall offer to provide to the new provider the member's treatment plan, if available, and consultation with the member's previous treating provider. The MCE and receiving MCE must coordinate information regarding prior authorized services for members in transition.

If there is a change in the member's person-centered service plan related to behavioral health condition or services, the MCE will ensure that the member's integrated care team receives an updated copy of the revised service plan to best meet the member's needs.

Confidentiality of protected health information (PHI) must be maintained, in accordance with the *Health Insurance Portability and Accountability Act* (HIPAA). See [Disclosure of Health Records Requiring Member Consent](#) for more information.

The MCE must require, through provider contract provisions, that members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. This treatment shall be provided within seven calendar days from the date of the member's discharge. If a member misses an outpatient follow-up or continuing treatment, the MCE must make sure that a behavioral health care provider or the MCE's behavioral health care coordinator contacts that member within three business days of notification of the missed appointment. *Contact* in this section is defined as utilizing any

and all appropriate communication methods for a good faith attempt to reach the member. The expectation of this outreach is to ensure that the member's needs are met and coordinate a new appointment or intervention to address unmet needs. If a member misses a behavioral health appointment, the MCE is expected to follow up with the member to ensure the member is not in crisis. If the member is in crisis, the MCE is required to support the member through crisis resolution and ongoing care.

3.g.6 Inpatient Hospitalizations

With the appropriate consent, the Care Coordinator and/or Service Coordinator must notify the integrated primary care team when a member is hospitalized or receives emergency treatment for behavioral health issues, including substance use disorder within five calendar days of the hospital admission or emergency treatment.

Additionally, Care Coordinators must contact members during an inpatient hospitalization, or as soon as practicable upon receiving notification of a member's inpatient behavioral health hospitalization.

In the event of an inpatient behavioral health hospitalization, the member's assigned Care Coordinator must work with the hospital discharge planner, behavioral health provider case manager and/or natural supports (i.e., family) to ensure that an outpatient follow-up appointment is scheduled in accordance with [Behavioral Health Continuity of Care](#) prior to discharge.

3.g.7 Partial Hospitalization Services for Behavioral Health

The State supports the implementation of partial hospitalization programs (PHP) to provide a range of care to either prevent hospitalization or act as a step-down service to transition members from inpatient hospitalization to community care. These programs must be highly intensive, have time-limited medical services that provide a transition from inpatient psychiatric hospitalization to community-based care or serve as a substitute for inpatient admission. PHPs are highly individualized, with treatment goals that are measurable and medically necessary. Treatment goals must include specific time frames for achievement of goals and must be directly related to the reason for admission.

To receive PHP services, members must have a diagnosed or suspected behavioral health condition, plus one of the following:

- short-term deficit of the individual's daily functioning or
- serious deterioration of the individual's general medical or behavioral health is highly probable without structured intervention.

The full-service description and program requirements for coverage of partial hospitalization are in the Indiana Administrative Code 405 IAC 5-20-8. See the [Mental Health and Addiction Services](#) provider reference module for billing instructions.

3.g.8 Substance Use Disorder and Serious Mental Illness

The §1115 Substance Use Disorder (SUD) and §1115 Serious Mental Illness (SMI) demonstration waivers enable federal financial participation (FFP) for short-term/acute inpatient stays (both SUD and SMI) and residential stays (SUD only) in a qualifying Institution for Mental Disease (IMD).

It is longstanding federal policy not to reimburse states for inpatient stays in facilities that qualify as IMDs regardless of facility designation. 42 CFR §435.1010 defines an IMD as:

"A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. An institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such."

The SUD and SMI demonstrations bypass the federal IMD exclusion by submitting to specific requirements for their respective qualifying acute inpatient stays by providing rigorous data analysis, evaluation, and

submission to the Centers for Medicare and Medicaid Services (CMS), and by meeting specified goals and benchmarks over the approved waiver periods.

Under both waivers, the State can draw down federal matching funds for these types of inpatient stays and services in IMDs, which reduces financial burden on the State for being the sole source of funding. These waivers also expand the State's network of SUD/SMI providers and allow for more access across the continuum of care by providing individuals with more appropriate treatment options.

The MCE will cover short term inpatient stays for serious mental illness (SMI) in a qualified Institution for Mental Disease (IMD) for *Indiana Pathways for Aging* members aged 60 to 64 and is required to maintain an average length of stay not to exceed 30 days for all IMD stays for SMI. A maximum of 60 days can be approved, if medically necessary, for short term IMD stays for SMI.

The MCE will cover short term inpatient stays for substance use disorder (SUD) in a IMD for *Indiana Pathways for Aging* members aged 60 to 64 for up to 15 days in a calendar month, as medically necessary, for individuals with substance use disorder. If a member's IMD stay exceeds 15 days in a calendar month and the member is awaiting placement in a state operated facility (SOF) for treatment, the member will be disenrolled from the plan and enrolled in fee for service. For stays exceeding 15 days in a calendar month in which the member is not awaiting placement in a SOF, the member will remain enrolled with the MCE and the State shall recover the entire monthly capitation payment for the member.

The MCE will cover short term residential stays for SUD in a qualified IMD for *Indiana Pathways for Aging* members aged 60 to 64 and is required to maintain an average length of stay not to exceed 30 days for all residential IMD stays for SUD.

The MCE must actively track and coordinate the care of members receiving care in an IMD. Anticipating and planning for a member's successful discharge should begin immediately upon a member's entry into an IMD.

Lists of qualified IMD providers under both §1115 waivers will be provided to the MCE. The MCE may not require or create incentives for the member to receive services in an IMD versus a setting covered under the State Plan.

The MCE must submit data related to IMD stays as outlined in the *MCE Reporting Manual*.

The proposed services and settings will be reimbursable and subject to the requirements contained in *42 CFR part 438*.

3.h Prevention and Wellness Program

The MCE must inform all members and/or caregivers of the prevention and wellness benefits that are available to them as part of their coverage. Prevention and wellness activities should also be incorporated into a member's care plan as appropriate.

The MCE's prevention and wellness program must include the following components:

- general information about the program that is sensitive to needs of the population regardless of race, color, ethnicity, culture, disability, age, or gender,
- ability to coordinate the delivery of prevention and wellness services within the program,
- current and up to date practice guidelines related to prevention and wellness,
 - MCE must include prevention and wellness practice guidelines that address both physical and mental health. At a minimum, practice guidelines should be updated every two years, or earlier as they are made publicly available. The MCE must make available the guidelines to providers as well as members and/or caregivers in multiple formats.
- methods to collect, analyze, and report data to measure performance of the prevention and wellness program and have the ability to communicate this to providers and members,
- program resources including but not limited to informational, educational, counseling, care management, and coaching,
- information provided to at-risk members and caregivers on disease prevention programs,

- ensuring that policies are in place that address prevention and management of disease progression,
- policies, procedures, and activities that promote independent functioning for activities of daily living and instrumental activities of daily living,
- outreach strategies for those that are identified as in need of preventive services,
- information on special health issues such as nutrition, loneliness and social isolation, injury prevention, informal caregiver health, alcohol, and other drug abuse (AODA) prevention, reducing self-mutilation behaviors, physical activity, skin integrity, self-care training, and coping with dementia-related illnesses and cognitive decline.

The activities and materials used in the prevention and wellness activities shall be accessible by the State and the Centers for Medicare & Medicaid Services (CMS). The MCE's plan for implementing the prevention and wellness program must be approved by the State, as well as any significant changes to the program. The State defines a *significant change* as a modification that occurs to an Indiana Medicaid program goal, objective, or priority; other than modifications done for clarity. The State reserves the right to request documentation related to the program at any time.

3.i Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are safety net providers, the State strongly encourages the MCE to contract with FQHCs and RHCs that meet all MCE's requirements regarding the ability of these providers to provide quality services. The MCE must reimburse FQHCs and RHCs for services at no less than the level and amount of payment that it would make to a non-FQHC or non-RHC provider for the same services. In accordance with section 5006(d) of the *American Recovery and Reinvestment Act of 2009 (ARRA)*, the MCE must pay any out-of-network Indian healthcare provider that is a FQHC for covered services provided to an American Indian/Alaskan Native member at a rate equal to the amount of payment that the MCE would pay to an in-network FQHC that is not an Indian health care provider for the same services.

In accordance with the Medicare, Medicaid, and *SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)*, the State will make supplemental payments to FQHCs and RHCs that subcontract (directly or indirectly) with the MCE. These supplemental payments represent the difference, if any, between the payment to which the FQHC or RHC would be entitled for covered services under the Medicaid provisions of BIPA and the payments made by the MCE.

FQHCs and RHCs providers should bill the MCE for one unit of code T1015 on the claim. If a claim is submitted with more than one unit, reimbursement of the "wrap" payment will be delayed because only one unit is allowed per member, per day, per diagnosis code. The T1015 line is information only. MCEs must pay the claim line at \$0 and not deny that claim line. If the claim line for T1015 is denied, then the wrap payment is not generated. Providers should be educated that they should not bill an amount on the T code line, but either way the MCE should pay this line at zero regardless of the amount so the State can pay the wrap payment.

The MCE is required to identify any performance incentives it offers to the FQHC or RHC. The State must review and approve any performance incentives. The MCE must report all such FQHC and RHC incentives which accrue during the contract period related to the cost of providing FQHC-covered or RHC-covered services to its members along with any fee-for-service and/or capitation payments in the determination of the amount of direct reimbursement paid by the MCE to the FQHC or RHC. If the incentives vary between the MCE's *Indiana Pathways for Aging* lines of business, the MCE must specify this in reporting to the State.

The MCE must perform quarterly claim reconciliation with each contracted FQHC or RHC to identify and resolve any billing issues that may impact the clinic's annual reconciliation conducted by the State.

The MCE is required to provide its utilization and reimbursement data for each FQHC and RHC in each month of the reporting period. The report shall be completed in the form and manner set forth in the *MCE Reporting Manual*, which is updated annually. A separate report must be provided for the MCE's *Indiana Pathways for Aging* lines of business.

The submitted FQHC and RHC data must be accurate and complete. The MCE must pull the data by NPI or LPI, rather than any other means. The MCE must establish a process for validating the completeness and accuracy of the data, and a description of this process shall be available to the State upon request. The claims files should not omit claims for practitioners rendering services at the clinic nor should the files contain claims for practitioners who did not practice at the clinic.

In addition, the State requires the FQHC or RHC and the MCE to maintain and submit records documenting the number and types of valid encounters provided to members each month.

Capitated FQHCs and RHCs shall also submit encounter data (in the form of shadow claims to the MCE) each month. The number of encounters will be subject to audit by the State or its representatives.

The MCE must work with each FQHC and RHC in assisting the State or its designee in the resolution of disputes concerning year-end reconciliations between the federally required interim payments (made by the State to each FQHC and RHC based on provider reported encounter activity) and the final accounting that is based on the actual encounter data provided by the MCE.

3.j 24-Hour Nurse Call Line

The MCE must provide nurse triage telephone services for members and informal caregivers to receive medical advice 24 hours a day, seven days a week from trained medical professionals. The 24-Hour Nurse Call Line must follow the requirements in [Oral Interpretation and Translation Services](#) and be equipped to provide advice for *Indiana Pathways for Aging* members who are seeking general guidance about health related questions and concerns or seeking services from hospital Emergency departments. The 24-hour nurse call line must:

- be well publicized and designed as a resource for members to help discourage inappropriate use of the emergency department,
- record all calls,
- have a system in place to document and communicate all issues with the member's PMP and the MCE (for referral to the member's care and service coordinator), and
- collect data sufficient to meet care and service coordinators, member assistance, and reporting needs.

The 24-nurse call line may share location information of nearby urgent care clinics within the MCE's Medicaid and Medicare (for dually eligible members) network. As appropriate, the 24-hour nurse call line may refer callers to 211, 988 Suicide and Crisis Hotline, LTC ombudsman, or member support services contractor.

3.k Carve-Outs and Excluded Services

3.k.1 Carve-outs

Categories of service excluded from the capitation payment for an MCE's enrolled *Indiana Pathways for Aging* membership but included in the managed care benefit package are called *carve-outs*. While the MCE retains responsibility for the delivery and payment of most care for its members, carve-outs remain the financial responsibility of the State and are reimbursed as fee-for-service (FFS) claims under the fiscal agent contract. While these services are not the financial responsibility of the MCE, the MCE must ensure coordination of all Medicaid covered services and implement strategies to prevent duplication and fragmentation of care across the healthcare delivery system.

The following services are carve-outs:

- **Medicaid Rehabilitation Option (MRO) Services**
 - Rendered by provider specialty 111 – Community Mental Health Center (CMHC) – to individuals, families, or groups living in the community who need intermittent aid for emotional disturbances or mental illness. MRO services include outpatient mental health services, partial hospitalization, case management and assertive community treatment (ACT) intensive case management. The MCE is not responsible for claims reimbursement for such services. However, the MCE is responsible for

care coordination for members receiving MRO services. For additional information about MRO services, see the [Medicaid Rehabilitation Option Services](#) provider reference module.

- **1915(i) State Plan Home and Community-Based (HCBS) Services**

- The State has three 1915(i) State Plan HCBS services programs: [Behavioral and Primary Healthcare Coordination](#) (BPHC), [Adult Mental Health and Habilitation](#) (AMHH) and Children's Mental Health Wraparound (CMHW). These are services for individuals who choose to remain in their home as an alternative to receiving services in an institution. These programs are intended to assist a person to be as independent as possible and live in the least restrictive environment possible while maintaining safety in the home.

3.k.2 Excluded Services

The *Indiana Pathways for Aging* program excludes some benefits from coverage under managed care. These benefits are available under traditional Medicaid or other waiver programs. A member who is, or will be, receiving excluded services must be disenrolled from the MCE to be eligible for the services under FFS. The MCE is responsible for the member's care until the member is disenrolled from the plan (unless stated otherwise).

Services excluded from *Indiana Pathways for Aging* are:

- **Psychiatric treatment in a state hospital**

- These facilities operate under the direction of the Family and Social Services Administration (FSSA), Division of Mental Health and Addiction (DMHA), or the Indiana Department of Health (IDOH). Members receiving psychiatric treatment in a state hospital will be disenrolled from *Indiana Pathways for Aging* and enrolled into another program (i.e., the [590 Program](#)).

- **Intermediate care facilities for individuals with intellectual disabilities (ICF/IID)**

- LTC services are available to IHCP members with an IID level of care who reside in an Intermediate Care Facility (ICF). Members who reside in an ICF will be disenrolled from *Indiana Pathways for Aging* and enrolled in Traditional Medicaid (FFS). Before a stay can be reimbursed by the IHCP, the level of care must be approved by the State. The MCE must coordinate care for its members that are transitioning into an ICF by working with the facility. The MCE is responsible for payment for up to 60 calendar days for its members placed in an ICF, while the level of care determination is pending; see [Long-Term Care](#) for billing information.

- **Traumatic brain injury (TBI) waiver**

- The TBI waiver provides home and community-based services to members who, but for the provision of such services, would require institutional care. *Indiana Pathways for Aging* members who become eligible for the Traumatic Brain Injury waiver will be disenrolled from the MCE and enrolled under Traditional Medicaid (FFS); see information about the TBI waiver in [Division of Aging HCBS Waivers](#).

- **Community integration and habilitation (CIH) waiver**

- The CIH Waiver program provides Medicaid HCBS to individuals residing in a range of community settings as an alternative to care in an ICF. *Indiana Pathways for Aging* members who become eligible for the Community Integration and Habilitation Waiver will be disenrolled from the MCE and enrolled under Traditional Medicaid (FFS); see information about the CIH waiver in [Division of Disability Rehabilitative Services HCBS Waivers](#).

- **Family supports waiver (FSW)**

- The Family Supports waiver program provides Medicaid HCBS to individuals residing in a range of community settings as an alternative to care in an intermediate care facility for individuals with intellectual/developmental disabilities or related conditions. *Indiana Pathways for Aging* members who become eligible for the Family Supports waiver will be disenrolled from the MCE and enrolled under Traditional Medicaid (FFS); see information about the FSW in [Division of Disability Rehabilitative Services HCBS Waivers](#).

3.1 State Plan Authority Long Term Services and Supports

3.1.1 Nursing Facilities

The MCE must provide nursing facility services for members. Nursing facilities must be licensed by the Indiana Department of Health and enrolled with the IHCP. The MCE must contract with any willing nursing facility provider who meets the criteria of licensure and IHCP enrollment and who is willing to accept the provisions of the MCE's contract; this provider requirement is in place for the first three years of MCE contract operations.

The MCE must not cover nursing facility services in a facility that is not located in Indiana. The MCE will not reimburse for bed-hold days in a nursing facility as a member benefit unless the member is under the care of hospice. The MCE shall educate all members residing in a nursing facility and confer with member's individual provider regarding types of bed-hold or leave-day policy that may exist in the facility. The MCE must ensure that a nursing facility complies with the following:

- does not charge member for services not requested,
- informs members of the bed-hold policies and periods,
- informs members, in writing, prior to a hospital transfer or departure for therapeutic leave that Medicaid does not pay for bed-holds, and
- has a written policy under which a resident, whose hospital or therapeutic leave exceeds Medicaid coverage limitations, is readmitted to the facility upon the first available bed in a semi-private room if the resident requires and is eligible for nursing facility-level services.

Regardless of the length of the leave, if the member remains eligible for nursing facility LOC and Medicaid, the member may choose to be readmitted to the facility in the first available bed or be provided with care in a home or community setting at the member's discretion. The MCE is responsible for care and service coordination to establish chosen services and must follow transition guidelines as set forth in the scope of work and *Indiana Pathways for Aging Care and Service Coordination Manual*.

Nursing Facility Level of Care and Length of Stay Determination

Nursing facilities experience system abrasion when MCEs have inconsistent processes in **(1)** technology systems (portals), **(2)** level of care/length of stay determination, and **(3)** receiving payment for a person transitioning from managed care to fee-for-service. While there are other abrasion areas, these are the top three.

Indiana Pathways for Aging MCEs are required to collaborate on making portals as consistent as possible. Specifically, nursing facilities would like the option to use their individual facility NPI rather than the hospital's NPI for which they are owned. MCEs are expected to design a portal containing a field for nursing facilities to incorporate their NPI for payment directly to the nursing facility.

The second abrasion point has been mitigated by requiring PASRR level of care and length of stay determination:

- The MCE will follow State policies for Level of Care (LOC) Level I and Level II and Pre-Admission Screening Resident Review (PASRR) requirements; reference the Provider Long Term Care module for additional information. **LOC and PASRR determinations are the responsibility of an independent state vendor with oversight from the State and MCEs will honor the level of care and length of stay determination approved by the designated vendor.** This applies to initial level of care and length of stay as well as ongoing re-assessments. The nursing facility will follow the State's PASRR requirements for submitting length of stay re-assessments to the State's vendor for redetermination.
- Level of Care 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 calendar days), or
 - denied for nursing facility stay.

- Before the nursing facility can be reimbursed for the care provided, the nursing facility must request PASRR for the member. The MCE will receive the length of stay re-assessment information from the nursing facility and is responsible for transferring the information to the enrollment services vendor. The State must then approve the PASRR request and designate the appropriate level of care in CoreMMIS. The MCE must coordinate care for members that are transitioning into long-term care by working with the facility to ensure timely submission of the PASRR request. The MCE is responsible for payment up to 60 days for the authorized care of members placed in a long-term care facility while level of care determination is pending.
- The MCE 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 PASRR approval, the MCE may not deny an authorization for the member to receive necessary care in a nursing facility.

The third abrasion point has been mitigated by considering the transition as a reported change.

Indiana Pathways for Aging MCEs will conduct ongoing collaboration to align processes to reduce nursing facility abrasion. *Indiana Pathways for Aging* MCEs and the State will meet regularly to discuss nursing facility abrasion points, solutions, and steps taken by *Indiana Pathways for Aging* MCEs to align procedures.

Service Coordination in Nursing Facilities

Indiana Pathways for Aging members who receive nursing facility level of care receive a care coordinator and a service coordinator. This includes *Indiana Pathways for Aging* members residing in a nursing facility for a short-term or long-term stay.

MCE Service Coordination Staffing in Nursing Facilities

The MCE may determine how service coordinators are staffed within a facility. Based on the State's experience with assisted living communities, the preference is to assign one or two service coordinators to a nursing facility. This practice promotes facility staff and service coordinators relationship building and trust in serving the member. Indiana has not staffed case management type services in nursing facilities for Medicaid members, so this will be a significant shift for nursing facilities. MCEs are expected to have regular touchpoints with nursing facilities especially upon program implementation to address any abrasion issues. If MCEs are unable to resolve issues that arise with nursing facilities, MCEs are required to notify the State immediately.

Service Coordination Visit Requirements in Nursing Facilities

- **Short-term Stay**
 - Upon enrolling with an MCE, the service coordinator will complete a face-to-face visit prior to the expiration date of the level of care previously approved, but no more than 90 days after the member enrolls in their selected/assigned MCE.
 - During the visit, the service coordinator will ensure the member's needs are being met by the nursing facility, coordinate any outside services needed by the member, and assess member desire transition to the community.
 - If the member identifies unmet needs, the service coordinator is required to engage with the nursing facility until the member's needs are met.
 - The service coordinator will track possible date of discharge for a short-term stay and work with the MCE's transition coordinator to ensure services are established in the member's subsequent residence before discharging from the nursing facility.
 - The service coordinator will support the member in development of a person-centered service plan, which must contain documentation requirements outlined in the *Indiana Pathways for Aging* scope of work for person-centered service planning.

- **Long-term Stay**

- Service coordinator will conduct quarterly face-to-face visits. During these visits, the service coordinator will assess that the nursing facility meets the member's needs, coordinate outside services, and assess the member's desire to transition back to the community.
- If the member communicates unmet needs, the service coordinator is required to engage with the nursing facility until the member's needs are met.
- The service coordinator will support the member in development of a person-centered service plan, which must contain documentation requirements outlined in the *Indiana Pathways for Aging* scope of work for person-centered service planning.

Additionally, the MCE must have a Transition Coordinator to assist members who lose NFLOC or are ready for discharge from a nursing facility. The MCE must assist the member and facility in creating a successful discharge or transfer to another residential setting. The MCE must continue payment to the facility while a discharge is on-going. This does not apply to a member who loses Medicaid eligibility.

Nursing Facility Acuity and Service Coordinator Case Load

Based on the level of support needed for a member in a nursing facility (long-term or short-term) as well as the minimum visit requirement, in the caseload formula, each long-term NF resident is weighted by an acuity level of 1. Written as "(# of members in an institutional setting x 1.0)"

A Service Coordinator could have a caseload of up to 100 long-term NF residents, but if with a maximize NF resident caseload, Service Coordinator cannot also serve HCBS recipients or NF residents transitioning to the home/community.

Complete Formula

(100 members in an institutional setting x 1.0) + (0 members identified as candidates for transition to the community x 2.0) + (0 members in an HCBS setting x 2.0) = 100

Simplified Formula

100 NF residents x acuity level of 1 = weighted caseload of 100

3.1.2 Home Health

Home health services are available to *Indiana Pathways for Aging* members when services are medically necessary, ordered in writing by a provider, performed in accordance with a written plan of treatment, and less expensive than any alternate modes of care. Provider orders can be written by physician, nurse practitioner, clinical nurse specialist, or physician assistant licensed in Indiana and credentialed by IHCP.

Covered home health services include skilled nursing, home health aide services, and skilled therapies (e.g., physical therapy, occupational therapy, speech-language pathology, etc.). The [Home Health Services](#) provider module provides guidelines for coverage of home health services which can range from acute home health services to long-term and continuous home health care, depending on the individual circumstances. As noted in scope of work Section 7.8.2, individuals in the *Indiana Pathways for Aging* program are likely to need long-term therapies to maintain their current health and activities. MCEs shall not use improvement in function as a criterion for approving the initiation or continuation of services that enable a member to maintain their health status or prevent a member from experiencing a more significant decline. For additional information on home health service coverage, including indicators for home health service and hourly guidelines, see the [Home Health Services](#) provider module.

Home Health Services are not limited to a member's home and are not limited to members who are homebound. Members may receive home health services in any setting in which normal life activities take place (excluding hospital, nursing facility, ICF, or any setting where payment is, or could be, made under Medicaid for inpatient services that include room and board)

For example, in addition to a member's temporary or permanent residence, home health services are permitted in HCBS congregate settings, such as, assisted living, adult day care centers, and adult family homes.

The MCE shall facilitate all member transitions to and from a home health care setting. This includes planning and preparation for the transition and the follow-up care to ensure the member's well-being. This MCE responsibility is regardless of primary payor status. Refer to scope of work Section 4.12 for specific care transition types. Additional information is also located in the *Indiana Pathways for Aging Care and Service Coordination Manual*.

The MCE is responsible for coordinating home health services with other services a member may be receiving from other payers and/or a Medicaid waiver.

Many *Indiana Pathways for Aging* members are dually eligible for both Medicare and Medicaid, and MCEs are responsible for coordinating care for all Medicare and Medicaid home health services regardless of Medicare service delivery system or Medicare plan benefit package through a single point of coordination on the member's Interdisciplinary Care Team (ICT). This includes engaging with Medicare payers as appropriate to coordinate the care and benefits of these dually eligible members. The MCEs will support a coordinated and integrated experience from the perspective of the dually eligible member. This includes continued member, provider, and staff education and assistance pertaining to Medicare and Medicaid and their interaction, available Medicare and Medicaid resources and a dedicated help line to take member phone calls and answer member questions about how the member's Medicare coverage affects the member's Medicaid benefits and services.

In addition, MCEs are responsible for complying with the IHCP Third-Party Liability (TPL) program to ensure compliance with all federal and state TPL regulations. Federal regulations establish Medicaid as the payer of last resort for Medicaid members. In Indiana, for the adult population served by the *Indiana Pathways for Aging* program, only the state-funded Victim Assistance and Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) are not billed before Medicaid. TPL responsibilities include identifying members who have third-party resources such as Medicare benefits and billing those resources prior to billing Medicaid. See [Appendix F](#) for additional information on TPL.

In addition to coordination of third-party benefits such as Medicare, the MCEs are responsible for coordinating care between home health services and any HCBS services a member may be receiving through a Medicaid waiver. Members on a waiver receiving personal care services through a home health or personal service agency, members are also able to receive state plan home health services simultaneously provided that the services are not duplicative. It is expected that the MCE coordinate care between home health and HCBS services to ensure that HCBS services received by a member are not duplicative of home health state plan services received by the member.

For members who are long-time users of home health services, MCEs will avoid disrupting member home health services without good cause. MCEs will consider the case history of each particular member and prioritize consistency in services.

In determining the appropriate number of hours authorized for home health services, MCEs will consider all the factors noted in the Home Health Services module including whether or not there are informal caregivers who are willing and able to provide care for the member, and if so, how many authorized home health hours the caregiver(s) are willing to and can reasonably cover. The MCEs will determine caregiver willingness and ability to provide care during home health agency's initial assessment visit, using person and family-centered principles, recognizing that caregiving is an additional stressor on the caregiver and family, and the number of hours identified during the assessment will be included in the home health agency plan of care. MCEs will not require documentation of caregiver schedules in making this determination.

Informal caregivers also have the option to be paid for providing home health aide services to the member under certain circumstances. While Indiana law generally excludes "an immediate member of the patient's family" from the definition of "home health aide," the Indiana Department of Health (IDOH) has interpreted Indiana law to not preclude immediate family members from being home health aides for family members provided they meet all home health aide training and certification requirements and are employed by an IHCP enrolled home health agency. However, if a family member is working for compensation as an employee of a home health agency, both the individual and the agency will be held to the same standards of care of a certified home health aide and subject to regulation by IDOH.

All home health services require prior authorization except as outlined in the Home Health Services module (as updated in IHCP bulletins).

For example, prior authorization is not required for home health services following a member's discharge from an inpatient hospital or skilled nursing facility within certain limits.

The MCEs will require home health agencies to utilize the IHCP Prior Authorization Request Form (universal PA form) and relevant procedure codes contained in the Home Health Services module when submitting home health prior authorization requests. The MCEs may require supporting documentation for prior authorization request as outlined in the Home Health Services module but may not request documentation that would not change the authorized services and hours. The State encourages the MCEs to utilize checklists on the prior authorization form to facilitate home health agency compliance with documentation requirements and to expedite prior authorization decisions. All home health prior authorization policies and procedures will be included in the MCE provider manual and made available to members.

To ensure consistency in prior authorization decisions, MCEs are required to follow the policy and guidelines contained in Home Health Services module in determining the medical necessity and authorized units of requested home health services and to utilize any acuity tools adopted by the State for this purpose.

MCEs will endeavor to make home health prior authorization decisions as quickly as possible, recognizing the importance of home health services in preventing hospitalization and institutional stays. If the MCE fails to decide and notify the home health agency provider within seven calendar days after receipt of all required documentation, authorization is deemed to be granted within the coverage and limitations of IHCP home health coverage.

The MCE may sometimes need additional clinical or other information from the provider or member to determine whether requested home health services are medically necessary. In addition, prior authorization requests are sometimes submitted without all the required documentation. In this situation, the MCE can request relevant additional information and suspend the first prior authorization request for up to 30 days after additional information is requested. Suspending the request does not mean the request is denied, but rather gives the requesting provider additional time to provide information that will facilitate a more accurate and appropriate determination. The suspension notification must clearly indicate what additional information is required to complete the prior authorization.

When a prior authorization request is suspended for additional information, the time parameters described above begin upon receipt of the requested information. If the prior authorization request is approved after receipt of the additional information, the dates authorized are those on the originally suspended prior authorization request. If the MCE does not receive the requested information within 30 calendar days after notifying the provider of the suspension, the prior authorization request can be systematically denied.

Once a prior authorization decision has been made, the MCE is required to send a notification letter to the requesting provider and applicable member. The State reserves the right to require the MCEs to utilize State-developed notification templates. If the prior authorization request is denied or modified, the notification letter must include a detailed explanation of the reasons for the decision, including IAC references and administrative and appeal rights available to the member, as well as notice of the member's right to continue home health services as requested during the administrative and appeal period.

MCEs should avoid sudden changes in home health services for members. If a denial or reduction of hours occurs, the MCE will work with the requesting provider and member to create a safe transition plan instead of stopping services abruptly.

Home health billing procedures must comply with the Home Health Services module and claim form, including fields for reporting overhead amounts and occurrence, procedure, and revenue codes applicable to home health. MCEs are required to reimburse providers for the overhead rate described in the Home Health Services module, and claim systems shall be set up to comply with the requirements including timely payment.

MCEs are required to conduct ongoing training for staff or subcontractors reviewing utilization management requests for home health services. MCEs will have a policy and procedure to ensure appropriate training is

conducted on utilization management on an ongoing basis, including timely training regarding any changes in IHCP policies. The MCEs will also provide training to home health agency providers about MCE home health utilization policies, tools, and processes. Transparency and consistency in the prior authorization request process eliminates the most significant home health provider abrasion point.

MCEs will be required to report on relevant home health statistics and results per the MCE Reporting Manual.

MCEs will be required to comply with the network adequacy requirements set forth in the *Indiana Pathways for Aging* scope of work. In addition, the MCEs must carefully monitor home health authorizations and usage to ensure that members are receiving authorized services on a timely basis.

Other objective measures that should be utilized to monitor the adequacy of the home health network include objective measures such as the time between prior authorization approval and receipt of authorized services and ratios of utilized to authorized home health hours. Special consideration should be paid to the equity aspects of the network, including whether home health services are consistently available in both urban and rural areas of the state, whether home health services are consistently available for all members regardless of race and ethnicity or other demographic factors, and whether home health services are available on a timely basis for all relevant member subpopulations, including, for example, subpopulations at greater risk for negative health outcomes as outlined in Section 4.4 of the *Indiana Pathways for Aging* scope of work. Additional information is also available in the Care and Services Coordination Manual.

Home health services are considered a “critical service” as defined in Section 4.18.5.2 of the *Indiana Pathways for Aging* scope of work; the MCE must comply with the provisions of the scope of work to address critical shortages of home health capacity. MCE policies and procedures must be established that identify, correct, track, and report gaps in critical services.

3.1.3 Hospice

Hospice care can be described as a specialized form of interdisciplinary healthcare designed to alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phase of a terminal illness or disease. It also provides for the psychological, social, spiritual, and other needs of the patient’s family before and after the patient’s death.

The MCE is responsible for providing hospice care, to members who meet the criteria in the [Hospice](#) provider reference module and in all settings (e.g., routine home hospice care, continuous home hospice care, inpatient respite hospice care, general inpatient hospice care, etc.).

Members may receive both hospice services and personal care services through HCBS attendant care simultaneously. It is unacceptable for members to choose between receiving hospice and personal care. Hospice services are intermittent and do not support the person remaining at home. Attendant Care should be used to support members who qualify for hospice.

Hospice providers should remember that the Medicare and Medicaid hospice programs are primarily for the treatment of terminal illness and related conditions. Home and Community-Based Services (HCBS) waiver programs and Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) may supplement Medicare or Medicaid hospice. From a funding-stream perspective, the IHCP has always noted that there is a hierarchy of funding streams, in the following order:

1. Private pay/Medicare (Medicare hospice)
2. Medicaid (Medicaid hospice)
3. HCBS waiver programs
4. CHOICE program

Hospices are required to list on the plan of care the frequency and scope of all hospice-covered services needed to treat the terminal condition. To ensure better coordination among the personal care services, the IHCP requires hospice providers to submit documentation as follows:

- All other caregiving services received by the member, including but not limited to services provided by HCBS waiver programs or CHOICE. This list must be included in the hospice authorization request

submitted via the IHCP Provider Healthcare Portal (portal) or using the Indiana Health Coverage Programs Prior Authorization Request Form. This could be an additional form after admission if services are just being started.

- The frequency and scope of the visits planned by each discipline to treat the member's terminal illness and related conditions. This list must be included in the hospice plan of care.
- The frequency and scope of overlapping services provided by the HCBS waiver program or CHOICE for the member's nonterminal conditions. Overlap of these services is permitted. This list must be included in the hospice plan of care.

The MCE must ensure that all hospice providers are enrolled with the IHCP and meet the requirements, including that a hospice provider is required to be Medicare-certified as a hospice [405 IAC 5-34-2], before enrolling the hospice provider in their network. The IHCP further requires a hospice to be licensed by the Indiana Department of Health (IDOH) as a requisite to enrollment as a Medicaid hospice provider. Hospice providers are expected to comply with the Medicare hospice conditions of participation under 42 CFR 418.

3.m Home and Community Based Services (HCBS)

Individualized care planning process must include HCBS level of care and appropriate home and community-based services. Details about the services are identified in the *Indiana Pathways for Aging HCBS Services Manual*. Information regarding the HCBS Settings Rule can be found in the *Indiana Pathways for Aging Settings Rule Guide*.

3.n Participant-Directed Attendant Care Services (PDACS)

The MCE must educate members, who are eligible for HCBS, on the option and offer the opportunity to self-direct attendant care services as an alternative option.

Participant-Directed Attendant Care Services (PDACS) empowers the member, or their representatives, to select, schedule, train, supervise, and (if necessary) terminate their own personal attendants. Members will utilize an Employer Authority model, in which the member employs their own attendant care provider, who can be a family member, a friend, a neighbor, or any other qualified attendant care worker as determined by the State.

Should the State decide to offer budget authority to members participating in PDACS, the MCE must 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 *Indiana Pathways for Aging*. The service coordinator will assess member interest in PDAC and provide the member with information regarding the philosophy of self-direction and the availability of PDACS.

The service coordinator will provide the member with the self-assessment instrument. The self-assessment instrument should be completed by the member with assistance from the member's service coordinator, as appropriate, and stored in the member's file. If the member elects to participate in PDACS, the service coordinator shall complete the PDACS Enrollment Checklist and secure the member's signature. If the service coordinator determines that a member requires assistance to participate in PDACS, the service coordinator shall inform and support the member in that their needs to designating a representative to manage participation in PDACS on their behalf.

Members are permitted to have a representative assist them in participating in PDACS. To participate in PDACS with the assistance of a representative, one of the following must apply:

- the member must have the ability to designate a person to serve as their representative or
- the member has a legally appointed representative who may serve as the member's representative.

A representative will meet, at minimum, the following requirements:

- be at least 18 years of age,
- have a personal relationship with the member and understand their support needs,

- know the member's daily schedule and routine, medical and functional status, medication regimen, likes and dislikes, and strengths and weaknesses, and
- be physically present in the member's residence on a regular basis or at least at a frequency necessary to supervise and evaluate each worker. Minimum weekly visits are necessary. However, depending on the needs of the member, daily visits may be a necessity. This frequency shall be determined through the person-centered service planning process.

A member's representative will not receive payment for serving in this capacity and will not serve as the member's worker for PDACS. The MCE will use a representative agreement to document a member's choice of a representative for PDACS, the representative's contact information, and to confirm the individual's agreement to serve as the representative and to accept the responsibilities and perform the associated duties defined therein. The MCE will notify the Financial Management Services (FMS) within three business days when it becomes aware of any changes to a representative's contact information.

A member may change their representative at any time. The member will immediately notify their service coordinator and the FMS when they intend to change representatives. The service coordinator will verify that the new representative meets the qualifications as described above. A new representative agreement will be completed and signed, in the presence of the service coordinator, prior to the new representative assuming their respective responsibilities. The service coordinator will immediately notify the FMS in writing when a member changes their representative and provide a copy of the representative agreement. The MCE will facilitate a seamless transition to the new representative, to minimize any interruptions or gaps in services. As part of the service plan development process, the service coordinator will educate the member about the importance of notifying the service coordinator prior to changing a representative.

The member's service coordinator shall provide support and assistance to members electing PDACS as detailed in Section 3.10 of the *Indiana Pathways for Aging* scope of work, including reviewing the benefits of self-direction.

If the member has not designated a representative and the service coordinator determines that the member does not require a representative to assist the member in directing their care and services, the service coordinator shall forward to the FMS a referral initiating the member's participation in PDACS. The referral will include, at a minimum:

- date of the referral,
- member's name, address, telephone number, and medical assistance number,
- name of the representative and telephone number (if applicable),
- member's Medicaid ID number,
- Member's *Indiana Pathways for Aging* enrollment date, and
- Service coordinator's name and contact information.

The service coordinator will also forward a copy of the written confirmation of the member's decision to participate in PDACS, the signed service plan, and the representative agreement (if applicable) to the FMS.

Referrals will be submitted daily via electronic submission using the agreed upon data interface and process. Referrals will be submitted on a member-by-member basis.

The back-up plan for PDACS will include the names and telephone numbers of contacts (workers, agency staff, organizations, supports, etc.) for alternate care and services, the order in which each will be notified, and the services to be provided by contacts. Back-up contacts may include paid and unpaid supports; however, it is the responsibility of the member electing consumer direction and/or their representative to secure paid (as well as unpaid) back-up contacts who are willing and available to serve in this capacity. The MCE will not be expected nor required to maintain contract providers "on standby" to serve in a back-up capacity in the case of member self-direction selection for attendant care services.

All persons and/or organizations noted in the backup plan for PDACS will be contacted by the member or representative to determine their willingness and availability to serve as backup contacts. For the initial backup plan, the FMS will confirm with selected persons and/or organizations their willingness and

availability to provide care when needed, document confirmation in the member's file, and forward a copy of the documentation to the MCE.

For members electing self-direction of HCBS services, the MCE will allow eligible members to utilize the State's financial management services vendor(s). The MCE will treat the State's financial management services vendor(s) and all direct service workers employed under the financial management services vendor(s) as in-network providers. A member's chosen care providers must enroll as IHCP providers under the State's financial management services vendor(s) unless those care providers are already IHCP enrolled through another means.

The FMS will provide training to the MCE's service coordinators as outlined [Staff Training](#). The FMS will fulfill, at a minimum, the financial administration and supports brokerage functions detailed in Section 3.10 of the *Indiana Pathways for Aging* scope of work for all members electing PDACS. The FMS will also provide information and supports on an as needed basis.

The MCE or the FMS must provide the following training to all members participating in the PDACS:

- understanding the role of representatives in PDACS,
- understanding the roles and responsibility of the service coordinators and the FMS,
- selecting qualified workers,
- abuse and neglect prevention and reporting,
- nondiscrimination prevention and reporting,
- serving as an employer, evaluating worker performance and managing workers,
- fraud, waste, and abuse prevention and reporting,
- performing administrative tasks such as reviewing and approving timesheets,
- utilization of electronic visit verification systems,
- scheduling workers and back-up planning; and
- ensuring workers maintain daily communication notes for authorized services provided.

Ongoing training will be provided by the FMS to members and/or representatives upon request and/or if the service coordinator or FMS determines that additional training is warranted.

The service coordinator has primary responsibility for oversight and monitoring members' utilization and management of PDACS.

The MCE must monitor:

- service utilization by members using PDACS,
- implementation of the back-up plan by the member or their representative,
- a member's participation in PDACS to determine, at a minimum, the success, and the viability of the service delivery model for the member, and
- any patterns, such as frequent turnover of representatives or workers, habitual mismanagement of authorized services, failure to cooperate with the FMS and changing between PDACS and agency-delivered attendant care services which may warrant intervention by the MCE.

If at any time an unusual occurrence is suspected, the member's service coordinator or the FMS will report the allegations using the web-based incident reporting system administered by the State. If the allegation concerns physical or sexual abuse and is in reference to a worker or representative, the FMS will contact the member/representative to determine if the member/representative wants to place the worker on unpaid leave until an investigation has been completed. If the representative is the subject of the allegation, the representative will not be allowed to decide whether to take leave, and such a decision will solely be up to the member. The member/representative may additionally decide to remove staff at their discretion. The FMS will notify the MCE regarding this communication with the member/representative and the member or

representative's decision. The service coordinator will work with the member to find a new representative and the FMS will work with the member to find a suitable replacement worker, if applicable. If the allegations are substantiated through the investigation, then the representative and/or worker will no longer be allowed to participate in PDACS in any capacity. If the investigation does not result in such disposition, the member may elect to retain the worker or representative.

A member may voluntarily withdraw from PDACS at any time. The member and/or representative will be advised to notify the service coordinator when participation is no longer desired.

The member shall be identified for involuntary termination from PDACS, if either the FMS or service coordinator identify any of the following:

- an immediate health and safety risk associated with participant-direction, such as, imminent risk of death or irreversible or serious bodily injury related to the provision of PDACS,
- paid caregiver abuse,
- misuse of funds,
- failure to follow PDACS policies and/or guidance,
- providing false information and/or documentation, and/or
- member has been convicted of illegal activity.

A paid caregiver providing PDACS to a member shall be identified for involuntary termination from PDACS, if either the FMS or service coordinator identify any of the following:

- an immediate health and safety risk associated with participant-direction such as imminent risk of death or irreversible or serious bodily injury related to the provision of PDACS,
- member abuse and/or neglect,
- misuse of funds following notification and technical assistance from the FMS and/or the service coordinator,
- failure to follow PDACS policies and/or guidance, following notification and technical assistance from the FMS and/or the service coordinator,
- providing false information and/or documentation, and/or
- determination of a paid caregiver in violation of 455 IAC 2-15-2.

The MCE will forward any cases in which the MCE plans to involuntarily terminate a member from PDACS to the State. If the State approves the MCE's request, the MCE will notify the member, which will activate the member's right to appeal the determination.

Upon receipt of a member's request to withdraw from PDACS, the service coordinator will conduct a face-to-face visit and update the member's service plan, as appropriate, to initiate the process to transition the member to agency-provided attendant care services. The member will be advised of their right to appeal the determination of involuntary termination. PDACS services shall continue during the appeal. Members or paid caregivers who have been involuntarily terminated may request to be reinstated to PDACS after 24 months have elapsed. The service coordinator will work with the FMS to ensure that the issues previously identified as reasons for termination have been adequately addressed prior to reinstatement. All members will be required to participate in PDACS training programs prior to reinstatement in PDACS.

3.0 Informal Caregiver Support

3.0.1 Informal Caregiver Training, Education, and Resources

For members who are determined to not meet NFLOC and who have an informal caregiver, the member's care coordinator will refer the member's informal caregiver to resources (including training and education appropriate and applicable to the member and caregiver's needs).

The MCE will refer all informal caregivers, regardless of the member's NFLOC determination, to trainings such as:

- how to assist/support the member with activities of daily living,
- incontinence support,
- prevention of health risks due to limited mobility,
- changing bandages,
- administering medications and injections,
- transferring from bed to chair,
- precautions to prevent infectious diseases in the home and community,
- 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, and
- on at least an annual basis, and when otherwise appropriate, education on how to identify and report suspected abuse and neglect.

The MCE must provide training, education, and resources in accessible formats to ensure access for the informal caregivers (e.g., in-person meetings, telephonic and web platforms, written toolkits and guidebooks, etc.). The MCE must observe the communication requirements in [Member Services](#).

Additionally, non-waiver supports should be coordinated by the MCE, with the informal caregiver, and may include providing directories and assistance in contacting community social and health resources and opportunities (e.g., community social supports, food banks, utility and housing assistance, legal services, financial services, insurance assistance, support groups, respite services, etc.). The MCE is encouraged to identify other community health resources and opportunities local to the member and their informal caregiver and provide to the State documentation on processes and the frequency of which this is completed.

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 MCE must 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,
- Participant-Directed Attendant Care (Self-Direction), and
- Informal Caregiver Coaching and Behavior Management:
 - The member's service coordinator shall provide the waiver service provider for informal caregivers who receive the Informal Caregiver Coaching and Behavior Management waiver service with the results of the informal caregiver assessment and a record of any referrals to training, education, or resources that the MCE has already provided to the informal caregiver to reduce assessment redundancy and/or service duplication.
 - The service coordinator must work with the informal caregiver, and informal caregiver coach as applicable, 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 MCE 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 appropriate),

- healthcare providers including contact information,
- emergency contacts,
- identification and contact information for back-up informal caregiver(s),
- contact information for informal caregiver coach and MCE care team, and
- informal caregiver resources available within the caregiver's/member's community of choice.

3.0.2 Informal Caregiver Coaching

An Informal Caregiver Coach (Coach) is a provider authorized to deliver the Informal Caregiver Coaching and Behavior Management waiver service, within the MCE's network, who is assigned to an informal caregiver.

The MCE must consider the Coach as a member of the MCE's care coordination team and must incorporate them in care/service planning as appropriate and with the consent of the member.

The Coach shall be the informal caregiver's primary point of contact. Informal Caregiver Coaching and Behavior Management waiver services must be delivered in one or more of the following formats:

- in-person,
- telephonically, and/or
- through HIPAA secure electronic communication platforms that enable the Coach and an informal caregiver to communicate efficiently and in a manner convenient to the informal caregiver.

Provider agencies must record any informal caregiver communications through an electronic communication platform to facilitate the sharing of relevant information with the MCE.

The Coach shall engage 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. The Coach shall deliver education, strategies, and tools related to the support of the member's needs and the informal caregiver's self-care needs on a routine basis.

3.0.3 Informal Caregiver Assessments

Consistent with the State'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 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. For additional information see *Indiana Pathways for Aging* scope of work, Section 4.8.2 and the *Indiana Pathways for Aging* Care and Service Coordination Manual.

3.p Continuity of Care

The State is committed to providing continuity of medical care during a member's transition period among the various IHCP programs. The MCE is financially responsible for providing medically necessary care during the transitions. Some examples of the need for special consideration include, but are not limited to, the following:

- 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 *Indiana Pathways for Aging* program from no coverage, commercial coverage, traditional fee-for-service, or 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 *Indiana Pathways for Aging* program to receive excluded or carved out 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 MCE must provide continuity of care for the authorization of services as well as choice of providers for 120 days. The MCE must establish policies and procedures for identifying outstanding prior authorization decisions at the time of the member's enrollment into their plan.

When receiving members from another MCE, fee-for-service, or commercial coverage, the MCE must honor the previous care authorizations for one of the following durations, whichever comes first:

- 120 calendar days from the member's date of enrollment with the MCE,
- the remainder of the prior authorized dates or service, or
- until the approved units of service are exhausted.

For a member who meets HCBS Level of Care and has an existing service plan (of care)/care plan approved by the State or another MCE, that service plan (of care)/care plan will be honored for 180 calendar days from the date of enrollment. If the member's current medical or HCBS provider is not a contracted provider the MCE will provide for the continuation of care from that provider for at least 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 will be 90 days from the date of member enrollment for the authorization of services as well as choice of providers. The MCE must honor previously approved State or other Medicaid MCE care plans for 180 days, after the first year of the program.

Skilled nursing facilities are an exception to the continuity of care periods. Since skilled nursing facilities serve as the member's residence, forced transitions can cause adverse health outcomes. As such, the MCE must 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 (NFLOC).

The date of member enrollment, for purposes of the prior authorization time frames set forth in this section, begin on the date the MCE receives the member's fully eligible file from the State. The MCE must establish policies and procedures for identifying outstanding prior authorization decisions at the time of the member's enrollment into their plan.

When members enroll in or change MCEs, active authorizations for services or procedures that were not completed in former plan will be the responsibility of new MCE. The prior authorizations may be for specific procedures, such as surgery, or for ongoing procedures authorized for specified durations. Requiring duplicate authorizations from the new health plan places an additional burden on the provider and can delay or inappropriately deny member's treatments or services.

When a member transitions to another source of coverage, the MCE shall be responsible for providing the receiving entity with information on any current service authorizations, utilization data and other applicable clinical information, such as prevention and wellness programs(s), case management or care management notes. This process shall be overseen by the transition coordinator.

The MCE will be responsible for care coordination after the member has disenrolled from the MCE whenever the member disenrollment occurs during an inpatient stay.

- When reimbursement for the stay is based on a diagnosis-related group (DRG) methodology, the admitting MCE is responsible for the entire inpatient stay through member discharge. The admitting MCE is financially responsible for the hospital DRG payment and any outlier payments (without a capitation payment) until the member is discharged from the hospital or the member's eligibility in Medicaid terminates. If the member is transitioning from the admitting MCE to another MCE, the admitting MCE must coordinate discharge plans with the member's new MCE.

- In instances when reimbursement for the inpatient stay is based on a LOC methodology, the admitting MCE is responsible for the days of the inpatient stay during which the member is enrolled with the MCE and for the transition of care coordination for the remainder of the stay. The admitting MCE is financially responsible for the *per diem* payments and any outlier payments (without capitation payment) associated with the days the member remains enrolled with the admitting MCE. If the member is transitioning from the admitting MCE to another MCE or from the admitting MCE to Traditional Medicaid, the receiving MCE or the Traditional Medicaid program is responsible for the *per diem* payments associated with the days the member is enrolled with the receiving MCE or in Traditional Medicaid, until the member is discharged from the hospital or the member's eligibility for Medicaid terminates. The admitting MCE is responsible for the transition of care coordination with the receiving MCE or with the inpatient provider, as applicable.

The entity that issued the original prior authorization provides the new health plan with the following:

- Member ID
- Provider ID
- Procedure codes
- Duration and frequency of authorized services
- Other information pertinent to the determination

This information can be provided in spreadsheet format, computer screen prints, authorization form copies, or any other mutually agreed-upon format.

Throughout any transition, confidentiality of protected health information (PHI) must be maintained in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

See [Behavioral Health Continuity of Care](#) for additional requirements regarding continuity of care for behavioral health services.

3.q Housing

Safe, stable, and affordable housing in the least restrictive community setting is a critical component of a member's overall well-being and care.

The MCE must have policies in place outlining the process to evaluate each member's housing needs as well as coordination of care processes to assist members in attaining and maintaining acceptable housing and supportive services.

If the MCE identifies a member at risk of homelessness, the MCE must assist the member in obtaining and maintaining a home in the community and make every effort to assist members in navigating community housing and housing support resources.

MCE 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 MCE must 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 MCE must have a strategy to strengthen networks with housing providers and develop access to affordable housing; this must include collaborating with other MCEs and other stakeholders to develop and implement strategies for the identification of resources to assist in placing members in affordable housing.

As listed in [Staffing Requirements](#) and [Staff Training](#) the MCE will have a housing coordinator, care managers, and service coordinators who have training on housing needs assessment and resource identification.

3.r Medical Equipment

Medical equipment is an essential support for members maintaining independence in the community and avoiding institutionalization or re-institutionalization. For members transitioning from a nursing facility back to home/community or discharging from the hospital back to the home/community, it is essential for the MCE to have medical equipment in place for the member upon relocation to home or other identified residence.

Members may receive medical equipment from the State Plan as well as HCBS waiver. The waiver supplements medical equipment not covered by State Plan. An incorrect practice is to wait for a prior authorization denial of medical equipment before obtaining it through the HCBS waiver. If the item is not allowable through State Plan, the MCE is required to move forward with securing it through waiver medical equipment and not waiting on a prior authorization denial. Waiting on a prior authorization denial will only cause delays in the member receiving services.

Medical equipment is not limited to members living at home. Medical equipment may also be used to support members living in congregate settings such as nursing facilities, assisted living facilities, adult family homes and attending adult day centers. It is not the responsibility of the congregate setting to pay for medical equipment for residents because these may be purchased through Medicaid State Plan or HCBS Waiver.

The MCE is responsible for coverage of Durable Medical Equipment (DME), Home Medical Equipment (HME) and Medical Supplies as detailed in [Durable and Home Medical Equipment and Supplies](#) provider module as well as Indiana Administrative Code. The MCE is responsible for coverage of Specialized Medical Equipment & Supplies (SMES) for members receiving HCBS LTSS.

- **Durable Medical Equipment (DME)** – Equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, and generally is not useful to a member in the absence of illness or injury [405 IAC 5-19-2].
- **Home Medical Equipment (HME)** – Equipment that is prescribed by a healthcare provider; sustains, restores, or supplants a vital bodily function; and is technologically sophisticated and requires individualized adjustment or regular maintenance. HME does not include walkers, ambulatory aids, commodes or any HME that the Indiana board of pharmacy specifies not to be regulated [IC 25-26-21-2].
- **Medical Supplies** – Items that are disposable, nonreusable and must be replaced on a frequent basis. Providers use medical supplies primarily and customarily to serve a medical purpose, and medical supplies are generally not useful to a person in the absence of an illness or an injury.
- **Specialized Medical Equipment & Supplies (SMES)** – Items that assist members in maintaining their health, welfare, and safety, and enable the member to function with greater independence in the home (e.g., lift chairs, medication dispensers, etc.).

The MCE will, at a minimum, provide coverage for the procedure codes that the IHCP covers for DME providers (specialty 250) and HME providers (specialty 251); see [Durable and Home Medical Equipment and Supplies Codes](#), accessible from the [Code Sets](#) page.

The MCE may require a physician order for all DME and HME. Additionally, the MCE may require a prior authorization (PA) for DME, HME and medical supplies. PA criteria shall be consistent with criteria outlined in 405 IAC 5-19; also see [Prior Authorization](#) provider module. The PA requirements in this and any referenced document should be used as a guideline for determining procedures requiring PA, but the IAC and

any subsequent bulletins are the primary reference. In accordance with 405 IAC 5-19-6, PA is required for most DME and HME rented or purchased with IHCP funds.

The MCE will provide coverage for Incontinence, Ostomy, and Urological Supplies based on Medical Necessity. The MCE will assure that incontinence, ostomy, and urological supplies can discretely be delivered by mail to members. The MCE may set a maximum allowable amount for incontinence supplies, but any maximum shall be at least as much (or more than) that which is covered by the IHCP FFS program.

3.r.1 MCE Service Coordination Requirements with Medical Equipment

While medical equipment may be a higher up-front cost, it is less expensive over time, specifically less cost than attendant care; and it supports the person's independence. For this reason, MCEs are required to think outside the box and use the most innovative medical equipment to support its members. The more innovative equipment, especially around incontinence supplies, has proven to stabilize a person at home longer and reduce nursing facility and hospital admissions.

Within the medical equipment service on the HCBS Waiver, there are "allowable" and "unallowable" equipment selections. The "allowable" section is a list of suggestions that a member could utilize, but service coordinators are expected to first understand the member's need for medical equipment and research possible equipment options to best meet the need. As long as the item is not covered under the "unallowable" section within the medical equipment service, it is allowed to be placed in the service plan. Medical equipment providers are experts in knowing what equipment is available to meet needs of specific conditions. It is expected that service coordinators will collaborate with medical equipment providers for recommendations of how to best meet a member's need.

The type of equipment used, the speed in which the equipment is placed in the home, and the training provided on the equipment are important factors to ensure a person remains in the home/community. It is expected that the MCE service coordinator will facilitate or provide training to the member to properly use the equipment. Routine follow up with the member during monthly visits on what's working/not working with the equipment as well as offer re-training is an MCE responsibility.

3.s Opioid Treatment Program (OTP)

The MCE must provide coverage for the daily Opioid Treatment Program (OTP). A daily OTP includes:

- administration and coverage of methadone,
- routine drug testing,
- group therapy,
- individual therapy,
- pharmacological management,
- HIV testing,
- hepatitis A, B, and C testing,
- pregnancy tests,
- tuberculosis testing,
- syphilis testing,
- follow-up examinations,
- case management, and
- one medical office visit every 90 days for the management of member activities identified in the individualized treatment plan that assist in member goal attainment. Goal supports includes referrals to other service providers and recovery support groups.
- OTP coverage will include those members as defined by the State and approved by CMS. The MCE is responsible for OTP services provided by the provider type Addictions Provider and the provider specialty OTP as defined in the [IHCP Provider Enrollment Type and Specialty Matrix](#).

Indiana Pathways for Aging program members who may be OTP-eligible members include:

- Members 18 years and older (age 60+ for applicability to this program) who have become addicted at least one year prior to admission and are placed in the Opioid Treatment Services (OTS) Level of Care according to all six dimensions of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria,
- All members released from penal institution (within six months of release),
- Pregnant members, or
- Previously treated members (up to two years after discharge).

3.t Dental Services

Dental services are critical to ensuring the overall health of members. As such, dental services are a covered benefit under the *Indiana Pathways for Aging* program that the MCE is responsible for managing and reimbursing. The MCE will develop a comprehensive oral health strategy, in consultation with dental providers, that ensures appropriate utilization of this benefit by members consistent with dental standards of care. The strategy must contain an MCE action plan to address barriers to oral health care and recognize disparities. Examples of effective strategy include member outreach (i.e., community events) and mobile dentistry. In addition to provider collaboration in plan development, the MCE shall garner input from relevant stakeholders including members. MCEs are encouraged to consider enhanced dental services beyond the minimum expectations of the State.

High dental needs are identified as posing a greater risk for negative health outcomes. Care coordination must include dental care assessment with the person-centered approach model of care. The MCE must ensure adequate and timely access by providing a robust dental network. Member education shall include all pertinent information on covered dental services and obtaining a provider (including assistance with making an appointment).

3.u Non-Emergency Medical Transportation Services

Non-emergency medical transportation (NEMT) services are a covered benefit under the *Indiana Pathways for Aging* program which the MCE is responsible for managing and reimbursing. NEMT services are intended to assist members in accessing care due to a lack of transportation or insufficient resources to cover travel expenses. NEMT services occur when needs are not immediate, such as scheduled appointments, dialysis, chemotherapy, physical therapy and picking up prescriptions. Hospital discharges to home and nonemergency interfacility transports, excluding hospital-to-hospital ambulance transports, are also considered NEMT services.

The MCE may provide transport to non-medical services at its own discretion and expense as an enhanced benefit (requires 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 including:

- ambulatory transportation,
- wheelchair transportation,
- basic life support (BLS) services, and
- advanced life support (ALS) services.

Under the *Indiana Administrative Code 405 IAC 5-30-1.5*, The MCE must allow for gas and mileage reimbursement when the transportation is provided by an able-bodied member, a member's family member or a member's friend. MCEs must offer gas/mileage reimbursement and pay a minimum per-mile rate as set annually by the Indiana Department of Administration. The MCE must have a State-approved process for gas and mileage reimbursement authorization, scheduling, and payment.

Note: Copies of personal records must be placed in a prominent location in the member's file and must accompany the member during transport for medical care or in accordance with State law.

3.u.1 Non-Emergency Medical Transportation Providers and Provider Network

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

All NEMT providers must:

- be enrolled as Medicaid provider in the Indiana Health Care Programs (IHCP),
- actively hold Indiana Motor Carrier Certification (unless exempt by law or carrier classification), and
- secure and maintain liability insurance of \$1 million plus a \$50,000 sexual molestation and abuse insurance rider for duration of contract term.

The MCE must 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. 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.

The MCE is responsible for ensuring all initial certification and enrollment are complete prior to contract with a provider. The MCE is also responsible for monitoring the providers including vehicle compliance inspections and driver education/training.

The MCE 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 MCE will also ensure providers are claiming the most appropriate transportation benefit when a member is enrolled in the MCE's aligned Dually Eligible Special Needs Plan (D-SNP), and the D-SNP offers non-emergency medical transportation benefits as part of its plan benefit package. The MCE must ensure sufficient communication and coordination with the relevant staff at its aligned D-SNP to ensure providers have sufficient awareness of how to access the appropriate member transportation benefit and accurately submit claims to the correct payer source.

The MCE must provide transportation network adequacy GeoAccess maps that detail whether members have access to ambulatory, wheelchair, bariatric wheelchair, stretcher, and bariatric stretcher within 92 counties. The MCE 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.

Transportation Provider Requirements

Under the *Consolidated Appropriations Act, 2021, Division CC, Title II, Section 209* the MCE 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 (excluding any public transit authority), meets specified minimum requirements. These minimum requirements under the State Plan must include that:

- Each provider is not excluded from participation in any federal health care program and is not listed on the exclusion list of the Inspector General of the Department of Health and Human Services,

- Each individual driver is not excluded from participation in any federal health care program and is not listed on the exclusion list of the Inspector General of the Department of Health and Human Services,
- Each such individual driver has a valid driver's license,
- Each such provider has established policy to address any violations of a state drug laws, and
- Each such provider has established policy and process to disclose to the State Medicaid program the driving history, including any traffic violations, of each individual driver employed by provider.

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

Additional Driver Requirements

The MCE is required to verify and keep record of (available to the State upon request) the below information for each driver employed by, or as, a Transportation Provider:

- Driver's name and date of birth,
- Legible copy of valid driver's license,
- Driver's license number, expiration date, and type of license,
- First aid training and current certificates including the certificate's expiration,
- Current Cardiopulmonary Resuscitation (CPR) training certification and the certification's expiration,
- Date of hire
- Date of termination (if applicable) and reason,
- Log of member complaints regarding driver,
- Any on-the-job accident history,
- Any on-the-job vehicular moving violation history,
- Date of completed Broker training, and
- Annual criminal background checks/monthly federal exclusion checks.

The MCE must ensure that all driver staff receive trainings including, but not limited to, those detailed in [Staff Training](#). The MCE must develop, and submit to the State, a driver/provider training curriculum to be used in new employee onboarding and as a part of corrective action should issues arise.

3.u.2 NEMT Communications

The MCE must operate a transportation call center that is available 24 hours per day, seven days per week and 365 days per year. There must be a dedicated facility provider line for scheduling and processing standing orders for transportation. The MCE must operate a web-based scheduling service so provider facilities, caregivers, and members can access assistance online. The MCE is encouraged to provide access to web-based scheduling service on the MCE's member website.

All MCE and Transportation Broker materials for providers must be State approved. The MCE is encouraged to develop materials (and submit to the State for approval prior to distribution) that effectively support relevant staff in securing timely and appropriate transportation for *Indiana Pathway for Aging* members.

NEMT Scheduling

For non-urgent rides, members should contact the MCE at least two business days in advance to arrange for transportation. This must be reserved through the MCE's reservation phone line or online. Members may request that rides be arranged with their preferred provider as long as that provider is enrolled with the IHCP and is contracted by (on/prior to date of transport) the MCE, and the provider's level of transportation is suitable for the member.

For hospital discharges to home, the hospital should contact the MCE. The MCE should work closely with the hospital to find the closest, most appropriate provider to transport and will respect preferred provider relationships.

For nonemergency interfacility transports between a hospital and a long-term care facility, facilities should contact the MCE's Nursing Home Dispatch Line. These interfacility transports should be seen as urgent transports. Urgent transports are required to be serviced within three hours of notice and the MCE is expected to make arrangements accordingly.

Emergency transports are not included as NEMT services and shall be managed via standard 9-1-1 protocols. Emergency transportation occurs when the member's needs are immediate, such as heart attack, stroke, transplant, serious injury, or other life-threatening situations. See the Emergency Transports in Response to 9-1-1 Dispatches sections for details. Additional information can also be located in the [Transportation](#) provider module.

Emergency Transports in Response to 9-1-1 Dispatches

IHCP considers all transports to an emergency room in response to 9-1-1 dispatches to be emergency transports. For 9-1-1 dispatched trips to an emergency room, ambulance providers should bill the appropriate procedure codes for emergency advanced life support (ALS), or basic life support (BLS) services based on the type of services provided during the transport. If an ambulance dispatched by 9-1-1 transports a member to a destination other than the emergency room, the transport is considered nonemergency, and reimbursement is subject to the billing rules of the transportation broker associated with the member's benefit plan and/or managed care entity (MCE) assignment.

3.u.3 NEMT Care Coordination

The *Indiana Pathways for Aging* 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 MCE is required to work with staff at all facility types and provider locations to ensure a timely and safe transport for members. MCE staff should be available to assist in troubleshooting and problem solving transportation issues.

All *Indiana Pathways for Aging* members shall be provided with a written summary of NEMT services and scheduling process upon enrollment. Care plans for members must include transportation needs and how those needs will be met. 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 must work with the member, caregivers, and facilities as appropriate to develop the care plan ensuring the members' access to medical care and services. Care coordinators must be available to troubleshoot issues, make changes to care plans as needed, and provide education. The MCE must have a clear, State-approved process to streamline the scheduling of standing orders, hospital discharges, and mileage reimbursement requests. The MCE must also clearly detail how transportation benefits for members enrolled in both Medicare and Medicaid (dually eligible) will be coordinated, especially if those members are enrolled in the MCE's aligned D-SNP and the D-SNP offers NEMT benefits as part of its plan benefit package.

The MCE must allow for an escort to ride with the member if the member requires any of the following:

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

Members are not required to provide evidence of their need for an escort. However, MCEs must educate member to alert the MCE during scheduling of particular transport/escort needs. In addition, the MCE must

ensure call center scheduling staff ask screening questions to determine if the member would be best served by having an escort.

3.u.4 Community Transportation

Community Transportation is described as *nonmedical transportation* services offered to enable members, who are receiving the HCBS benefit, access to non-medical community services, activities, and resources. This service is offered in addition to medical transportation and shall not replace. Services provided under nonmedical transportation services will not duplicate services provided under the Medicaid State Plan or any other waiver service.

Whenever possible, family, neighbors, friends, or community agencies that can provide the service without charge shall be used. The MCE 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.

For more information including service standards, documentation standards, disallowed activities, and provider qualifications, see the [Division of Aging Home and Community-Based Services Waivers](#) provider reference module.

3.u.5 Attendant Care Aide Transportation

Transportation to community appointments is available for individuals utilizing the attendant care service. Attendant care aides are not provided as NEMT services and are not eligible for reimbursement. Any transportation needs for medical appointments must go through the MCE.

The attendant care providers can accompany members during their appointments to provide companionship and help ensure information is understood.

The following are examples of reimbursable attendant care transportation services when provided by an attendant care aide:

- Transportation to and from community events, including but not limited to:
 - Daily errands
 - Grocery shopping
 - Participation in community activities
 - Transportation to nonmedical appointments
- Accompanying the member in the nonemergency medical transportation (NEMT) van and assisting with activities of daily living, including but not limited to:
 - Ambulation (sitting, standing, walking)
 - Transfers between vehicle and medical appointment, transfers from a waiting room to medical office, and transfers from vehicle to home
 - Mobility during meeting with medical professional
 - Mobility when returning home from medical appointment
 - Toileting during course of medical trip (to and from and during medical appointment)
 - Eating during course of medical trip (to and from and during medical appointment)
- Providing companionship activities or hands-on assistance while driving the member to and from medical appointments:
 - The attendant care aide is not prohibited from driving a member to a medical appointment but cannot receive reimbursement for driving. To receive reimbursement, the attendant care aide must perform hands-on activities throughout the course of the trip (to and from medical appointment).
 - The aide could also provide companionship activities, including assisting the member in navigating the medical appointment. The attendant care aide may bill for the time it takes to perform each hands-on service for the member.

The following are examples of **non-reimbursable** attendant care transportation services when provided by an attendant care aide:

- Only driving member to and from medical appointment without providing any hands-on care to the member.
- Fuel or mileage associated with taking the member to a medical or nonmedical event unless the provider is billing under the separate waiver service of nonemergency medical transportation.
- Requiring a Medicaid waiver member to pay for fuel or mileage associated with agency staff assisting members in the community or medical appointment.

Any nonmedical or companion services provided through the attendant care service must remain within the overall allotted hours on the member's service plan.

Additional Attendant

Transportation providers sometimes need to employ an additional attendant to help transfer members. In situations where the driver cannot transfer a member without assistance, such as a wheelchair-bound member with upstairs housing and the residence has no wheelchair ramp, the provider may need support of an additional attendant. The additional attendant who assists must be an employee of the billing provider and is not required to remain for the trip. Providers must document the need for an additional attendant on the driver's ticket. Type of documentation is subject to post payment review by the State. The IHCP limits the number of additional attendants to a maximum of two extra units although usually one attendant is sufficient. The IHCP limits reimbursement for an additional attendant to Non-ambulatory Service Transportation, wheelchair van, and ambulance transportation. For ambulance providers, the additional attendant is the third or fourth attendant because the IHCP requires ambulances to have two attendants. For additional information, please see the Transportation provider module.

3.v Medication Therapy Management Services

The MCE shall cover Medication Therapy Management (MTM) services. The goals listed below must remain at the forefront of MCE program processes to the benefit of *Indiana Pathways for Aging* members who are identified as high risk due to a combination of chronic disease state and multiple unique prescribed medications. The MTM program implemented must:

- be member focused.
- improve medication use to ensure optimum therapeutic outcomes.
- reduce risk of adverse events.
- improve adherence.
- be furnished by pharmacists or other qualified providers.

General requirements of the MTM services are based on the CMS Medicare Part D MTM program requirements as described in Title 1, Part 423, Subpart D, § 423.153. While members may refuse to participate in the MTM program, the MTM activities which do not require the member's direct involvement shall continue to be performed by the MCE. The MCE must continue to work with members who do not participate in, or cooperate with, the program. A significant part of MTM involves reviewing members' medication profiles looking for drug-drug interactions, drug-disease interactions, adverse reactions, drugs added to counteract side effects of other drugs, or drugs added that have redundant mechanisms of action and thereby increase the risk of toxicity. All the interventions listed are with the prescriber and do not necessarily require member interaction. The MCE is expected to retain metrics for members with whom the MCE attempts to engage but refuse to participate or cooperate. The MCE shall continue to attempt to involve those members and shall attempt to engage non-participating members, at minimum, on an annual basis.

The MTM program must:

- Provide interventions (e.g., Comprehensive Medication Review, Targeted Medication Review, review concerns members have about their medications, make recommendations to providers and members about

medications) to be performed by registered pharmacists or other licensed medical professionals such as nurses, nurse practitioners, prescribers and other physicians.

- During the first four months after contract initiation, as members transition to *Indiana Pathways for Aging*, the MCE must engage targeted members within 180 days. Following this 4-month period, the MCE must engage new members targeted for MTM within 60 days.
- Continue working with members who do not participate in, or cooperate with, the program. A significant part of MTM involves reviewing members' medication profiles looking for drug-drug interactions, drug disease interactions, adverse reactions, and drugs added to counteract side effects of other drugs. All of the aforementioned involve interventions with the prescriber and do not necessarily require member interaction.
- Interact with engaged members, following the initial MTM service, on a frequency as determined by the MCE, based on member need, but not less than once per year.
- Provide all MTM enrollees, at least annually, information about safe disposal of controlled prescription drugs, pursuant to 42 C.F.R. § 423.153(d)(1)(vii)(E).
- Include members with the following targeted conditions:
 - Alzheimer's Disease and other Dementias
 - Chronic Heart Failure (CHF)
 - Diabetes
 - Dyslipidemia
 - End-Stage Renal Disease (ESRD)
 - Hypertension
 - Respiratory Disease (e.g., Asthma, COPD, CF, etc.)
 - Bone Disease (e.g., Arthritis, Osteoporosis, Osteoarthritis, Rheumatoid Arthritis)
 - Mental Health Disorders (e.g., Depression, Psychosis, Schizophrenia, Bipolar Disorder, etc.)
 - Neuromuscular Disorders (e.g., Multiple Sclerosis, Parkinson's Disease)
 - Viral Disease (e.g., Hepatitis C, HIV, AIDS)

In performing MTM functions, the MCE must demonstrate a thorough understanding of the federal regulations and guidelines which direct the monitoring, oversight, intervention and reporting of psychotropic drug utilization. Further, in performing MTM functions the MCE must collaborate and cooperate with the prescriber interventions made as a result of the Indiana Psychotropic Medication Initiative.

The MCE must offer a minimum level of Comprehensive Medication Review (CMR) services to each member enrolled in the program that includes interventions with members and prescribers.

CMR must include personal medication list, medication action plan, summary of recommendations, and medication refill reminders.

The MCE's Medication Therapy Management program must target members with the following criteria:

1.
 - a) three or more of the targeted conditions, based on drug claims, and
 - b) eight or more chronic drug claims within the past 12 months, and
 - c) likely to incur annual costs for covered Medicare Part D drugs greater than or equal to the CMS specified MTM cost threshold.
2. *At-risk beneficiaries (ARBs)*, defined at § 423.100 as members with an active coverage limitation under a Drug Management Program (DMP)

There may be some overlap between the populations that meet the eligibility criteria under (1) and (2).

For example, a beneficiary who is an ARB under the plan's DMP (2) who also meets MTM criteria based on having multiple chronic diseases, multiple Medicare Part D drugs and meeting the cost threshold (1).

Despite the possibility for overlap, the MCE must identify all targeted members eligible for MTM and apply the same requirements for targeting regardless of whether the member meets the criteria under (1), (2), or both.

Medication Therapy Management Reporting is required on a semi-annual basis. The State may request reporting and metrics on an ad hoc basis to monitor the MCE's effective oversight of this targeted population. The reporting requirements are the same as CMS requirements; refer to the *MCE Reporting Manual* for report specificity.

3.w Enhanced Services

The State encourages the MCE to cover programs that enhance the general health and quality of life of its *Indiana Pathways for Aging* members, including but not limited to programs that address preventive health, risk factors, or quality of life. These enhanced programs and services are above and beyond those required and covered in the *Indiana Pathways for Aging* program.

All enhanced services shall comply with the member incentives guidelines set forth in [Member Incentive Programs](#) and other relevant state and federal rules regarding inducements. All enhanced services offered by the MCE must be pre-approved by the State by using the Enhanced Services and Incentive Request form.

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

- Transportation arrangements (e.g., transportation to obtain pharmacy services, attend member education workshops on nutrition, healthy living, parenting, etc.),
- Tobacco dependence treatment services,
- Prevention and wellness incentives,
- Healthy lifestyle incentives,
- Group visits with nurse educators,
- Medical equipment or devices not already covered in the *Indiana Pathways for Aging* program, 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 avoid unintended consequences, disparities, and access issues. The following set of guiding principles shall be considered in benefit design and implementation:

- **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 based on 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 be of 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 MCE 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.

Section 4: Care Coordination

All members will be offered person-centered Care Coordination reflective of their needs to assist them in planning, accessing, and managing their health care and health care-related services.

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. Service Coordination is a process of assessment, discovery, planning, facilitation, advocacy, collaboration, and monitoring of the holistic LTSS and related environmental and social needs of the individual.

The MCEs shall adopt and adhere to service standards as outlined in *Indiana Pathways for Aging Care* and Service Coordination Manual.

Section 5: Member Services

5.a Marketing and Outreach

All marketing efforts must be targeted to the general community in the MCE's entire service area. In accordance with *Code of Federal Regulations 42 CFR 438.104*, the MCE cannot conduct, directly or indirectly, door-to-door, telephone, or other *cold-call* marketing enrollment practices. *Cold-call marketing* is defined in *42 CFR 438.104*. The MCE may market via digital, mail, and mass media advertising such as digital media, radio, television, and billboards, social/digital media and community-oriented marketing directed at potential members. Community oriented marketing such as participation in community health fairs is encouraged. Tokens or gifts of nominal value may be distributed at such events to potential members, so long as the MCE acts in compliance with all marketing provisions provided for in *42 CFR 438.104*, and other federal and state regulations and guidance regarding inducements in the Medicare and Medicaid programs.

Upon request by members, or potential members, marketing materials must be available in the member's preferred language and/or format. The MCE shall document the member's preferred language and/or format and deliver all future materials to the member in the preferred manner. The MCE shall submit product naming and associated domains to the State for review and approval to minimize confusion for members and providers.

All member marketing and outreach materials must be submitted to the State for approval before distribution. Any outreach and marketing activities (written and verbal) must be presented and conducted in an easily understood manner and format, at or below a fifth-grade reading level, and must not be misleading or designed to confuse or defraud. The MCE must not conduct individual enrollee marketing activities. This prohibition includes, but is not limited to, the following information and activities:

- Materials and/or activities that mislead, confuse, or defraud or that are unfair or deceptive practices or that otherwise violate federal or the State consumer protection laws or regulations. This includes materials which mislead or falsely describe covered or available services, membership or availability of network providers, and qualifications and skills of network providers.
- Overly aggressive solicitation, such as repeated telephoning or continued recruitment after an offer for enrollment is declined, or similar techniques,
- Offers of gifts or material or financial gain as incentives to enroll,
- Compensation arrangements with marketing personnel that utilize any type of payment structure in which compensation is tied to the number of persons enrolled,
- Direct solicitation of prospective enrollees,
- Directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities,
- Use of independent marketing agents in connection with marketing activities. Independent marketing agents shall not mean staff necessary to develop or produce marketing materials or advertising or other similar functions,
- Seeking to influence enrollment in conjunction with the sale or offering of any private insurance,
- Distributing marketing materials to select or partial service areas for which the MCE is authorized to serve,
- The MCE shall not use the Indiana Medicaid MCE name in any form of general marketing without the State of Indiana's prior written approval,
- Any activity deemed contrary to the goals of the *Indiana Pathways for Aging* by the State of Indiana,
- Any assertion or statement that the member or potential member must enroll with the MCE's health plan to obtain benefits or avoid losing benefits, and/or
- Any assertion or statement that the MCE is endorsed by CMS, the federal or the State government or a similar entity.

The MCE may distribute or mail informational brochures or flyers to potential members. The State must preapprove all promotional and informational literature/graphics before displaying or distributing.

5.b New Member Materials

The MCE must distribute member materials as required by the *Indiana Pathways for Aging* scope of work. Required materials, described below, include member handbooks, provider directories, quarterly member newsletters and identification cards at a minimum. The MCE may distribute additional materials and information, other than those required to members, to promote health and/or educate enrollees (provided the materials are State approved). All member materials shall be in plain language and written at fifth grade reading level including the [Member Welcome Letter](#) and [Member Handbook](#).

5.b.1 Member Welcome Packet

Within five calendar days of a new member's full enrollment, the MCE must send a Welcome Packet. For *Indiana Pathways for Aging* members, the *Welcome Packet* must include, but is not limited to, a new member letter, member ID card, explanation of where to find information about the MCE's provider network, a copy of the member handbook, and information about other locations from which the member handbook can be accessed, including a summary of items found within. The member ID card must include the State assigned Member ID. The packet must include a welcome letter. The welcome letter shall include:

- education confirming the member's enrollment with the MCE as part of the *Indiana Pathways for Aging* MCE contact information with an explanation to access information,
- specific information on coordination of care with current providers and how the member can receive care coordination assistance, and
- the member's effective enrollment date with the MCE.

The Welcome Packet must also include information about selecting a primary medical provider (PMP), completing a health screening, and any unique features of the MCE.

For example, if the MCE provides incentives to members for completing a health screening, a description of the member incentive must be included in the Welcome Packet.

For *Indiana Pathways for Aging* members, the Welcome Packet shall include educational materials and recommended preventive care services for the member's benefit year.

Additionally, the Welcome packet shall include information on where to find information about the MCE's provider network. The MCE shall include a current provider directory and/or information on how to find a network provider near the member's residence online and via member helpline assistance. The provider directory must include the information outlined in [Provider Network and Provider Directory](#).

5.b.2 Member Handbook

The MCE must develop a member handbook specifically for *Indiana Pathways for Aging* members. The MCE must utilize and build from the State's *Model Member Handbook*. The MCE's member handbook must be submitted annually, for State review, plus any time changes are made. The member handbook must include the MCE's contact information and internet website address and describe the terms and nature of services offered by the MCE, including the following information required under 42 CFR 438.10(g). The member handbook may be offered in an electronic format as long as the MCE complies with 42 CFR 438.10(c)(6). The *Indiana Pathways for Aging* member handbook must, at minimum, include the following:

- MCE's contact information (address, telephone number, TDD number and website),
- MCE's office hours and days, including the availability of a 24-hour nurse call line,
- The amount, duration, and scope of services available under the *Indiana Pathways for Aging* scope of work in sufficient detail to ensure that members are informed of the services to which they are entitled, including,

but not limited to the differences between the benefit options and how members can obtain information from the State about how to access the services,

- Standards and expectations for receiving preventive health services,
- How [Emergency Care](#) is provided, that a prior authorization is not required, and that the enrollee has a right to use any hospital or other setting for emergency care,
- The extent to which, and how, after-hours and emergency coverage are provided, as well as other information required under 42 CFR 438.10(f), such as what constitutes as emergency,
- The [Post-stabilization Care Services](#) rules set forth in 42 CFR 422.113(c),
- The extent to which and how urgent care services are provided,
- Any applicable policies on referrals for specialty care and other benefits not provided by the member's PMP,
- The procedures for obtaining benefits including authorization requirements, family planning services, and supplies from out-of-network providers,
- Process for changing PMPs,
- Information regarding how to access covered behavioral health services, including information about behavioral health conditions that may be treated by a PCP within their scope of practice,
- Information on available Home and Community Based Services (HCBS) benefits and education on how to access HCBS,
- Information on long-term services and supports (LTSS) and education on how to access LTSS,
- Information about the availability of [Pharmacy](#) services and how to access pharmacy services,
- Information about all relevant or applicable the State ombudsman programs,
- Information and education on the member's right to choose between nursing facility and HCBS,
- A description of the Care Coordinator and Service Coordinator role and responsibilities,
- Information about the availability of [Non-emergency Transportation](#) and how to access assistance with their responsibilities for scheduling, using, and cancelling rides through the MCE's transportation broker or care management,
- Any restrictions on the member's freedom of choice among network providers,
- Special benefit provisions (for example, co-payments, deductibles, limits, or rejections of claims) that may apply to services obtained outside the MCE's network,
- Policies and procedures for obtaining [Out-of-Network Services](#),
- Standards and expectations to receive preventive health services,
- Policy on referrals to specialty care,
- Procedures for notifying members affected by termination or change in any benefits, services, or service delivery sites,
- Procedures for appealing decisions adversely affecting member's coverage, benefits, or relationship with the MCE,
- Procedures for making complaints and recommending changes in policy and services,
- [Grievance](#), [Appeal](#), and [State Fair Hearing](#) procedures as required at 42 CFR 438.10(g)(2)(xi), and described in Section 5.14 of the *Indiana Pathways for Aging* scope of work. Member handbook shall include:
 - the right to file grievances and appeals.
 - requirements and timeframes for filing a grievance or appeal.
 - availability for assistance in the filing process.

- ombudsman and independent advocacy services available as sources of advice, assistance, and advocacy.
- toll-free numbers that the member can use to file a grievance or appeal by phone.
- the fact that, if requested by the member and under certain circumstances: 1) benefits will continue if the member files an appeal or requests a State fair hearing within the specified timeframes; and 2) the member may be required to pay the cost of services furnished during the appeal if the final decision is adverse to the member.
- state fair hearing information on the right to a hearing, method for obtaining a hearing, and the rules that govern representation at a hearing.
- [Members' Rights](#) and protections, as enumerated in 42 CFR 438.100 and as further detailed in Section 5.11 of the *Indiana Pathways for Aging* scope of work,
- Information about the external grievance procedure (External Review by Independent Review Organization) process,
- Responsibilities of members,
- Services not covered by the MCE because of moral or religious objections,
- Standards and procedures for changing MCEs, and circumstances under which this is possible including, but not limited to providing contact information and instructions for how to contact the enrollment broker to transfer MCEs due to one of the “for cause” reasons described in 42 CFR 438.56(d)(2)(iv). Just cause reasons include:
 - receiving poor quality of care.
 - failure of the MCE to provide covered services.
 - failure of the MCE to comply with established standards of medical care administration.
 - lack of access to providers experienced in dealing with the member’s health care needs.
 - significant language or cultural barriers.
 - corrective action levied against the MCE by the State.
 - limited access to a primary care clinic or other health services within reasonable proximity to a member’s residence.
 - determination that another MCE’s formulary is more consistent with a new member’s existing health care needs.
 - lack of access to medically necessary services covered under the MCE’s contract with the State.
 - a service is not covered by the MCE for moral or religious objections, as described in Section 7.8.2 of the *Indiana Pathways for Aging* scope of work.
 - related services are required to be performed at the same time and not all related services are available within the MCE’s network, and the member’s provider determines that receiving the services separately will subject the member to unnecessary risk.
 - the member’s primary healthcare provider disenrolls from the member’s current MCE and re-enrolls with another *Indiana Pathways for Aging* MCE.
 - circumstances determined by the State or its designee to constitute poor quality of health care coverage.,
- The process for submitting disenrollment requests including information listed in [Member Disenrollment from MCE](#),
- The process by which an American Indian/ Alaskan Native Medicaid beneficiary may elect to **opt-in** to managed care (inclusion is optional) or remain in fee-for-service (FFS),
- Information about advance directives,
- How to [report a change](#) in income, change in family size, etc.,
- Information about the availability of the prior claims payment program for certain members and how to access the program administrator,

- Information on alternative methods or formats of communication for visually impaired, hearing-impaired and non-English speaking members and how members can access those methods or formats,
- Information on how to contact the Enrollment Broker, the [Ombudsman](#) (See Section 5.14.9 of the *Indiana Pathways for Aging* scope of work) and other state-designated entities involved in enrollment services, member support services, and choice counseling,
- Information on Medicare eligibility and when to enroll,
- Statement that MCE will provide information on the structure and operation of the health plan,
- In accordance with 42 CFR 438.10(f)(3), that upon request of the member, information on the MCE's provider incentive plans will be provided,
- Information on how to report suspected fraud or abuse.

5.b.3 Member ID Card

Within five calendar days of a new member's full enrollment with the MCE, the MCE must send the member a new ID card. A new ID card must be mailed to the member after any break in coverage of more than 15 days and upon request of a member. The ID card must be durable and shall comply with all state and federal requirements and at a minimum, shall include:

- MCE's name and *Indiana Pathways for Aging* program logo,
- phone numbers for general inquiries and MCE information,
- phone numbers for information and/or authorizations, including for physical health, behavioral health, and long-term services and supports,
- descriptions of procedures to be followed for emergency or special services,
- member's State assigned identification number (no other identification numbers may be used),
- member's name (First, Last and Middle Initial), and
- member's enrollment effective date.

For members dually eligible for Medicaid and Medicare who are enrolled in a DSNP, refer to [Dual Eligible Special Needs Plan \(D-SNPs\) Requirements and Coordination](#) for additional requirements. Within one year of *Indiana Pathways for Aging* go-live, the MCE shall implement a single, unified benefit care for all dually-eligible member enrolled in aligned D-SNP.

5.c Member Enrollment and MCE Selection

Plan selection can be made while pending enrollment in *Indiana Pathways for Aging*. The enrollment broker will be responsible for providing outreach to members on plan selection and choice counseling to the member. If an individual does not select a plan while pending enrollment there will be an assignment process in place directed by the State. The member's enrollment in the selected or assigned *Indiana Pathways for Aging* plan will be effective the first day of the month of eligibility determination. Plan assignment will favor plan alignment between Medicare and Medicaid to the greatest extent allowable. Other factors may be considered such as the residential provider of the member (if applicable). The MCE's companion D-SNP must be exclusively aligned with its *Indiana Pathways for Aging* programs Medicaid plan and will only be allowed to enroll dual eligible members who are also enrolled in its *Indiana Pathways for Aging* programs Medicaid plan. Members enrolled in the MCE's *Indiana Pathways for Aging* programs Medicaid plan who later become Medicare-eligible for the first time will be default enrolled into the MCE's companion D-SNP.

The State reserves the right to amend the assignment logic and may incorporate HEDIS or other quality indicators into the assignment logic at a future date. Member assignment will not be available to any MCE who does not successfully complete readiness review. Default assignment will not be available for any plan that has an associated D-SNP that fails to meet the minimum Medicare Star rating of three stars as defined in 42 CFR 422.252. Information about member enrollment and MCE selection shall be subject to the requirements as described in [Member Information, Education, and Outreach](#).

5.c.1 Enrollment and Practice Discrimination

Per 42 CFR 438.3(d), the MCE shall accept individuals eligible for enrollment in the order in which they apply without restrictions. The MCE shall not, based on health status or need for health care services, discriminate against individuals. Additionally, the MCE shall not discriminate against individuals on the basis of race, color, age, national origin, sex, sexual orientation, gender identity, genetic information, income status, *Indiana Pathways for Aging* program membership, or disability and will not use any policy or practice that has the effect of discriminating in such manner.

Examples of prohibited practices include, but are not limited to, the following:

- denying or not providing a member any covered service or access to an available facility,
- providing to a member any medically necessary covered service which is different, or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at large, except where medically necessary,
- subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service; restricting a member in any way in their enjoyment of any advantage or privilege enjoyed by others receiving any covered service, and
- assigning times or places for the provision of services on the basis of the race, color, age, national origin, sexual orientation, gender identity, genetic information, income status, *Indiana Pathways for Aging* membership, or disability of the members to be served.

The MCE shall assure members their rights as specified in 42 CFR 438.100. See also, [Members' Rights](#).

The MCE shall ensure members and individuals with disabilities are accommodated to actively participate in the provision of services and have physical access to facilities, procedures, and exams.

For example, the MCE shall provide appropriate auxiliary aids and services to individuals with impaired sensory, manual, or speaking skills.

The MCE must provide accommodations to members and individuals with disabilities at no cost to afford such individuals an equal opportunity to benefit from the covered services.

If the MCE knowingly executes a subcontract with a provider with the intent of allowing or permitting the provider to implement barriers to care, (i.e., the terms of the subcontract act to discourage the full utilization of services by some members) the MCE is in default of its contract with the State.

If the MCE identifies a problem involving discrimination or accommodations for individuals with disabilities by one of its providers, the MCE shall promptly intervene and require a corrective action plan from the provider. Failure to take prompt corrective measures may place the MCE in default of its contract.

MCE shall also adhere to Section 1557 of the *Affordable Care Act* / 45 CFR 92.1.

5.c.2 Member Enrollment Rosters

On behalf of the State, the fiscal agent notifies each MCE of members enrolled in its *Indiana Pathways for Aging* program. Using information obtained from the Indiana Eligibility Determination Services System (IEDSS) transmissions and from MCE assignments entered in CoreMMIS by self-selection and auto-assignment, the fiscal agent generates daily *Health Insurance Portability and Accountability Act* (HIPAA) 834 MCE benefit enrollment and maintenance transactions, also known as *enrollment rosters* or *834 file(s)*. The processes that create data for the programs' rosters begin each evening Monday through Friday. The rosters are typically generated during the early morning hours of Tuesday through Saturday; exceptions are State holidays. IEDSS files do not run on holidays. The following holidays affect IEDSS processing if they also occur on business days:

- New Year's Eve
- New Year's Day
- Martin Luther King, Jr. Day

- Good Friday
- Primary Election Day
- Memorial Day
- Independence Day
- Labor Day
- Columbus Day
- Election Day
- Veteran's Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Eve
- Christmas Day

See the [834 MCE Benefit Enrollment and Maintenance Transaction](#) companion guide for file layout and data usage. The companion guides are available on the [Electronic Data Interchange \(EDI\) Solutions](#) page at in.gov/medicaid/providers.

MCE member enrollment rosters provide MCEs with detailed lists of members for whom the MCE is responsible. Change files indicate new, terminated, or deleted members, or changes to continuing member records that have occurred since the previous change file was created. Audit files, created once monthly, list all members effective with the MCE as of the date the audit file was created. *Indiana Pathways for Aging* audit files run on the 1st of each month. The following files are provided to the MCEs:

- 834 Audit Files ran on the 1st of the month,
- 834 Monthly Term Audit Files ran on the 5th of the month, and
- 834 Monthly Term Change Files ran on 20th.

The segments of the member enrollment rosters are categorized in the *834 MCE Benefit Enrollment and Maintenance Transaction* companion guide. The following are the changes:

- new enrollees,
- terminated enrollees, and
- deleted enrollees who appeared as eligible members on the previous roster, but whose eligibility terminated before the actual effective date with the MCE.

Summary reports are also generated and posted to File Exchange for each of the MCEs. There are occasions when an MCE may not have any data to report for a given cycle and will receive an empty 834 file.

The following items are other elements that are included in *Indiana Pathways for Aging* enrollment rosters:

- **Aid Category**
 - IEDSS-assigned designation for IHCP benefits.
 - Gainwell-assigned Waiver or NFLOC designation for IHCP benefits
- **MCE Assignment Reasons** – Numeric identifier that provides the assignment start and stop reasons that linked the member to the plan.
- **Open Enrollment Status Record** – provides the status of the member's open enrollment:
 - **O:** Open
 - **C:** Closed
- **Open Enrollment Effective and End Dates** – provides the time spans of the member's open enrollment and when MCE changes can occur.
- **Capitation Category** – provides the capitation category for which the MCE is reimbursed.

5.c.3 Primary Medical Provider (PMP) Selection

The MCE must assure that each member has a PMP who is responsible for providing an ongoing source of primary care appropriate to the member's needs. Following a member's enrollment, the MCE must assist the member in choosing a PMP. Unless the member elects otherwise, the member shall be assigned to a PMP within 30 miles of the member's residence.

Providers that may serve as PMPs include:

- geriatricians,
- internal medicine physicians,
- gynecologists,
- general practitioners,
- family medicine physicians,
- endocrinologists (if primarily engaged in internal medicine), and
- advanced practice nurses and physician assistants.

The MCE must document at least three telephone contact attempts made to help the member choose a PMP. If the member has not selected a PMP within 30 calendar days of the member's enrollment, the MCE must assign the member to a PMP. The member must be assigned to a PMP within 30 miles of the member's residence, and the MCE must consider any prior provider relationships when making the assignment.

Other considerations for PMP assignment or auto-assignment by the MCEs are as follows:

- Must authorize out-of-network care by any IHCP provider if panel slots are not available for the appropriate scope of practice within 30 miles of member's residence.
- Must consider PMP assignment history (the fiscal agent provides 12 months of history; can also use MCE claims history).
- Must take panel limits into consideration.
- Must ensure provider scope of practice considered.
- Must maintain lock-in PMP assignment when member is in the RCP.
- The MCE's PMP auto-assignment process must comply with State guidelines and must be approved by State before implementation.

PMP Assignment History File from Fiscal Agent to the MCE

When a member is assigned to a new MCE, the fiscal agent sends the receiving MCE the member's prior 12 months of PMP history. The 12-month look-back is based on dates that are earlier than the start date of the new segment and fall within the previous 365-day time frame, regardless of how far in the future the placeholder assignment starts.

For example, a placeholder created on February 3 for an effective date of March 1 starts counting 365 days backward from March 1. If the placeholder effective date is February 15, the countdown begins from February 15. This logic therefore captures members affected by PMP disenrollment/re-enrollment.

This history is an electronic file that is posted to File Exchange. It is a proprietary file and is not HIPAA compliant. The PMP Assignment History files are generated in response to placeholder assignments received from the MCEs. The assignment history files are not generated by regions as 834 transactions are; one file generates per program when the process runs. The *Member Assignment* file layout is available on the *MCE Secure* page at <https://www.in.gov/medicaid/partners/medicaid-partners/managed-care-health-plans/mce-secure-landing-page/> under *File Layouts*.

The member's PMP assignment history file includes the following information, from most recent to oldest:

- Member ID – 12 numeric characters

- PMP name – Up to 30 alphanumeric characters
- PMP Medicaid ID (IHCP Provider ID) – Nine numeric characters
- PMP group ID (IHCP Provider ID), if any – Nine numeric characters
- PMP start reason
- PMP stop reason
- Effective date for each instance of a member's PMP linkage – Required, eight characters (CCYYMMDD)
- End date for each instance of a member's PMP linkage – Required, eight characters (CCYYMMDD)

For any members who have a placeholder segment added during the current report cycle and whose previous MCE assignment does not match the current assignment, the PMP assignment file captures PMP assignment history. PMP assignments must meet the following criteria to be captured on the PMP history file:

- The member changed MCEs during open enrollment.
- The member changed MCEs for just cause.
- The member had a gap in the IHCP eligibility and is now assigned to a different MCE than they were previously assigned.
- Same-plan assignments may appear in this case if the member was assigned to the placeholder MCE before the member's last assignment with a different MCE, as long as the assignment is within the past 365 days.
 - The member was assigned to a different MCE under another IHCP program.

For example, the member is changing from Hoosier Care Connect to Indiana Pathways for Aging and is assigned a different MCE.

- The member was assigned to the same MCE under another IHCP program.

For example, the member is changing from the Hoosier Care Connect to Indiana Pathways for Aging under the same MCE plan. The MCE ID for each program are different.

- PMP assignments that are not captured on the PMP history file are as follows:
 - Members whose most recent assignment was with the same MCE, regardless of if there was a gap in coverage. MCEs must be aware of their prior members' history.
 - Members who have already been captured on the history file for a given placeholder assignment. These members do not make repeat appearances on subsequent file runs.
 - Members who had a gap of more than 365 days with an MCE, even if that MCE is different than the one they have just been assigned.

PMP Assignments from the MCE to Fiscal Agent

MCEs must report PMP assignments to the fiscal agent so the information can be stored in CoreMMIS. Providers see the member's PMP when verifying eligibility using the IHCP EVS options. MCEs must submit files for Indiana Pathways for Aging PMP assignments. Files must be submitted by 6 p.m. daily, Monday through Friday. Only one file per day is processed.

5.c.4 Provider Network and Provider Directory

In accordance with 42 CFR 438.10(h), the provider directory must include the following information:

- primary care physicians, specialists, and hospitals,
- name, location, and telephone number of providers,
- identification of non-English language spoken by providers,
- provider web sites, if applicable,
- if the provider has accommodations for people with physical disabilities,

- describe the accommodations each provider has for people with physical disabilities,
- pharmacies and behavioral health providers,
- contact information for all brokers contracted with the MCE, and
- identification of providers that are not accepting new patients.

A printed copy of the provider directory must also be available to members and the State upon request. The MCE must include the provider network information, by county, on its member website.

5.c.5 Member Disenrollment from MCE

Indiana Pathways for Aging members can change their MCE only at the following intervals:

- Within 90 days of starting coverage,
- At any time, their Medicare and Medicaid plans become unaligned,
- Once per calendar year, for any reason, and
- During the Medicare open enrollment window (mid-October-mid December) to be effective the following calendar year.
- Additionally, any Medicaid member may change their MCE for *Just Cause*. The “for cause” reasons are described in 42 CFR 438.56(d)(2)(iv). Determination as to whether a member has met one of these reasons is solely the determination of the Enrollment Broker and the State. Valid reasons are (but not limited to):
 - receiving poor quality of care or circumstances determined by the office or its designee to constitute poor quality of health care coverage.
 - Poor quality of care includes failure to comply with established standards of medical care administration and significant language or cultural barriers.
 - failure to provide covered services.
 - failure of the MCE to comply with established standards of medical care administration.
 - lack of access to providers experienced in dealing with the member’s health care needs.
 - significant language or cultural barriers.
 - corrective action levied against the MCE by the office.
 - limited access to a primary care clinic or other health services within reasonable proximity to a member’s residence.
 - determination that another MCE’s formulary is more consistent with a new member’s existing health care needs.
 - lack of access to medically necessary services covered under the MCE’s contract with the State.
 - a service is not covered by the MCE for moral or religious objections, as described in Section 7.8.2 of the *Indiana Pathways for Aging* scope of work.
 - related services are required to be performed at the same time and not all related services are available within the MCE’s network, and the member’s provider determines that receiving the services separately will subject the member to unnecessary risk.
 - the member’s primary medical provider disenrolls from the member’s current MCE and reenrolls with another MCE. If a member’s PMP disenrolls from the member’s current MCE and re-enrolls in a new MCE, the member can change plans to follow their PMP to the new MCE.

Members must file a grievance with their MCE before a determination will be made upon their just cause request. If the member remains dissatisfied with the outcome, they can contact the Enrollment Broker to request disenrollment. Members may submit requests to change MCEs to the Enrollment Broker verbally or in writing. The MCE shall provide the Enrollment Broker’s contact information and explain that the member must contact the Enrollment Broker with questions about the process.

The Enrollment Broker reviews the request and makes a disenrollment recommendation. In making the disenrollment recommendation, the Enrollment Broker will review a copy of the member's grievance and appeals record from the MCE, to confirm that the grievance and appeals process was exhausted. All Enrollment Broker reviews which result in a recommendation to approve MCE disenrollment are sent to the State, who makes the final determination on the request.

Additionally, enrollees are permitted to request disenrollment when the State imposes granting this right as an intermediate sanction as specified at *42 CFR 438.702(a)(3)*. The State is responsible for notifying enrollees of these rights.

In accordance with *42 CFR 438.3(d)(3)*, which addresses enrollment and disenrollment, the MCE may neither terminate enrollment nor encourage a member to disenroll because of a member's health care needs or a change in a member's health care status. A member's health care utilization patterns may not serve as the basis for disenrollment from the MCE.

The MCE must notify the State within 30 calendar days of the date it becomes aware of the death of one of its members. The MCE should report changes or discrepancies in member information via the Constituent Care email box at cc.FSSA@fssa.in.gov.

In general, MCE reports should relay the details related to the change or discrepancy, including the member's identification number or MID, as well as the MCE's source for the change or discrepancy. Notices of member deaths should include the following details:

- member's full name
- member's address
- member's Social Security Number
- member's Medicaid ID
- date of death

Note: The MCE has no authority to pursue recovery against the estate of a deceased IHCP member.
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5.c.6 Member Information Changes

Members are required to report information changes to the DFR within 10 days and should do so via the online benefits portal, sending a written request to the FSSA document center or by calling 800-403-0864. Members who call the MCE to report income, address, or other demographic changes should be referred to the DFR. Members who receive SSI benefits are required to report certain changes to the Social Security Administration, rather than the DFR. The MCE will support members in meeting these reporting requirements since loss of SSI has a direct impact on Medicaid eligibility.

If the MCE has information about a change in member circumstances that may affect Medicaid eligibility, the MCE must provide that information to DFR as soon as possible but in no event more than 10 calendar days from the date of discovery.

Information to be reported includes:

- An initial LOC determination that qualifies an individual for additional LTSS services or a change in a member's LOC,
- The member has died,
- The member has been incarcerated,
- The member has a verified move either within the state or to another state,
- The member has known changes in income or assets, or
- The member has a change in marital status.

The DFR is the official source of record for member demographic information. By referring members to the DFR for demographic information changes, the MCE is meeting the requirement to report changes and discrepancies in member demographic information about which they become aware.

The preferred method for updating member addresses is to direct the member to submit an address update via the FSSA Benefits Portal. MCEs can instruct members to submit an address update via the benefits portal:

- Members select 'Report a Change' at <https://fssabenefits.in.gov/bp/>
 - the member is able to see their current address with DFR and to submit an address update that will be received electronically
 - this is the preferred method for members comfortable and capable of performing online tasks

For members not comfortable with the benefit portal update process, authorized staff at the MCE should submit address updates via email to DFR. Authorized MCE staff include those that have been appointed as the contact person(s) for the DFR and have permission to request updates to member data. Address update requests should only be submitted following direct contact and verification with the member as outlined below.

- Unless a member provides verification, seeing an out-of-state provider or a provider (e.g., ER) providing a different address for the member should not result in the submission of an address update.
- When a new address is received from a provider, the member must be contacted to verify the address prior to submission to DFR.
- After the address change has been verified by the member, authorized MCE staff can submit address updates using a spreadsheet template. Data submitted on the spreadsheet should include:
 - Member's Medicaid ID,
 - first and last name,
 - old and new address,
 - current phone number,
 - who in the household the address change impacts,
 - an indicator showing if the move is out of state, and
 - the name of the MCE representative submitting the verified request.
- Address update requests should be sent to the Constituent Care email box at cc.FSSA@fssa.in.gov. Only verified address update requests may be submitted to DFR by authorized MCE staff.

The MCE may also direct members to mail an address update request to the FSSA document center. The mailed request should include the new address, member first and last name, member ID or last four digits of the social security number, the new address and who in the household has moved. These requests should be mailed to:

**FSSA Document Center
PO Box 1810
Marion, IN 46952**

The MCE may report address discrepancies when a member calls and states they have already updated their address with the DFR via their Customer Service team reporting process, but the MCE system still reflects their previous address. System issues may be involved when the member states they have already updated their information with the DFR and a file has not been received for an address change within 30 days.

The MCE is encouraged to periodically scan its systems to identify obvious errors, such as nonsensical addresses. The MCE should report nonsensical or erroneous addresses to the DFR via the Constituent Care email box at cc.FSSA@fssa.in.gov. The MCE should not use *State Form 44151, Report of Change* to report this information. If discrepancies are found, MCE reports should contain the details of the change or discrepancy, including the:

- The member's ID,
- the member's name, and
- how the MCE became aware of the change or discrepancy.

When the MCE identifies that a member may not reside in Indiana, the MCE shall attempt to contact the member to verify their residency and/or intent to return to Indiana. The MCE should report potential out-of-state residency if:

- an acceptable explanation is not given by the member.,
- the member confirms that they have moved to another state, or
- no contact is made after three or more attempts.

The MCE should report changes or discrepancies in member information via the Constituent Care email box at cc.FSSA@fssa.in.gov.

In general, MCE reports should relay the details related to the change or discrepancy, including the member's identification number or MID, as well as the MCE's source for the change or discrepancy.

The DFR evaluates reported changes and discrepancies against DFR records and verifies the accuracy of the information. If the DFR cannot confirm or cannot otherwise correct the issue, the DFR relays such to the MCE via an email response. If the need for a change is confirmed, the DFR makes updates to the member's file, which is, in turn, relayed to CoreMMIS. The DFR will evaluate reported discrepancies against the DFR records and verify the accuracy of the information. If the need for a change is confirmed, the DFR will make updates to the member's file, which will in turn be relayed to CoreMMIS. This update may be received through an address change or a closure file. A case does not need to be sent through review again. If fraud is suspected, the DFR will make a referral to the Bureau of Investigations and Benefit Recovery at that time. If a file is not received regarding any changes within 90 days of a change or closure, it means that the member confirmed a valid Indiana address, or the out-of-state mailing address was found to be allowable. The case will remain open. It is also possible for a case to remain open while a fraud investigation has been opened but not yet resulted in prosecution.

It's important for MCEs to note the following regarding updating member addresses with DFR:

- Address updates can generate 2032 follow-up requests. The more information provided by the member, the less likely that DFR will have to follow up with the member. MCEs need to encourage the member to read all mail and emails received and return all requested documentation.
- Information provided by the member should include
 - full names of everyone in the household that moved., and
 - full names of anyone added to the household as result of the move.
- If the member is receiving any other benefits, such as SNAP or TANF, additional follow up from DFR will be required.
- MCEs should encourage members to submit official change of address to USPS. The updated address information is received by DFR directly from the postal service.

5.d Managed Care Entity Member Services Helpline

The MCE must maintain a single statewide toll-free telephone helpline for *Indiana Pathways for Aging* members who have questions, concerns, complaints, or requests. The helpline shall be available to individuals who are authorized to speak to customer service on behalf of a member (e.g., a family member, informal caregiver, supported decision maker(s), legal guardian, or another designated representative).

Indiana based helpline staff must take at least 70% of the member helpline calls, except when an emergency rollover is required. The State must be notified if such an emergency is taking place. A minimum of 50% of helpline staff must be direct employees of the MCE.

The MCE must staff its member services helpline to provide sufficient live-voice access to its members during (at a minimum) a 12-hour business day, Monday through Friday from 8 a.m. to 8 p.m. Eastern Standard Time (EST). The call center shall open 60 days prior to the MCE's go live date, with State approval. The member services helpline must offer language translation services for members whose primary language is not English and must offer telephone-automated messaging in English and Spanish. The MCE must provide Telecommunications Device for the Deaf (TDD) services for hearing impaired members.

There must also be at least one fluent Burmese speaker and one fluent Spanish speaker physically present (i.e., not via a language translation line) to answer member calls during all “live” operating hours. A member services messaging option must be available after business hours in English and Spanish, and member services staff must respond to all members’ messages by the end of the next business day. If the MCE’s member services helpline number or function changes, the MCE must notify the State and the fiscal agent’s managed care director about those changes. The MCE call centers are authorized to close on the following holidays:

- New Year’s Day
- Martin Luther King, Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving
- Christmas

For all days with a closure, early closing or limited staff attendance, members must have access to the [24-Hour Nurse Call Line](#). Call center closures, limited staffing or early closures must not burden a member’s access to care.

MCEs may request additional days to holidays, such as the day after Thanksgiving, be authorized for limited staff attendance. This request must be submitted to the State at least 30 days in advance of the date being requested for limited staff attendance and must be approved by the State.

Member services helpline staff shall be trained in the *Indiana Pathways for Aging* program to ensure that member questions and concerns are resolved as expeditiously as possible. The MCE must have the ability to warm transfer members to outside entities including the Enrollment Broker, the Division of Family Resources (DFR) and provider offices. Additionally, the MCE must ensure the warm transfer of calls for members that require attention from an MCE care coordinator or service coordinator. The MCE must ensure the care coordinator has access to all information necessary to resolve the member’s issues. Any messages left with care coordinators must be returned by the next business day.

The MCE must maintain a system for tracking and reporting the number, type of member calls, and the inquiries received during business hours and non-business hours. The MCE must monitor its member services helpline and report telephone service performance to the State on a regular basis. The MCE’s member services helpline staff must be prepared to respond to member concerns or issues including, but not limited to, the following:

- Access to healthcare services
- Identification or explanation of covered services
- Special healthcare needs
- Procedures for submitting a member grievance
- Procedures for appealing decisions adversely affecting members’ coverage, benefits, or relationship with the MCE
- Potential fraud or abuse including adult protective services
- Changing PMPs
- Incentive and enhanced benefit programs
- Disease management, care coordination, and service coordination services
- Health crises; including but not limited to; suicidal callers
- Balance billing issues
- Referrals to local services or community-based organizations for assistance

In addition to the member services helpline, which is staffed during regular business hours, the MCE must operate a toll-free 24-hour nurse call line. The MCE must provide nurse triage telephone services for members to receive medical advice from trained medical professionals 24 hours a day, seven days a week.

Upon a member's enrollment with the MCE, the MCE shall inform the member about the member services helpline. The MCE shall encourage its members to call the member services helpline as the first resource for answers to questions or concerns about *Indiana Pathways for Aging*, PMP issues, benefits, MCE policies, etc.

The MCE shall maintain sufficient equipment and staff to ensure the following:

- For any calendar month, at least 97% of all phone calls to the helpline must reach the call center menu within 30 seconds.
- For any calendar month, at least 85% of all phone calls to an approved automated helpline must be answered by a helpline representative within 30 seconds after the call has been routed through the call center menu. *Answered* means that the call is picked up by a qualified helpline staff person.
- For any calendar month, at least 95% of all phone calls to an approved automated helpline must be answered by a helpline representative within 60 seconds after the call has been routed through the call center menu. *Answered* means that the call is picked up by a qualified helpline staff person.
- If the MCE does not maintain an approved automated call distribution system, for any calendar month, at least 95% of all phone calls to the helpline must be answered within 30 seconds.
- Hold time does not exceed one minute in any instance, or 30 seconds, on average.
- For any calendar month, the lost call (abandonment rate) associated with the helpline does not exceed 5%.

The MCE shall provide a backup solution for phone service in the event of a power failure or outage or other interruption in service. Such plan shall include, at minimum, the following:

1. A notification plan that ensures the State is notified when the MCE's phone system is inoperative, or a back-up system is being utilized; and
2. Manual back-up procedure to allow requests to continue being processed if the system is down.

In addition to the member services helpline, which is staffed during regular business hours, the MCE shall operate a toll-free [24-Hour Nurse Call Line](#).

5.e Electronic Communications

The MCE must provide an opportunity for members to submit questions or concerns electronically, via email and through the member website. If a member's email address is required to submit questions or concerns electronically to the MCE, the MCE must help the member establish a free email account.

The MCE must respond within one business day to questions and concerns submitted by members electronically. If the MCE is unable to answer or resolve the member's question or concern within 1 business day, the MCE must notify the member that additional time is required and identify when a response will be provided. A final response must be provided within 3 business days.

The MCE must have reporting capability for email communications received and responded to, such as total volume and response times. The MCE must be prepared to provide electronic communications to the State upon request and in accordance with the *MCE Reporting Manual*.

The MCE must collect information on member's preferred mode of receipt of MCE-generated communications and send materials in the selected format. Options must include the ability to receive paper communications via mail, or electronic communications through email (or a secure web portal when confidential information is to be transmitted). When a member notifies the MCE of selection to receive communications electronically, that choice must be confirmed through regular mail with instructions on how to change the selection if desired. Additionally, emails must be sent to members alerting them anytime an electronic notice is posted to the portal; no confidential information must be included in emails. In the event such a notification email is returned as undeliverable, the MCE shall send the notice by regular mail within

three business days of the failed email. When applicable, the MCE must comply with a member's preferred mode of communication.

If the member elects to receive electronic communications, electronic communication shall not be used in lieu of any assistance planning requirements required by the *MCE Policy and Procedure manual*.

5.f Member Information, Outreach Education, and Engagement

The MCE must provide the information listed in this section within a reasonable period, following notice from the State fiscal agent of the member's enrollment in the MCE. This information must be included in the member handbook. In addition, the MCE must notify members at least once per year of their right to request and obtain the information listed in this section in accordance with *42 CFR 438.10*. If the MCE makes *significant changes* to the information provided under this section, the MCE must notify the member in writing of the intended change at least 30 calendar days before the intended effective date of the change, in accordance with *42 CFR 438.10(f)(4)*. The State defines *significant changes* as any changes that may affect member accessibility to the MCE's services and benefits.

The MCE is responsible for developing and maintaining member education programs designed to offer members clear, concise and accurate information about the MCE's program and the MCE's provider network. The State encourages the MCE to incorporate community advocates, support agencies, health departments, other governmental agencies and public health associations in its outreach and member education programs. The State also encourages the MCE to develop community partners with these types of organizations to promote health and wellness within its membership.

The MCE shall also develop a formal process for ongoing education of stakeholders prior to, during and after implementation of the *Indiana Pathways for Aging* program. This includes publicizing methods by which members can ask questions regarding the *Indiana Pathways for Aging* program. Stakeholders include, but are not limited to, providers, advocates, and members. The MCE shall submit this formal process to the State for review and approval in the timeframe and manner determined by the State. The MCE must demonstrate how these educational interventions reduce barriers to healthcare and improve health outcomes for members.

The MCE must comply with the information requirements at *42 CFR 438.10*. All written materials for members or potential members shall be in a font size no smaller than 12-point. All enrollment notices, informational and instructional materials must be provided in a manner and format that is easily understood. This means to the extent feasible, written materials shall not exceed a fifth-grade reading level and be in plain language. This fifth-grade reading level requirement does not pertain to specific medical terminology (e.g., a member's diagnosis, drug names, treatment regimens, etc.). When using specific medical terminology, above a fifth-grade reading level, the MCE is encouraged to provide simple definitions, where possible. Contractions, abbreviations, and jargon must not be used in member materials. All written materials should be clear, simple, meaningful, and easily readable; for tips, see CMS' [Guidelines for Effective Writing](#).

The MCE's educational activities and services must also address the special needs of specific *Indiana Pathways for Aging* subpopulations, as well as its general membership. The MCE must demonstrate how these educational interventions reduce barriers to healthcare and improve health outcomes for members.

The MCE must have in place policies and procedures to ensure that materials are accurate in content, accurate in translation relevant to language or alternate formats, and do not defraud, mislead, or confuse the member. The MCE must provide information requested by the State, or the State's designee, for use in member education and enrollment, on request. Member education shall include, but not be limited to:

- information on benefit coverage,
- information on how to access the health care system appropriately (e.g., keeping appointments, appropriate use of Emergency Room services, hot to file grievances and appeals), and
- information on covered dental services.

In accordance with *42 CFR 438.10(e)*, the State must provide potential members with general information about the basic features of managed care and information specific to each MCE operating in the potential member's service area. At minimum, this information will include factors such as MCE service area,

benefits covered, and network provider information. The State shall provide information on *Indiana Pathways for Aging* MCEs in a comparative chart-like format. Once available, the State also intends to include MCE quality and performance indicators on materials distributed to facilitate MCE selection. The State reserves the right to develop a rating system advertising MCE performance on areas such as consumer satisfaction, network access and quality of care and services. To facilitate the State development of these materials, the MCE must comply with the State, or its designee, requests for information needed to develop informational materials for potential members.

The MCE shall make written information available in English and Spanish and other prevalent non-English languages identified by the State, upon the State's or the member's request. At the time of enrollment with the MCE, the State shall provide the primary language of each member. The MCE shall utilize this information to ensure communication materials are distributed in the appropriate language. In addition, the MCE shall identify additional languages that are prevalent among the MCE's membership. For purposes of this requirement, prevalent language is defined as any language spoken by at least 3% of the general population in the MCE's service area. Written information shall be provided in any such prevalent languages identified by the MCE.

Per *Section 1557 of the Affordable Care Act / 45 CFR 92.1*, the MCE shall ensure that for significant publications and communications taglines (short the Statements written in non-English languages to alert individuals with limited English proficiency to the availability of language assistance services, free of charge, and how the services can be obtained) must be included in the State's top 15 languages spoken by limited English proficient populations, and for small-size significant publications and significant communications a tagline must be included in the State's top two languages spoken by limited English proficient populations. The MCE will provide auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner, to ensure an equal opportunity to participate in the program.

Pursuant to the *Americans with Disabilities Act of 1990 (ADA) / 42 USC §12101 et. seq.*, all communications with members must be consistent with the ADA's prohibition on unnecessary inquiries into the existence of a disability. MCE shall have information available in alternative formats and through the provision of auxiliary aids and services for the MCE's health programs and activities, in an appropriate manner that takes into consideration the member's needs, including those who have visual impairment or limited reading proficiency, and at no cost to the member.

5.f.1 General Information Review, Approval, and Requirements

All member and potential member communications required in this section, or otherwise developed by the MCE, must be pre-approved by the State.

The MCE must develop and assign an MCE-designated inventory control number on **all** member promotional, education, or outreach materials with *date issued* or *date revised* **clearly** marked. The purpose of this inventory control number is to facilitate the State's review and approval of member materials and to document its receipt and approval of original and revised materials. The MCE must also **clearly** display the *date of last approval by the State* on all member materials. The MCE must keep a log of all member materials used during the year and must submit its member handbook to the State annually for review.

The MCE must submit all marketing, promotional, educational and outreach materials to the State for review and approval at least 30 calendar days before the materials' expected use and distribution. When submitting documents for review the MCE must identify, to the State, that the document is for the *Indiana Pathways for Aging* program (as well as any other program(s), as applicable). The MCE must also clearly indicate the method of communication for the submitted documents (e.g., text message, website, social media, etc.). Documents submitted for review must be as close to their final form as possible (e.g., no spelling, grammar, or formatting issues).

The MCE must get the State's approval to use or display program logos **each time** the MCE wishes to do so. The MCE must not assume the State will approve using the logo just because the State has previously approved the logo's use. The MCE must obtain the State's approval before distributing or using materials. The State reserves the right to assess liquidated damages or other remedies if the MCE uses or distributes unapproved member materials. This is included under Corrective Action in Exhibit 2.

All the State-approved member and potential member communication materials must be available on the MCE's member website within three business days of distribution. The member materials must be organized online in a user-friendly format.

The MCE must produce member materials and may distribute member materials **only** if they are approved by the State, and compliant with *42 CFR 438.10*. If the State requests, the MCE must provide information about how the materials will be used for member education and enrollment.

This information may include, but is not limited to, the following:

- A provider directory listing the MCE's providers and identifying each provider's specialty, service locations, hours of operation, telephone numbers, public transportation access, and other demographic information, in accordance with and the scope of work.
- MCE member bulletins or newsletters issued not fewer than four times a year that provide updates related to covered services and access to providers,
- Updated policies and procedures specific to the *Indiana Pathways for Aging* populations,
- MCE telephone system scripts and commercials-on-hold,
- MCE-distributed literature about all health or wellness programs the MCE offers,
- The MCE's marketing and promotional brochures and posters, and
- A member handbook that describes the terms and nature of services offered by the MCE and contact information, including the MCE's website address.

The MCE must make written information available in English and Spanish and other prevalent non-English languages, as identified by the State, at the member's request. The MCE must identify additional languages that are prevalent among members, inform members that information is available on request in alternative formats, and tell members how to obtain alternative formats. The State defines *alternative formats* as Braille, large-font letters, audiotape, prevalent languages, and verbal explanations of written materials.

The MCE must offer braille as an alternative format for receiving member materials. The MCE must offer Grade 1 uncontracted and Grade 2 contracted Braille to members upon request for alternative formats. When a member has requested materials in braille, the MCE must supply future materials in braille to the member. The MCE may review with the member the specific document types which the member wishes to receive in braille versus other formats. The MCE may outreach to members to inquire if braille documents are still the desired format.

All written materials for members or potential members shall be in a font size no smaller than 12-point. All written materials should be as close to fifth grade reading level as possible. This fifth-grade reading level requirement does not pertain to specific medical terminology (e.g., a member's diagnosis, drug names, treatment regimens, etc.). When using specific medical terminology, above a fifth-grade reading level, the MCE is encouraged to provide simple definitions, where possible. Abbreviations and jargon must not be used in member materials. All written materials should be clear, simple, meaningful, and easily readable; for tips, see CMS' [Guidelines for Effective Writing](#).

The MCE must notify its members of the respective programs' covered services that the MCE does not cover on moral or religious grounds and must offer guidelines for how and where to obtain those services, in accordance with *42 CFR 438.102*. The MCE must provide this information to members before and during enrollment and within 90 calendar days after adopting the policy with respect to any particular service.

The MCE must inform members that, at a member's request, the MCE provides information on the structure and operation of the MCE, in accordance with *42 CFR 438.10(f)(3)* and *438.3(i)*, which provides information on the MCE's provider incentive plans.

The MCE is responsible for developing and maintaining member education programs designed to offer members clear, concise, and accurate information about the MCE's program, the MCE's provider network, and the *Indiana Pathways for Aging* program. The State encourages the MCE to incorporate community advocates, support agencies, health departments, other governmental agencies and public health associations in its outreach and member education programs. The State also encourages the MCE to develop community

partners *Indiana Pathways for Aging* with these types of organizations to promote health and wellness within its membership.

5.f.2 Oral Interpretation and Translation Services

In accordance with 42 *CFR* 438.10(d), the MCE must arrange for oral interpretation services to its members free of charge for services it provides, including:

- Member services helpline
- 24-hour nurse call line
- Transportation
- Assessment and stratification
- Disease management
- Care management
- Complex case management
- Right Choices Program (RCP)

The requirement to provide oral interpretation applies to all non-English languages and is not limited to prevalent languages. Oral interpretation services must also include sign language interpretation services for the deaf. The MCE must notify its members of the availability of these services and how to obtain them.

Additionally, the MCE must ensure that its provider network arranges for oral interpretation services to members seeking healthcare-related services in a provider's service location. This includes ensuring that providers who have 24-hour access to healthcare-related services in their service locations or via telephone (for example, hospital emergency departments, PMPs) shall provide members with 24-hour oral interpreter services, either through interpreters or telephone services.

For example, the MCE must ensure that network providers provide TDD services for hearing impaired members, oral interpreters, and signers.

5.f.3 Member Website

The MCE must provide information to members through an Internet website in the State-approved format, compliant with Section 508 of the *US Rehabilitation Act*, to ensure compliance with existing accessibility guidelines. The website must be live and meet the requirements of this section on the effective date of the *Indiana Pathways for Aging* contract. The State must preapprove the MCE's website information and graphic presentations. The website must be accurate and current, culturally appropriate, written at or below a fifth-grade reading level, and available in English and Spanish. The MCE must inform members that information is available in alternative formats on request and advise how to request another format. To minimize download and wait times, the website must 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 MCE must date each webpage, change the date with each revision and allow users print access to the information. Such website information must include, at minimum, the following:

- Information required in the Enrollment Packet,
- Searchable provider networks for *Indiana Pathways for Aging* identifying each provider's specialty, service locations, hours of operation, telephone numbers, public transportation access and other demographic information,
- Updates to the online provider network information at least every two weeks and conspicuously indicate date of last update,
- Contact information for member inquiries, member grievances, or appeals,
- Member services telephone number, telecommunications device for the deaf (TDD) number, hours of operation and after-hours access numbers, including the 24-hour Nurse Call Line,
- Member portal with access to electronic explanation of benefits (EOB) the statements,

- Preventive care and wellness information,
- Information about the cost and quality of healthcare services,
- A list of covered benefits and services by program,
- Description of the MCE's disease management programs, care management and care coordination services,
- Marketing brochures and posters,
- MCE-distributed literature regarding all health or wellness promotion programs offered by the MCE,
- Information on the value and benefits of aging at home,
- Member's rights and responsibilities as enumerated in *42 CFR 438.100*,
- The member handbooks,
- Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices,
- Links to the State's website for general Medicaid, and the *Indiana Pathways for Aging* information,
- Information on pharmacy locations and preferred drug list,
- A list of all prior authorization criteria for prescription drugs, including mental health drugs,
- Transportation access information including NEMT,
- Information about access to dental services and how to access the MCE's dental network,
- A list and brief description of each of the MCE's member and provider outreach and education materials available,
- Executive summary of the MCE's Annual Quality Management and Improvement Program Plan Summary Report,
- Information about the copayment system and schedule,
- Information on behavioral health covered services and resources, and
- A secure portal through which member may complete the Health Needs Screening (HNS).

5.f.4 Preventive Care Information

The MCE is responsible for educating members regarding the importance of using preventive care services in accordance with preventive care evidence-based standards. The plan must include reminders that encourage members to obtain the State-recommended preventive care services for their age, gender, and pre-existing conditions. Further information on education requirements for disease specific conditions, disease management, and care coordination communication are located in Section 4 of the *Indiana Pathways for Aging* scope of work and the *Indiana Pathways for Aging Care and Service Coordination Manual*.

The MCE must, on an ongoing basis, contact via all appropriate media any member who has not utilized preventive services or has no claims activity within the last 15 months to schedule preventive care.

5.f.5 Advance Directive Information

The MCE must comply with the requirements of *42 CFR 422.128* for maintaining written policies and procedures for advance directives with respect to all adult individuals receiving medical care by or through the MCE's health plan. Specifically, each MCE must maintain written policies and procedures that meet requirements for advance directives in Subpart I of *42 CFR 489*. *Advance directives* are defined in *42 CFR 489.100* as "a written instruction, such as a living will or durable power of attorney for healthcare, recognized under the State law (whether statutory or as recognized by the courts of the State), relating to the provision of healthcare when the individual is incapacitated."

Written information about the MCE's advance directive policies, including a description of applicable State law, must be provided to members, in accordance with *42 CFR 438.10(g)(2)* and *438.3(j)*. Written information must reflect changes in the State law as soon as possible, but no later than 90 calendar days after the effective date of the change. Each MCE must provide written information to those individuals with respect to their rights under the State law, and the MCE's policies respecting the implementation of those

rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience. See 42 CFR 422.128(b) for further information regarding this requirement.

This information must be provided at the time of initial enrollment. If the member is incapacitated at the time of initial enrollment and is unable to receive information or articulate whether or not they have executed an advance directive, the information may be given to the member's family or surrogate. Once the member is no longer incapacitated or unable to receive such information, the MCE must ensure the information is provided to the individual, directly, at the appropriate time.

The MCE must inform individuals that complaints concerning noncompliance with the advance directive requirements may be filed with the State.

The MCE must inform the members that, upon the member's request, the MCE will provide information on the structure and operation of the MCE and, in accordance with 42 CFR 438.10(f)(3)), will provide information on the MCE's provider incentive plans.

Grievance, appeal and fair hearing procedures and time frames must be provided to members in accordance with 42 CFR 438.10(g)(2)(xi). See [Member Inquiries, Grievances, and Appeals](#) for additional guidance, as well as the kind of information the MCE must provide to members.

5.f.6 Member and Stakeholder Education and Engagement

The MCE must convene a minimum of four regional member and informal caregiver advocacy committees at least quarterly. These regional meetings shall occur in separate areas of the state, a minimum of 60 miles from each other regional meeting occurring that quarter.

The purpose of the committees is to provide member, informal caregiver, and advocate input into program development and feedback on the member experience. The MCE must present information to the committee and seek its advice regarding: the experience of members and their informal supports service gaps, approaches to member outreach and education, reinvestment opportunities, and regarding MCE's proposed approaches to initiatives and interventions MCE will implement to improve quality of care.

Additionally, the committee should be used to establish relationships with the member. The partnership allows members to feel empowered to advocate for themselves to provide authentic feedback aside from the power of attorney or authorized representatives. It is essential for the member to provide private feedback without caregivers or advocacy individuals to ensure authentic member feedback.

The committee must review member materials, including the member handbook and website, and review the MCE's Health Equity and Cultural Competency plan.

The MCE must have a feedback loop with the committee on recommendations taken and not taken.

The committee must review trends and summaries of member grievances and appeals. The committee shall be asked to provide advice to the MCE on how the MCE can resolve common member concerns.

The MCE must include a cross representation of members, families/representatives, and advocacy groups that reflect the population and community served specifically a majority of people with lived experiences. Sub-committees may be created to focus on specific topics such as LTSS or Behavioral Health.

The MCE must facilitate member participation providing transportation, interpretation services, compensation, virtual connectivity, meetings conducted in the prevalent non-English languages of the membership, personal care assistance, and compensation for attendance (through an enhanced benefit). The MCE must provide 30 days advance notice to members. Meetings shall be conducted in various formats such as informational or decision-making meetings or focus groups.

The MCE must have member advocacy organizations as standing members of the committee, especially organizations with a focus on and led by individuals with special health care needs, aging individuals, individuals with disabilities, and social determinant of health organizations.

State compliance staff shall be informed of each meeting time and location at least two weeks in advance, so they may plan to attend. Minutes from the meetings shall be provided to the MCE's Board of Directors and to the State within one month of the meeting date.

5.f.7 Health Equity and Cultural Competency

In accordance with 42 CFR 438.206, the MCE shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Per 42 CFR 438.206, at the time of enrollment with the MCE, the State shall provide the race, ethnicity, and primary language of each member. The MCE must incorporate the Office of Minority Health's National Standards on Culturally and Linguistically Appropriate Services (CLAS) into the provision of healthcare services for its members. This information shall be utilized by the MCE to ensure the delivery of services in a culturally humble way. Furthermore, the MCE will ensure all services are delivered through a health equity lens, meaning the MCE is able to address barriers experienced and identified by specific populations.

MCE shall create and submit a Health Equity and Cultural Competency plan for State approval which incorporates the Office of Minority Health's National Standards on Culturally and Linguistically Appropriate Services (CLAS). **The plan is due January 31 of each year.** The plan shall be reviewed by the member and informal caregiver advisory committee as described in Section 5.5 of the *Indiana Pathways for Aging* scope of work. The CLAS standards are available at <https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf>.

The plan shall include at a minimum:

- The creation of a Health Equity and Cultural Competency Workgroup that includes the MCE's Equity Officer, and members of the MCE representing the diversity of the MCE's membership, including individuals with disabilities. This workgroup shall provide input to the MCE relative to equity and cultural competency for the plan and shall be actively involved in initiatives to reduce disparities in services and outcomes for the MCE's membership. Individuals participating shall be compensated for their time.
- Incorporation of the CLAS enhanced standards adopted by the Department of Health and Human Services and linked to herein.
- A foundational assessment of health equity within the MCE's membership population, including detail on inequities in accessing care in the member's setting of choice.
- A description of how the health plan will ensure that services are provided in a culturally competent and trauma-informed manner to all members so that all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, understand their condition(s) or needs, the recommended treatment(s), and the effect of the treatment or service on their condition, including side effects. See additional details set forth in *Indiana Pathways for Aging* scope of work, Section 6.1.2 Access to Culturally and Linguistically Competent Providers.
- A description of how the health plan will effectively provide services to people of all cultures, races, ethnic backgrounds and national origins, geographies, sexual orientations, gender identities, abilities, and religions in a manner that recognizes, affirms, and respects the worth of the individual members and protects and preserves the dignity of each member.
- Identification of inequities and their root causes for the MCE's membership including inequities that arise with certain diagnoses (such as dementia), the development of targeted interventions that are trauma informed and measures to reduce these inequities, and a description of how to evaluate progress in disparity reduction efforts will be collected and analyzed.
- The utilization of Community Health Workers as part of broader community health integration initiatives and promotion of culturally competent care.
- A training plan in equity and cultural competency for the MCE's staff. Documentation of periodic training shall be provided in the annual assessment.

The plan shall be assessed by the MCE annually and submitted to the State. The assessment shall provide the outcome results used to measure progress in the prior year, and any new interventions the MCE will incorporate in the next year.

The MCE shall follow the guidance provided by the National Committee for Quality Assurance (NCQA) regarding the stratification of HEDIS measures by race and ethnicity.

The MCE shall ensure that all subcontractor's services and sites are accessible and that all subcontractors are culturally competent.

5.f.8 Cost and Quality Information

Making cost and quality information available to members increases transparency and has the potential to reduce costs and improve quality. The MCE shall make cost and quality information available to members to facilitate more responsible use of health care services and inform health care decision-making. Example cost information includes average cost of common services, urgent versus emergent care costs, etc.

For services that may be at risk for improper payments, the MCE must develop processes to verify with members that said targeted services billed by providers were actually received by said members, in order to obtain direct verification of services rendered and increase oversight. Processes and procedures must be identified in the MCE's Program Integrity Plan, specific services for member verification may be identified by the State PI Section and this may change based upon fraud trends. Processes for verifying services with members shall be included in the MCE's Program Integrity Plan.

The MCE shall provide a member portal with access to electronic EOB statements for members.

The MCE must provide explanations of benefits (EOBs) to all members monthly, at minimum. EOBs shall be available via paper and secure web-based portal. EOBs shall be delivered to members based on their preferred mode of receipt of MCE communications. At a minimum, EOBs shall be designed to address requirements in 42 CFR § 433.116(e) and (f), and 455.20.

The MCE must capture quality information about its network providers and must make this information available to members. In making the information available to members, the MCE must identify any limitations of the data. The MCE must also refer members to quality information compiled by credible external entities.

5.g Member-Provider Communication

The MCE must comply with 42 CFR 438.102, which relates to provider-enrollee communications. The MCE must not prohibit or restrict a healthcare professional from acting within their lawful scope of practice, advising, or advocating on behalf of a member who is their patient regarding the following:

- The member's health status, medical care, or treatment options, regardless of whether benefits for such care are provided under the *Indiana Pathways for Aging* program,
- Any information the member needs to decide among all relevant treatment and service options,
- The risks, benefits, and consequences of treatment, or non-treatment; and
- The member's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions.

This provision does not require the MCE to provide coverage for a counseling or referral service if the MCE objects to the service on moral or religious grounds.

The MCE must not prohibit health professionals from advising members of their right to participate in decisions regarding their health, including the right to refuse treatment and express preferences for future treatment methods. The MCE may not take punitive action against a provider that requests an expedited resolution or supports a member's appeal.

5.g.1 Member and Potential Member Communications Review and Approval

All member and potential member (advertising) communications required in this section or otherwise developed by the MCE must be pre-approved by the State. The MCE must develop and assign an MCE-designated inventory control number on **all** member promotional, education, or outreach materials with *date issued* or *date revised* **clearly** marked. The purpose of this inventory control number is to facilitate the State's review and approval of member materials and to document its receipt and approval of original and revised materials. The MCE must also **clearly** display the *date of last approval by the State* on all member materials.

The MCE must submit all member and potential member communications, including letters, bulletins, forms, advertisements, notices, handbooks, brochures, and any other marketing, educational or outreach materials to the State for review and approval at least 30 calendar days prior to expected use and distribution. Substantive changes to member and potential member communications shall also be submitted to the State for review and approval at least 30 calendar days prior to expected use and distribution. When submitting communications for review the MCE must identify, to the State, that the communication is for the *Indiana Pathways for Aging* program (as well as any other program(s), as applicable). Documents submitted for review must be as close to their final form as possible (e.g., no spelling, grammar, or formatting issues).

The MCE shall not refer to or use the State or other state agency name or logo in its member and potential member communications without prior written approval. The MCE shall request in writing approval from the State for each desired reference or use at least 30 calendar days prior to the reference or use. Any approval given for the State or other state agency name or logo is specific to the use requested and shall not be interpreted as blanket approval. The MCE shall include the State program logo(s) in their marketing or other member communication materials upon State request.

All member communication materials that have been approved by the State may be distributed by the MCE for the period of the *Indiana Pathways for Aging* contract and must be re-approved after any contract renewals.

The State will assess liquidated damages as set forth in Exhibit 2 of the *Indiana Pathways for Aging* scope of work and impose other authorized remedies for the MCE's non-compliance in the use or distribution of any non-approved member or potential member communications.

All the State-approved member and potential member communication materials must be available on the MCE's member website within three business days of distribution. The member materials must be organized online in a user-friendly format.

5.g.2 Member Communications - Returned Mail

- If a member receives Service Coordination, it is the service coordinator's responsibility to track returned member mail and assist the member with updating their address with provider, the MCE, DFR, etc.
- For members not receiving service coordination, ultimately the MCEs are responsible for tracking returned member mail.

MCEs must have policies and procedures in place regarding handling and processing of returned mail which shall include outreach to the member for each piece of returned mail to verify the mailing address. Outreach consists of at least one call to verify the mailing address.

If the MCE contacts the member and verifies the mailing address has changed, MCE must notify DFR of the change. In addition, the MCE should educate the members on contacting DFR to report changes as outlined in the [providing information that may affect eligibility](#) portion of the [Eligibility Determination Process](#) section of this Manual.

If the MCE finds that the mailing address provided on the 834 does not match the DFR information or the member confirms they have already updated their address with DFR, the MCE must submit an updated

address request to the State Member Services team. The State Member Service team can request that a reseed from IEDSS be sent to *CoreMMIS*, so the updated address is included in 834 file.

5.h Members' Rights

The MCE must guarantee the following rights protected under *42 CFR 438.100* to its members:

- The right to receive information, in accordance with *42 CFR 438.100*, which relates to information on the manage care program and plan in which the member is enrolled
- The right to be treated with respect and with due consideration for the member's dignity and privacy
- The right to receive information about available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand
- The right to participate in decisions regarding their healthcare, including the right to refuse treatment
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations pertaining to the use of restraints and seclusion
- The right to request and receive a copy of their medical records, and request that they be amended or corrected, as specified in the HIPAA Privacy Rule set forth in *45 CFR parts 160 and 164, subparts A and E*
- The right to be furnished healthcare services, in accordance with *42 CFR 438.206* through *438.210*

The MCE must also comply with other applicable the state and federal laws regarding member rights, as set forth in *42 CFR 438.100(a) through 42 CFR 438.100(c)*. The MCE must have written policies in place regarding the protected member rights listed above.

The MCE must have a plan in place to ensure that its staff and network providers consider member rights when furnishing services to the MCE's members. Members must be free to exercise protected member rights. The MCE must not discriminate against a member who chooses to exercise their rights.

5.i Redetermination Assistance

MCEs may assist members in the eligibility redetermination process and are permitted to do the following:

- Conduct outreach calls or send letters to members reminding them to renew their eligibility and reviewing redetermination requirements with the member
- Answer questions about the redetermination process
- Help the member obtain required documentation and collateral verification needed to process the application
- In providing assistance during redetermination, MCEs are **NOT** permitted to do the following:
 - Discriminate against members, particularly high-cost members or members who have indicated a desire to change MCEs
 - Talk to members about changing MCEs; refer questions about changing MCEs to the enrollment broker
 - Provide any indication about the member's eligibility; refer questions about eligibility to the DFR
 - Engage in or support fraudulent activity associated with helping the member complete the redetermination process
- Sign the member's redetermination form
- Complete or send redetermination materials to the DFR on behalf of the member

MCEs must provide redetermination assistance equally across their membership and be able to demonstrate to the State that their redetermination procedures are applied consistently.

5.j Additional Information Available Upon Request

The MCE shall have written policies guaranteeing to provide all other information to members as required by CMS including but not limited to the following information to any enrollee who requests it.

The MCE shall inform members that information is available upon request in alternative formats and how to obtain them. State defines alternative formats as braille, large font letters, audiotape, prevalent languages, and verbal explanation of written materials. The MCE shall offer braille as an alternative format for receiving member materials. When a member has requested materials in braille, the MCE shall supply future materials in braille to the member. The MCE may review with the member the specific document types the member wishes to receive in braille versus other formats.

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

For first-time or one-time requests from a member, the MCE shall mail the alternate version of the document in no more than seven business days from the date of the request.

For example, if the member received a wellness visit reminder flyer and called the MCE to ask for the flyer to be sent in braille, the MCE shall take no more than seven business days to mail the braille version from the date of the member request call.

For first-time or one-time requests from a member, when the mailing is governed by NCQA or statutory requirements, the MCE shall have two additional days from the NCQA or statutory timeframe to mail the document if no mailing has yet been sent to the member. For first-time or one-time requests from a member, when the mailing is governed by NCQA or statutory requirements and the statutory notice has already been fulfilled with a regular printed letter, the MCE shall mail the alternate version of the document in no more than seven business days from the date of the request.

For existing on-going alternate format requests, the MCE shall have two additional business days from when the document would normally be required to be mailed, to mail the document in the alternate format. The additional two days applies for contract requirements (such as ID cards) and additional mailings at the will of the MCE, such as a wellness visit reminder postcard.

For example, if a member had previously requested materials in braille, and an ID card would be sent to the member in five business days, the timeline would be seven business days for the braille version.

For existing on-going alternate format requests which must comply with NCQA or State law requirement, such as utilization management letters, the MCE shall mail the documents in the alternate format within the statutory or NCQA required timeline.

The MCE shall provide notification to the State, to the Enrollment Broker, to the [Ombudsman](#), and to its members of any covered services that the MCE or any of its subcontractors or networks do not cover on the basis of moral or religious grounds and guidelines for how and where to obtain those services, in accordance with 42 CFR 438.102, which relates to provider-enrollee communications. This information shall be relayed to the member before and during enrollment and within 90 calendar days after adopting the policy with respect to any particular service. Refer to *Indiana Pathways for Aging* scope of work, Section 7.8.2 for additional information.

The MCE shall inform the members that, upon the member's request, the MCE will provide information on the structure and operation of the MCE and, in accordance with 42 CFR 438.10(f)(3), will provide information on the MCE's provider incentive plans.

Grievance, appeal and fair hearing procedures and timeframes shall be provided to members in accordance with 42 CFR 438.10(g)(2)(xi), which requires specific information be provided to enrollees. See [Member Inquiries, Grievances, and Appeals](#) for further information about grievance, appeal, and fair hearing procedures, as well as the kind of information that the MCE shall provide to members.

The MCE shall be responsible for developing and maintaining member education programs designed to provide the members with clear, concise, and accurate information about the MCE's program and the MCE's network. The State encourages the MCE to incorporate community advocates, support agencies, health departments, other governmental agencies and public health associations in its outreach and member education programs. The State encourages the MCE to develop community partnerships with these types of organizations, in particular with, community mental health centers, county health departments and community-based organizations that serve older adults and/or persons with disabilities to promote health and wellness within its membership.

The MCE is required to provide written notice of a provider's disenrollment to any member that has received primary care services from that provider or otherwise sees the provider (including HCBS providers) on a regular basis going back 12 calendar months. Such notice must be provided to members at least 30 calendar days prior to the effective date of the termination. However, if the practice or practitioner notifies the MCE less than 30 days prior to the effective date of the termination, the MCE shall then notify members as soon as possible but no later than 15 calendar days after receipt of the notification from the practice or practitioner. Additionally, upon the request of a member, the MCE shall also provide information on the structure and operation of the health plan as well as information on physician incentive plans.

In the first and third quarter of every contract year, the MCE shall identify members who are potentially eligible for the Supplemental Nutritional Assistance Program (SNAP). The MCE shall use the federal poverty level of 130% to identify potentially eligible members. The MCE shall conduct an educational outreach campaign to the members identified as potentially eligible. The MCE does not need to outreach to all potentially eligible members at once but can conduct outreach on a rolling basis during the quarter identified and the following quarter (e.g., reach out to each potentially eligible member once in the first or second quarter and once again in the third or fourth quarter of every contract year). The educational information provided to members shall include information on SNAP benefits, eligibility, and how to enroll. The MCE shall develop communication strategies that meet the requirements of this section and provide innovative approaches to ensure member understanding of the program. The MCE must, at minimum, provide program information to the member through required notices and other communications prescribed by the State.

The MCE's educational activities and services shall also address the needs of specific program subpopulations (e.g., I/DD, dementia, members with complex needs, etc.) as well as its general membership. The MCE must have a comprehensive member outreach strategy to make persons aware of the benefits available to its members. The MCE shall demonstrate how these educational interventions reduce barriers to health care, social supports, and improve outcomes for members.

The MCE shall have policies and procedures to ensure that materials are accurate in content, accurate in translation relevant to language or alternate formats, and do not defraud, mislead, or confuse the member. Policy should include a cadence of routine review to update materials or validate content. The MCE shall provide information requested by the State, or the State's designee, for use in member education and enrollment.

5.k Procedures Regarding Potential Abuse, Neglect, and Exploitation (ANE) of Older Adults

5.k.1 MCE Responsibility

Indiana is a mandatory report state meaning everyone is required by law to report cases of suspected neglect, battery, and/or exploitation of an endangered adult to an adult protective service (APS) unit or law enforcement. The MCE will make reasonable efforts through member interactions, education, and interventions (such as but not limited to supporting a member's connection to community supports) to ensure that members are free from abuse, neglect, self-neglect, and exploitation (ANE). The MCE will provide educational materials and training opportunities to members, families, informal caregivers, guardians, and providers which cover the prevention, identification, and reporting of ANE of older adults.

The MCE will ensure prompt reporting and communication with the State and other appropriate entities regarding incidents of ANE and will proactively provide interventions to members regarding the ANE.

5.k.2 Policies and Procedures

The MCE shall have policies, procedures, protocols, and training to ensure that MCE staff and any subcontractor staff that provide services to members:

- are able to recognize and screen members for signs of abuse, neglect, self-neglect, and exploitation as defined in 455 IAC 2-4-2; 455 IAC 1-2-2(g-h).
- have processes to initially screen members for ANE, upon signs of ANE, or regularly if the member has a history of ANE; screening tools must be verified by the National Center on Elder Abuse or must be another evidence-based tool approved by the State.
- can identify members who may be at risk of abuse, self-neglect and exploitation and in need of adult protective services (APS) or the services of the State Long-Term Care (LTC) Ombudsman or the Indiana Department of Health.
- to support at-risk members, families, informal caregivers, and guardians with resources on ANE prevention, including informal caregiver education and support and strategies to reduce member and informal caregiver social isolation.
- understand reporting requirements and report incidents involving member abuse, neglect, self-neglect and exploitation consistent with IC 12-10-3-9.
- refer members at risk or in need of services to the appropriate resource including the LTC Ombudsman, or other appropriate agency, such as an Area Agency on Aging (AAA).
- report within 24 hours to the State regarding incidents of ANE, including interventions underway and anticipated intervention as described in Section 7.1.14 of the *Indiana Pathways for Aging* scope of work.
- to update the member's care plan as needed to balance member needs for safety, protection, physical health, and freedom from harm with overall quality of life and individual choice. Each issue of safety and risk shall be incorporated individually into the member's care plan.
- ensure that members, families, informal caregivers, and guardians and staff are provided educational materials on ANE prevention, recognition, and reporting with training materials that are approved by the State.
- to ensure follow-up occurs to that verifies the member's needs are addressed on an ongoing basis.
- to ensure follow up on intervention success has been completed within one week and reported to the State.

5.k.3 Access to Adult Protective Services (APS) and the State Ombudsman Program

For members where APS, any relevant State Ombudsman, or the State Member Support Services contractor may need to be involved, the MCE shall involve the entity in the following capacities:

- The MCE will, as appropriate, invite an APS/any relevant State Ombudsman staff person/State Member Support Services contractor to participate in the member-centered planning process including plan development and updates, comprehensive assessment, and re-assessments.
- The MCE will, as appropriate, invite an APS/any relevant State Ombudsman staff person/State Member Support Services contractor to participate on the interdisciplinary team to the extent that the staff person makes recommendations as necessary to fulfill their APS/any relevant State Ombudsman responsibilities.
- The MCE will designate a staff person to serve as a member advocate and liaison between APS/any relevant State Ombudsman staff person/State Member Support Services contractor and the member to assist APS, any relevant State Ombudsman staff, and the State Member Support Services contractor working in developing service options for The MCE's members or potential members.

5.k.4 Examination and Treatment Services

The MCE will arrange for the provision of examination and treatment services by providers with expertise and experience in dealing with the medical/psychiatric aspects of caring for victims and perpetrators of elder abuse, abuse of adults with intellectual or developmental disabilities, and domestic violence. Such expertise shall include the identification of possible and potential victims of elder abuse and domestic violence, statutory reporting requirements, and local community resources for the prevention and treatment of elder abuse and domestic violence.

The MCE will ensure that members, who must be separated from an alleged abuser, are immediately transitioned to another setting. Continuity of care shall be upheld during and after the transition. The MCE will consult with human service agencies on appropriate providers in their community.

The MCE will further assure that providers with appropriate expertise and experience in dealing with perpetrators and victims of domestic abuse, elder abuse, and incest are utilized in service provision including trauma counseling and resource connection for members who have experienced ANE.

5.k.5 Adult Protective Services and State Ombudsman Relations

The MCE will make efforts to build working relationships with all the Adult Protective Services (APS) units and Ombudsmen programs through regular meetings and written policies. The MCE may enter memorandums of understanding with the Indiana's Adult Protective Services units and the State Ombudsman programs. MOUs will follow the policies and procedures issued by the State and shall be submitted to the State for review and approval.

5.l Member Inquiries, Grievances and Appeals

The MCE must have written policies and procedures governing the resolution of grievances and appeals. At a minimum, the grievance system must include a grievance process, an appeal process, expedited review procedures, external review procedures and access to the State's fair hearing system. The MCE must maintain records of grievances and appeals in accordance with *42 CFR 438.16* which includes the following:

- A general description of the reason for the appeal or grievance
- The date received
- The date of each review or, if applicable, review meeting
- Resolution at each level of the appeal or grievance, if applicable
- Date of resolution at each level, if applicable
- Name of the covered person for who the appeal or grievance was filed
- The record must be accurately maintained in a manner accessible to the State and available upon request to CMS.

The MCE must operate unified appeals and grievance processes with their companion DSNP plan, meeting the requirements in *42 CFR 422.629* through *42 CFR 422.634*.

The State will review this information as part of the State's quality strategy. The MCE's grievances and appeals system, including the policies for recordkeeping and reporting grievances and appeals, must comply with *42 CFR 438*, Subpart F, as well as *IC 27-13-10* and *IC 27-13-10.1* [when the MCE is licensed as a health maintenance organization (HMO)] or *IC 27-8-28* and *IC 27-8-29* (when the MCE is licensed as an accident and sickness insurer).

The term *inquiry* refers to a concern, issue, or question that is expressed orally by a member that will be resolved by the close of the next business day.

The term *grievance*, as defined in *42 CFR 438.400(b)*, is an expression of dissatisfaction about any matter other than an "action" as defined below. This may include dissatisfaction related to the quality of care of services rendered or available, aspects of interpersonal relationships such as rudeness of a provider or

employee, or the failure to respect the member's rights. All grievances are appealable under *IC 27-13-10-7* and *27-13-10-8*.

The term appeal is defined as a request for a review of an action. An action, as defined in *42 CFR 438.400(b)*, is the following:

- denial or limited authorization of a requested service, including the type or level of service,
- reduction, suspension, or termination of a previously authorized service,
- denial, in whole or in part, of payment for a service excluding the denial of a claim that does not meet the definition of a clean claim. A "clean claim" is one in which all information required for processing the claim is present,
- failure to provide services in a timely manner, as defined by the State,
- failure of an MCE to act within the required time frames,
- denial of a member to exercise their right, under *42 CFR 438.52(b)(2)(ii)*, to obtain services outside the network when the member resides in a rural area with only one MCE, and
- denial of a member's request to dispute a financial liability including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

The MCE must notify the requesting provider and give the member written notice of any decision considered an adverse benefit determination *action* taken by the MCE, including any decision by the MCE to deny a service authorization request (a request for the provision of a service by or on behalf of a member), or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of *42 CFR 438.404*. The notice must include:

- The adverse benefit determination the MCE has taken or intends to take,
- The reasons for the adverse benefit determination,
- The member's or the provider's right to file an appeal and the procedure for requesting such an appeal,
- The procedure to request an external grievance procedure (External Review by Independent Review Organization) following exhaustion of the MCE appeals process,
- The procedure to request a State fair hearing following exhaustion of the MCE appeals process,
- The circumstances under which expedited resolution is available and how to request it; and
- The member's right to have benefits continue pending resolution of the appeal, how to request continued benefits and the circumstances under which the member may be required to pay the costs of these services.

5.1.1 Inquiry Processing Requirements

The MCE must resolve inquiries by the close of the next business day after receipt. If an inquiry is not resolved in the timeframe, it becomes a grievance. An inquiry resolved in the required timeframe does not require written notice of a resolution to the member. The MCE must maintain a system for tracking and reporting inquiries it receives during business and non-business hours.

5.1.2 Grievance Processing Requirements

The MCE's policies and procedures governing grievances must include provisions that allow for the following filing, notice, and resolution time frames:

- Members must be allowed to file grievances verbally or in writing within 60 calendar days of the occurrence that is the subject of the grievance. Members may file a grievance regarding any matter other than those described in the definition of an action.
- The MCE must acknowledge receipt of each grievance within three business days. For grievances, the MCE is not required to acknowledge receipt of the grievance in writing, however, if the member requests

written acknowledgement, the acknowledgement must be made within five business days of receipt of the request.

- The MCE must make a decision on non-expedited grievances as expeditiously as possible, but not more than 30 calendar days following receipt of the grievance. This time frame may be extended up to 14 calendar days if resolution of the matter requires additional time. If the time frame is extended, for any extension not requested by the member, the MCE must give the member written notice of the reason for the delay. The MCE must provide the member with a written notice of any extension within two calendar days of the extension, including the reason for the extension and the member's right to file a grievance if they disagree with the extension.
- The MCE must provide an expedited grievance review if adhering to the resolution timeframe of 30 calendar days would seriously jeopardize the life or health of a member, or the member's ability to regain maximum function, or by the member's request. Expedited grievances must be resolved within 48 hours of receipt. If the MCE denies a request for an expedited review, the MCE shall transfer the grievance to the standard grievance timeframe. Further, the MCE must make a reasonable effort, including a phone call to the member, to provide the member with prompt oral notification of the denial for an expedited review, and shall follow up with a written notice to the member and, where appropriate, the provider within two calendar days.
- The MCE must respond in writing to a member within five business days after resolving a grievance or expedited grievance. The resolution includes notice of the member's right to file an appeal, the process for requesting an appeal, the expedited review options, the right to continue benefits during the appeal (as long as the request complies with timeliness standards), and an explanation that the member may have to pay for care received if an adverse appeal decision is made. For grievances related to a member's request to change MCEs, information on how to request a plan change must be included in the notice. The MCE must make a reasonable effort, including a phone call to the member, to provide oral notification of expedited grievance resolution. For grievances related to violations of the setting rule (42 CFR 441.301(c)) the MCE shall report to their state contact the outcome of the MCE's grievance review.

The MCE must routinely review grievance and appeal data to determine broad member impact and how to improve member experience and member outcomes.

5.1.3 Appeals Processing Requirements

The MCE appeals process must accomplish the following:

- Allow members, or providers, acting on the member's behalf, 60 calendar days from the date of action notice to file an appeal according to Indiana Administrative Code (*LSA Document #11-724*). A provider, acting on behalf of the member and with the member's written consent, may file an appeal. The MCE cannot require providers to use a specific form to submit an appeal on behalf of the member.
- In accordance with 42 CFR 438.406, the MCE must ensure that verbal requests seeking to appeal an action are treated as appeals. For oral appeals with expedited resolutions, the MCE shall maintain documentation of the oral appeal and its resolution. As of March 1, 2020, oral requests no longer need to be followed by a written request.
- The MCE must acknowledge receipt of each standard appeal within three business days. The MCE must make standard, non-expedited, appeals within 30 calendar days of receipt of the appeal. This time frame may be extended up to 14 calendar days, pursuant to 42 CFR 438.408(c). If the time frame is extended, for any extension not requested by the member, the MCE must give the member written notice of the reason for the delay.
- Upon determination of the appeal, the MCE must ensure there is no delay in notification or mailing to the member and/or member's representatives of the appeal decision.
- Maintain an expedited review process for appeals when the MCE, or the member's provider, determines that pursuing the standard appeals process could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. The MCE must dispose of expedited appeals within 48 hours after the MCE receives notice of the appeal, unless this time frame is extended, pursuant to 42 CFR

438.408 (c). In addition to the required written decision notice, the MCE must make reasonable efforts to provide the member with verbal notice of the disposition of the appeal.

- In accordance with 42 CFR 438.410, if the MCE denies the member's request for an expedited resolution of an appeal, then the MCE must transfer the appeal to the standard 30 calendar daytime frame and give the member written notice of the denial within two days of the expedited appeal request. The MCE must also make a reasonable attempt to provide prompt verbal notice to the member.

The MCE's policies and procedures governing appeals must include provisions that address the following:

- The MCE must not prohibit, or otherwise restrict, a healthcare professional acting within the lawful scope of practice, from advising or advocating on behalf of a member, in accordance with 42 CFR 438.102. A provider, acting on behalf of the member and with the member's written consent, may file an appeal.
- The MCE must not take punitive action against a provider that requests or supports an appeal on behalf of a member.
- The MCE must consider the member, representative, or estate representative of a deceased member as parties to the appeal throughout the appeals process.
- In accordance with 42 CFR 438.406, the MCE must allow the member and member representative an opportunity to examine the member's case file, including medical records, and any other documents and records considered during the appeals process.
- The MCE must allow the member and member representative to present evidence, and allegations of fact or law, in person as well as in writing.
- The MCE must inform the member and member representative of the limited time available to present evidence and allegations of fact or law, in the case of expedited appeal resolution.
- The MCE must ensure that there is no delay sending the appeal decision to the member and member's representative. The MCE's appeal decision notice must describe the actions taken, the reasons for the action, the member's right to request the State fair hearing, the process for filing a fair hearing and other information set forth in 42 CFR 438.408(e).
- The MCE must acknowledge receipt of each grievance and appeal.
- The MCE must notify members of the disposition of grievances and appeals pursuant to IC 27-13-10-7 (if MCE is licensed as an HMO) or IC 27-8-28-16 (if MCE is licensed as an accident and sickness insurer).
- The MCE must provide members any reasonable assistance in completing forms and taking other procedural steps, including but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. Oral interpretation services shall not substitute for written translation of vital materials in accordance with 42 CFR 438.401(d)(1) and 42 CFR 431.10.
- The MCE must ensure that the individuals rendering decisions on grievances and appeals were not involved in previous levels of review or decision-making and are health care professionals with appropriate clinical expertise in treating the members condition or disease if the decision will be in regard to any of the following:
 - An appeal of a denial based on lack of medical necessity
 - A grievance regarding denial of expedited resolution of an appeal
 - Any grievance or appeal involving clinical issues.

MCEs shall not require a designated form for members to submit a grievance or appeal. The State reserves the right to require the MCE to utilize a universal member grievance and appeal form provided by the State.

5.1.4 External Review by Independent Review Organization

In accordance with IC 27-13-10.1-1 and IC 27-8-29-12, the MCE must maintain an external grievance procedure for the resolution of decisions related to an adverse utilization review determination, an adverse determination of medical necessity, or a determination that a proposed service is experimental or investigational. An external review does not inhibit or replace the member's right to appeal an MCE

decision to the State fair hearing. A member may seek external review by an Independent Review Organization (IRO), and such process may run concurrently with a State fair hearing.

Within 120 days of receipt of the appeal decision, a member or a member's representative may file a written request for a review of the MCE's decision by an independent review organization (IRO). Within 72 hours, for an expedited appeal, or 15 business days for a standard appeal, the IRO will render a decision to uphold or reverse the MCE's decision. The determination made by the independent review organization is binding on the MCE. IRO clinicians do not have to be Indiana licensed.

An independent external review of an authorization denial must be performed by an approved independent review organization (IRO). The Indiana Department of Insurance (IDOI) maintains a list of approved IROs to be used by MCEs for independent external reviews. MCEs and other health maintenance organizations in the State are required to rotate through the list of IDOI-approved IROs before using an IRO again. For each requested independent external review, the MCE must select the next IRO on the list to perform the review, unless the subsequent IRO vendor is unable to fulfill the request, in which case that IRO may be skipped.

5.1.5 State Fair Hearing Process

In accordance with *42 CFR 438.408*, the State maintains a fair hearing process that allows members the opportunity to appeal the MCE's decisions to the State. Appeal procedures for applicants and recipients of Medicaid are found at *405 IAC 1.1*. The State fair hearing procedures include the following requirements:

- The member may request a State fair hearing within 120 days of exhausting the MCE's internal procedures.
- The parties to the State fair hearing must include the MCE, as well as the member and their representative or the representative of a deceased member's estate.
- If dissatisfied with the outcome of the State fair hearing, the member may request an agency review within 10 days of receipt of the administrative law judge's decision. Pursuant to *405 IAC 1.1-3-1*, if the member is not satisfied with the final action after agency review, the member may file a petition for judicial review in accordance with *IC 4-21.5-5*. The MCE will be subject to the contract compliance remedies, set forth in Exhibit 2 of the *Indiana Pathways for Aging* scope of work, for failing to provide a timely and satisfactory response to documentation required for an appeal or failure to represent the State at the State fair hearing. The MCE may request an agency review of a decision made by an administrative law judge, at the MCE's discretion.
- The MCE must include the State fair hearing process as part of the written internal process for resolution of appeals and must describe the fair hearing process in the member handbook.
- All notices of actions with appeal rights and notices of final action by the MCE where the next course of action is a State Fair Hearing shall have the following language included:
 - "This is an administrative action by the State of Indiana. If you disagree with this decision, you can appeal it. Appeals are handled by the State of Indiana Office of Administrative Law Proceedings. You may contact the State of Indiana Office of Administrative Law Proceedings at:

Mail: Office of Administrative Law Proceedings
100 N. Senate Avenue Suite N802
Indianapolis, IN 46204
Phone: 317-234-6689
Email: fssa.appeals@oalp.in.gov

5.1.6 Continuation of Benefits Pending Appeal & Reinstatement of Benefits

In certain member appeals, the MCE is required to continue the member's benefits pending the appeal, in accordance with *42 CFR 438.420*. The MCE shall continue the member's benefits if:

- the member or provider files the appeal within 10 days of the MCE mailing the notice or the intended effective date, whichever is later.

- the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- the services were ordered by an authorized provider.
- the original period covered by the original authorization has not expired.
- the member requests extension of benefits.

If benefits are continued or reinstated while the appeal is pending, the benefits shall be continued until one of the following occurs:

- the member withdraws the request,
- ten days pass after the MCE has mailed the notice of an adverse decision, unless a State fair hearing and request for continuation of benefits until the State hearing is resolved, is requested within these ten days, or
- the time period or service limits of a previously authorized service(s) has been met.

If the final resolution of the appeal is adverse to the member, that is, it upholds the MCE's action, the MCE may recover the cost of the services furnished to the member while the appeal was pending, to the extent that they were furnished solely because of the requirements to maintain benefits in accordance with *42 CFR 431.230* and *42 CFR 438.420*. The MCE must notify the member in advance that costs may be recovered. The MCE may arrange for the member to pay back any such amounts owed in monthly installments, not to exceed four months.

In accordance with *42 CFR 438.424*, if the MCE or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE shall authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires. If the MCE or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE shall pay for those services.

5.1.7 Member Notice of Grievance, Appeal and Fair Hearing Procedures

The MCE must provide specific information about member grievance, appeal and the State fair hearing procedures and time frames to members, as well as to providers and subcontractors when they contract with the MCE. The information provided must be approved by the State and as required under *42 CFR 438.10(g)(2)(xi)*, include the following:

- The right to file grievances and appeals
- The requirements and time frames for filing a grievance or appeal
- The availability of assistance in the filing process
- Ombudsman and independent advocacy services available as sources of advice, assistance, and advocacy
- The toll-free numbers that the member can use to file a grievance or appeal by telephone
- The fact that, if requested by the member and under certain circumstances, the following will occur:
 - Benefits will continue if the member files an appeal or requests the State fair hearing within the specified time frames.
 - The member may be required to pay the cost of services furnished during the appeal if the final decision is adverse to the member.
- The right to request External Review by an Independent Review Organization
- The State fair hearing information must include the following:
 - The right to a hearing
 - The method for obtaining a hearing
 - The rules that govern representation at the hearing

5.1.8 Ombudsman

The State will operate or contract with a statewide Ombudsman program for the benefits of individuals in the *Indiana Pathways for Aging* program. The Ombudsman will be available to help these individuals, their information caregivers, and families resolve questions or problems and serve as a source of assistance, advice, and advocacy.

The MCE must identify and dedicate specific staff to serve as contacts for the State's Ombudsman program. The MCE must respond directly to the Ombudsman inquiries. The MCE must not interfere with a member's use of the Ombudsman program, including the Ombudsman involvement with member grievances and appeals.

Additional information will be communicated to the MCEs once vendor is determined, and this manual will be updated.

5.1.9 State Member Support Services Contractor

The State operates or contract with a statewide Member Support Services program for the benefit of individuals in *Indiana Pathways for Aging*. The Member Support Services contractor is available to help these individuals, their informal caregivers, and families resolve questions or problems and serve as a source of assistance, advice, and advocacy.

The MCE shall identify and dedicate specific staff to serve as contacts for the State's Member Support Services program. The MCE shall respond directly to Member Support Services inquiries. The MCE shall not interfere with a member's use of the Member Support Services program, including the Member Support Services contractor's involvement with member grievances and appeals.

5.m Health Needs Screening (HNS)

MCEs must conduct a health needs screening (HNS) for new members who enroll in their plan. The health needs screening helps identify the member's physical and behavioral healthcare needs, and special healthcare needs, and identifies members who might need disease management, case management, or care management services. The HNS may be conducted in person, by telephone, online, or by mail. The State encourages the MCEs to conduct the screening at the same time the PMP selection outreach occurs.

The MCE must use the standard health needs screening tool developed by the State. The MCE is permitted to supplement the state HNS tool with additional questions. Any additions to the state HNS must be approved by the State.

The MCEs are responsible for conducting HNS for all new members. For purposes of the health needs screening requirement, new members are defined as members that have not been enrolled in the MCE's plan in the previous 12 months. The HNS must be conducted within 30 calendar days of a new member's enrollment in the MCE's plan. The MCE is also required to conduct a subsequent HNS when a member's healthcare status is determined to have changed since the original screening, such as evidence of overuse of healthcare services identified through such methods as claims review.

All screener questions are required and must be asked of all members, depending on question-related rules, such as gender-specific, age range, or follow-up based on response. The HNS layout provides a list of valid responses for each question. Valid responses are noted on the screening form in a check-box format. There are additional valid responses not shown on the HNS form as follows:

- *Member refusal* – MR must be reported when member does not answer a question.
- *Not applicable* – N/A must be reported only when a question does not apply to the member. N/A is appropriate only where it is indicated as a valid response on the HNS layout.

The MCE nonclinical staff may conduct the health screening. The results of the health needs screening must be transferred to the State in the form and manner required by the State. Data from the health screening form, current medications, and self-reported medical conditions are used to develop stratification levels for members in *Indiana Pathways for Aging*. While the MCE may use its own proprietary stratification

methodology to determine which members must be referred to specific disease management programs, ranging from member detailing to care management, the State applies its own stratification methodology which may, in future years, be used to link stratification level to the per member, per month capitation rate.

The initial screening may indicate that the member has a special healthcare need or required follow-up. In this case, the initial health needs screening must be followed by a Comprehensive Health Assessment Tool (CHAT) by a healthcare professional. The CHAT may include, but is not limited to, discussion with the member, a review of the member's claim history, and contact with the member's family or healthcare providers. These interactions must be documented and available for review by the State. The MCE must keep up-to-date records of members with special healthcare needs, based on the HNS, including documentation of the CHAT completion, and contacts with the member, their family, or healthcare providers.

5.m.1 Health Needs Screen Extract

MCEs must submit a monthly extract of completed HNS by the 15th of every month. The monthly file should contain assessments completed in the previous month that were done within the 30-day timeframe. The time period being reported should include the first day of the previous calendar month through the last day of the previous calendar month. MCEs are required to include any late records with their following month's submission. MCEs should only submit HNS that are considered to be complete. The definition of *complete* is an assessment that has at least 11 of the 13 questions answered and was completed within the required 30-day timeframe.

Extracts should be placed at State's SFTP location in the respective MCE folder.

5.n Comprehensive Health Assessment (CHAT)

The MCE shall conduct a comprehensive health assessment of all members initially stratified into care management, complex case management or RCP following the initial screening to further identify the appropriate level of care coordination services. The comprehensive health assessment is referred to as CHAT – comprehensive health assessment tool. The assessment will be all-inclusive and identify the clinical, psychosocial, functional, and financial needs of the member. The comprehensive health assessment will be used to develop and implement a comprehensive care plan to meet the member's needs and shall be completed according to the timeframes below:

- For members who are receiving LTSS in a nursing facility at the time of enrollment, the CHAT or State-approved nursing facility assessment(s) shall be conducted by phone or face-to-face within 30 calendar days of the MCE effective date.
- For members who meet NFLOC and are either receiving HCBS, waiting to receive, or opt to receive HCBS at the time of enrollment, the CHAT shall be conducted by phone or face-to-face within 30 calendar days of the MCE effective date.
- For members who do not meet NFLOC and are not receiving LTSS in any setting at the time of enrollment, the CHAT shall be conducted by phone or face-to-face within 90 calendar days of the MCE effective date.

The MCE will develop a Comprehensive Health Assessment to be approved by the State. The MCE's Comprehensive Health Assessment must contain, at a minimum, elements prescribed by the State and may be augmented with condition-specific and/or MCE-specific elements.

The MCE will 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 assessment may include, but is not limited to, a review of the member's claims history and/or contact with the member, member's family, PMP (if applicable), or other significant providers. A clinician on the MCE's care management team will review the findings of the health assessment and provide the findings to the member's primary providers, including the member's PMP and/or behavioral health care providers, if applicable.

In accordance with 42 CFR 438.208(c)(2), the MCE must have a healthcare professional assess the member through a detailed health assessment if the health screening identifies the member as potentially having a

special healthcare need. When further assessment confirms the special healthcare need, the member must be placed in care management. The MCE must offer continued coordinated care services to any member transferring into the MCE from another MCE with special healthcare needs. MCE activities supporting special healthcare needs populations must include but are not limited to the following:

- Conducting the initial screening and more detailed health assessment to identify members who may have special needs
- Scoring the initial screening and more detailed health assessment results
- Distributing findings from the health assessment to the member's PMP, the State and other appropriate parties, in accordance with state and federal confidentiality regulations
- Coordinating care through a Special Needs Unit or Complex Case Management services in accordance with the member's care plan
- Participating in clinical studies of special healthcare needs, as directed by the State

5.o Member Cost Sharing

The MCE shall adhere to state and federal law, the State Plan and the requirements set forth in *42 CFR 447.50* through *447.57* when imposing any cost sharing charges on members.

Federal regulations at *42 CFR 447.56* place aggregate limits on cost-sharing and prohibit total member cost-sharing per family from exceeding 5% of the family's income, as determined by the State, in a monthly or quarterly period.

To ensure a family's total cost-sharing does not exceed 5% of the family's income in a calendar quarter, the MCE shall accept family income data from the State's fiscal agent and track the copayments, premiums, member debt collected, and/or other cost sharing information available to the MCE against the total family income data provided by the State. Any service not specifically listed as a covered benefit in the applicable benefit plan may not be applied against the member's 5% contribution calculation. When a family's total cost-sharing expenditures come close to exceeding 5% of the family's income in the quarterly period, the MCE shall coordinate with the State and shall notify providers and the family that additional cost sharing during the period is reduced or waived.

The member's household size and monthly countable income will be used in calculating the 5% quarterly cost-sharing limit. Monthly countable income should be multiplied by 3 to find quarterly income, and then divided by the household size to assess the individual's portion of income. Five 5% of individual countable quarterly income is the cap to be used to determine when cost-share limit has been met. When 5% is met, this is communicated back to *CoreMMIS* via the Supplemental File so that the Provider Portal indicates to each provider that the member is not to be charged copays at that time. The status should be reset at the beginning of the following quarter. MCEs send a letter to the individual to indicate when cost-share has been met for the quarter, including that it will be reset at the start of the following quarter.

5.p Member Liabilities

Liability is the term applied to the monetary amount that IHCP members in long-term care (HCBS or nursing facility) must contribute toward their monthly care. The MCE must be knowledgeable and able to answer questions on liabilities and provide current information to member's inquiries and liability issues.

DFR is responsible for determining the amount of a member's waiver or patient liability. All income is counted in the eligibility determination, but when determining the liability amount, certain deductions are applied. After all deductions have been applied, the liability amount is set for the individual. Those deductions include (*IHCPPM 3455.15.10*):

- A personal needs allowance (PNA)
 - \$52 per month
 - The amount of the current year's special income level (SIL) for a waiver liability [*405 IAC 2-1.1-1(g)*]
 - Veterans' pensions as specified in *IC 12-15-7-2*, if applicable

- Sheltered workshop earnings
- Court ordered guardianship fees, up to \$35 per month
- Spousal allocation, if applicable
- Family allocation, if applicable
- Out of pocket health insurance premiums, such as third-party insurance

Member information reflected in CoreMMIS is updated daily from the information relayed by the eligibility and enrollment system (IEDSS) and will be communicated to the appropriate MCE. Liability amounts will not change in the middle of a month, but eligibility should be checked on the first of the month to verify the liability amount, as it can change on the first of the month.

Available Income in Excess of the Special Income Level (SIL)

A member will be required to put any personal funds which are in excess of the Special Income Limit (SIL) into a Miller Trust for each month in which their income exceed the SIL limit. The special income level can be located in Section 3010.20.15 of the *Indiana Health Coverage Program* policy manual. For more information about the Miller Trust, see IHCPPM 2615.75.15 and <https://www.in.gov/fssa/ompp/home/miller-trust/>.

Deviation of Liability

If a member has unpaid Medicaid bills for claims prior to Medicaid approval (such as unpaid nursing home bills), then a possible *deviation of liability* (deduction in the initial liability assignment calculation) can be requested. The request for deviation as well as verification of such bill would need submitted to the DFR with proof that the claim was unpaid by a third-party insurance (up to and including Medicare), such as an EOB. It is the member's responsibility to supply this verification, this information will not be requested by DFR. If approved, the deviation would reduce the members liability for the time span that would allow the member to pay off the balance of their outstanding bill. The member is responsible for paying these expenses.

5.p.1 Waiver Liabilities

A *waiver liability* is similar to a deductible and applies to members who live in the community (e.g., their own home, an adult family home, a community-based residential facility, assisted living facility or a residential care apartment complex) and receive home and community-based services (HCBS).

For members with a waiver liability, imposed in accordance with 42 C.F.R. § 435.726, the MCE must provide a system to track Medicaid-allowable expenses. In accordance with 42 CFR 435.726, when the Medicaid-allowable LTSS expenses exceed the waiver liability amount, they must be paid by the MCE; Medicaid will not reimburse LTSS services until the waiver liability has been met. Only State Plan services can be paid without regard to whether the waiver liability has been met. The provider must verify the waiver liability obligation and balance in the portal when checking eligibility.

Monthly waiver liability summary notices must be sent to the member and any authorized representative. The notice must detail the services and amounts applied to the waiver liability. With the exception of pharmacy claims, the member is not required to pay the provider until the expense has been included in the waiver liability summary notice.

5.p.2 Patient Liabilities

Patient liability applies to members who reside, or are likely to reside, in a nursing home or intermediate care facility for 30 or more consecutive days.

For members with patient liabilities, imposed in accordance with 42 C.F.R. § 435.725, liability amounts are to be deducted from the total reimbursement of monthly claims to the facility.

Providers must apply current income to current needs. As an example, a social security benefit check received in October must be applied to October charges. The only exception is the direct deposit benefit

check that is sometimes recorded by the bank at the end of one month instead of early in the next month when it would normally be received. Because most resources are available on a calendar month basis, all accounts that involve resource deductions must be billed on a calendar-month basis, for example, June 1 through June 30, or July 1 through July 31.

Providers are not to indicate or exclude the liability when submitting claims. The patient liability amount should be visible in the provider portal, or when the provider checks eligibility. State Plan services can be paid without regard to whether the patient liability has been met.

Note: Providers must deduct patient resources from the payment in the month that the resources are received. Veterans pensions will not prevent a member from receiving the monthly personal needs allowance typically allotted for Medicaid members.

When a member transfers between facilities during a billing period, the member liability is deducted from the first claim received and processed by the MCE. Therefore, the facilities involved in the transfer must coordinate any liability deductions.

5.p.3 Retroactive Adjustment of Member Liabilities

When the DFR supplies a patient liability amount that is added, removed, or modified retroactively, claims should be automatically adjusted. The claims that are subject to adjustments are long term care, hospice, and medical claims billed by specialty 040-Rehabilitation Facility.

5.q Member Medicaid Suspension

Resource Suspension

For Medicaid members residing in a nursing home or on HCBS waivers, if a change in circumstances causes temporary resource or asset ineligibility for Medicaid, the member may be suspended for up to two months. If the member is eligible before the end of the suspension period, eligibility is to be reinstated without a reapplication. If after the suspension period the member remains ineligible, Medicaid will be discontinued. It is the member's responsibility to verify how the resources/assets were spent and that they are under the resource limit for Medicaid [IHCPPM 2237.00.00].

Incarcerated Members and Members Admitted to a Psychiatric Facility

For Medicaid members who become incarcerated or admitted to a psychiatric facility that results in ineligibility, the member's Medicaid is suspended until the member is released from the facility. Medicaid benefits can remain in suspension status for up to two years.

In cases of Medicaid suspension, the members Medicaid will display as closed. If/when the Medicaid is reinstated, the status must display in the portal.

5.r Transfer of Property Penalties

Transfer of property penalties (TOP) are applied when an individual, or someone acting on their behalf, gives away or transfers assets to qualify for Medicaid. When an individual transfers asset(s) without receiving adequate consideration [IHCPPM 2640.10.20] in return, a TOP is to be applied. The MCE should be knowledgeable and able to answer questions and provide information to members who contact them with questions on transfer of property penalties. However, eligibility determination is the responsibility of the State.

DFR is responsible for determining the amount and length of a member's TOP.

A transfer of property penalty is calculated using the *uncompensated value* of the transferred resource(s). The *uncompensated value* is the fair market value of the resource(s), minus loans, encumbrances, and consideration received. Certain transfers can cause a member to be allowed a *de minimis* of up to \$1200 per calendar year; the member is responsible for providing the proof necessary to apply the *de minimis* transfer allowance.

The penalty is calculated, in the eligibility system, by dividing the uncompensated value (minus the de minimis, if applicable) by the *facility rate* as of the date of the Medicaid application [IHCPPM 2640.10.20]. A monthly *facility rate* is set by the State, annually, and can be located in IHCPPM 3006.00.00. The amount will then be rounded up two decimal places, resulting in the length of the penalty period (for example, 2.2621607 months are rounded to 2.27 months). The dates of any penalty period will be communicated to the MCE from the CoreMMIS system.

During a penalty period, LTSS services above the member's State Plan benefits are not payable by Medicaid. Provider portal and eligibility-checking systems must indicate the start and end dates of member ineligibility due to transfer of property penalty to providers. Transfer of property penalties will always start on the first day of a month but can end on any day of a month.

There could be instances where a penalty is removed or adjusted. The MCEs will receive notification from CoreMMIS if a penalty has been removed or adjusted, so that it can be updated into the MCE's system and have any claims reprocessed, as needed.

5.s Managed Care Entity Application Assistance and Distribution to Non-members

The State permits contracted vendors in *Indiana Pathways for Aging* program to distribute applications to the general community but forbids them from acting as a state employee or a choice counselor of applicants. According to federal regulations, no cold-call marketing is allowed. The State defines *cold-call marketing* as any unsolicited personal contact by the MCE with a potential enrollee for the purpose of selling, promoting, surveying, or soliciting a State-sponsored health insurance plan.

Note: The term “applicant” in this document refers to **non-Medicaid members** who are applying for State Medicaid assistance.

MCEs must abide by all federal regulations when outreaching and must obtain approval from the State before distributing any materials to members or potential members. The MCE must give the State a written request and submit a draft at least 30 calendar days before the distribution of materials through the established document review process. On the cover sheet, the MCE must indicate if the materials will be distributed at outreach events for Medicaid applications.

The MCE must ensure that the distribution of the State Medicaid application abides by the following requirements:

- MCEs cannot act as agents of the State or represent themselves as the State caseworkers.
- MCEs cannot allow an applicant to authorize the MCE to act as the applicant's representative or to act on behalf of the applicant.
- MCEs may distribute the Indiana Health Care application forms.
- MCEs may not distribute:
 - State Form 48552 (7-98) Pending Verification
 - State Form 49154 (2-99) Request for Earnings Information for *Indiana Pathways for Aging*
 - Change Request Form
 - Authorization for Release of Information (State Form 44150 (R5/7-99))
- MCEs may set up an area with a table, chair, clipboard and writing utensils, where members can fill out applications.
- MCEs must not indicate whether the member will be eligible; this decision must be made by the Division of Family Resources.
- MCEs will not sign the member's forms.

MCEs will not influence MCE selection; members must be referred to the enrollment broker (EB) for choice counseling.

5.t SNAP Alignment Language

MCE documentation that refers to Supplemental Nutrition Assistance Program must receive a secondary review through the Department of Family Resources (DFR). If the MCEs use the aligned language below, documentation submissions will not require the secondary review. The MCE must still submit the document for approval following the normal document approval process.

- What is SNAP?
 - SNAP stands for the Supplemental Nutrition Assistance Program. SNAP previously was known as food stamps. SNAP is a benefit that helps people and families buy food to stay healthy.
 - SNAP helps low-income and no income people and families buy nutritious food. SNAP benefits are loaded on an Electronic Benefits Transfer (EBT) card. The EBT card can be used like a debit or ATM card at the grocery store.
 - With your SNAP benefits you can buy food like bread, cereal, fruit, vegetables, and meat. You can also buy plants or seeds that grow food.
 - Amazon, Walmart, and ALDI let you order food online with your SNAP EBT card and have it delivered (fees may apply).
 - SNAP can help you buy healthy food and support your budget!
 - To learn more about SNAP food assistance, visit [in.gov/fssa/dfr/snap-food-assistance/](https://www.in.gov/fssa/dfr/snap-food-assistance/).
- How to apply
 - You apply for SNAP benefits by completing an application. You can apply for SNAP online, by mail, by fax, or in person at your county Division of Family Resources (DFR) office.
 - To apply online or print an application visit the fssabenefits.in.gov
 - To find your county office visit [in.gov/fssa/dfr/2999.htm](https://www.in.gov/fssa/dfr/2999.htm)
 - You can call 800-403-0864 to have an application mailed to you.
 - After you apply for SNAP, applicants will be contacted by DFR will contact you for an interview. This interview will determine your eligibility for SNAP.
 - Applying for SNAP is easy! You can apply for SNAP benefits through the State Benefits Portal, fssa.benefits.in.gov, by:
 - filling out an online application.
 - printing and mailing the application.
 - asking for a paper application by mail.
 - by calling DFR at 800-403-0864.
- Am I eligible for SNAP?
 - Your household could be eligible for SNAP benefits. If you apply, the Division of Family Resources will determine your eligibility for SNAP.
 - To qualify for SNAP, you must meet certain income and asset requirements.
 - If your income is below the monthly limit, and you have \$5,000 or less in assets (like a bank account) you may be eligible for SNAP. Check your eligibility by calling 800-403-0864 or online at fssabenefits.in.gov.
 - You can visit, [in.gov/fssa/dfr/snap-food-assistance/do-i-qualify-for-snap](https://www.in.gov/fssa/dfr/snap-food-assistance/do-i-qualify-for-snap) to see if you qualify for SNAP.
 - To learn more and apply, you can contact your local Division of Family Resources (DFR) office at 800-403-0864 or online at fssabenefits.in.gov.

Section 6: Provider Enrollment and Network Development

Managed care entities (MCEs) contracting with the State to administer the *Indiana Pathways for Aging* program are required to develop and maintain a comprehensive provider network for the provision of covered services to their members. This provider network must include providers serving individuals 60 and older with long-term care needs and be in compliance with the terms of this section as well as Federal regulations at 42 *CFR* 438.68 and 438.206. In accordance with 42 *CFR* 438.3(l) the MCE must allow each member to choose their health professional to the extent possible and appropriate. The MCE shall ensure that its provider network is supported by written provider agreements, is available and physically, programmatically, and geographically accessible and provides adequate numbers of facilities, physicians, pharmacies, ancillary providers, service locations and personnel for the provision of high-quality covered services for its members. Further information about IHCP Provider Enrollment is located at: <https://www.in.gov/medicaid/providers/973.htm>.

MCEs must also be enrolled in Core Medicaid Management Information System (*CoreMMIS*). In addition to supporting capitation and claim processing functions, MCE enrollment in *CoreMMIS* allows the MCE to submit, through the Provider Healthcare Portal (portal), the enrolled primary care providers participating in the MCEs' *Indiana Pathways for Aging* programs.

6.a Managed Care Entity Enrollment in *CoreMMIS*

MCEs are required to complete the *MCE Enrollment Form*, available on the [Miscellaneous MCE Documents](#) page of the Managed Care Health Plan restricted site at in.gov/medicaid/partners.

Managed Care Health Plan restricted site: in.gov/medicaid/partners

Username: **MCEhealthplans**

Password: MCEs may obtain the password by contacting their State contract compliance officer.

The MCEs must submit the form to the fiscal agent's care programs director. The form includes the following:

- MCE name
- Address
- Contact name
- Telephone number
- Electronic funds transfer (EFT) information
- MCE contact information

If this information changes after enrollment, the MCE must complete the *MCE Enrollment Update Form* and submit it to the fiscal agent.

If the MCE has network contracts in *Indiana Pathways for Aging* program, the MCE is required to complete *Indiana Pathways for Aging MCE Enrollment Addendums* for each region and submit them to the State for approval. The State forwards the network information to the fiscal agent.

When the required information is verified, the fiscal agent enrolls the MCE in *CoreMMIS* and sends confirmation letters to the State and the MCE. MCEs are enrolled statewide, and the confirmation letters contain the MCE's unique 10-digit identification number (9999999999).

6.b Managed Care Entity Provider Network Requirements

The MCE must develop a robust network to include providers serving individuals 60 and older with long-term care needs. The MCE shall continually assess network adequacy and capacity using multiple data sources to monitor appointment standards, member grievances, appeals, quality data, quality improvement data, utilization of services, member satisfaction surveys, and demographic data requirements. The MCE shall also develop non-financial incentive programs to increase participation in its provider network when feasible.

The MCE must accept any willing HCBS provider, not inclusive of case management and service coordination, or LTSS provider for three years from the effective date of the *Indiana Pathways for Aging* contract. For all providers, the MCE must have an open network and accept any qualified IHCP provider acting within their scope of practice until the MCE demonstrates that it meets all access requirements.

The State regularly and routinely monitors network access, availability, and adequacy. The State may impose the remedies, or require the MCE to maintain an open network (beyond the required three years of contracting with providers), if the MCE fails to meet the following network composition requirements:

- the anticipated enrollment.
- the expected utilization of services, taking into consideration the characteristics and needs of the MCE's *Indiana Pathways for Aging* members enrollment and anticipated enrollment.
- the numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted services.
- staff capacity within personal care and home health agencies to service each of Indiana's 92 counties regardless of the physical location of the agency.
- the numbers of network providers that are not accepting new members.
- the proximity to public transportation and/or the reliance upon non-emergency medical transportation.
- the geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical and programmatic access for members with disabilities.
- the ability to offer HIPAA-secure virtual/telehealth services, as appropriate.

The MCE must ensure that its provider network:

- is supported by written provider agreements,
- is re-assessed monthly, or more frequently if the MCE identifies trends in gaps of services,
- is available and geographically accessible, and
- provides adequate numbers of facilities, physicians, ancillary providers, service locations, and personnel for the provision of high-quality covered services for its members, in accordance with 42 CFR 438.206.

In some cases, members may receive out-of-network services. To receive reimbursement from the MCE, out-of-network providers must be IHCP providers. The MCE must encourage out-of-network providers, particularly emergency services providers, to enroll in the IHCP. An out-of-network provider must be enrolled in the IHCP to receive payment from an MCE.

6.b.1 Network Development and Management Plan

The State requires the MCE to develop and maintain a comprehensive network to provide services to its *Indiana Pathways for Aging* members. The MCE must develop and maintain a Network Development and Management Plan (NDMP) demonstrating the MCE has adequate LTSS and HCBS provider capacity to meet the needs of all *Indiana Pathways for Aging* members meeting Nursing Facility Level of Care.

The NDMP must be updated and submitted to the State annually and include the following elements:

- Summary of nursing facility provider network by county.
- Summary of HCBS provider network, including, by service and county for both the minimum of two providers per county and the required enrollee to provider ratios.
- For providers serving the entire state, the MCE must ensure the provider has contact with staff to fulfill service requirements for individuals throughout the state.
- Description and demonstration of monitoring activities to ensure that LTSS-specific access standards are met.
- Demonstration of the MCE's ongoing activities to identify each needed service consistent with the member's service plan and the requirements with this manual that could not be delivered due to inadequate provide capacity.
 - The MCE must document the process to analyze service gaps, identifying systemic issues, and implement remediation and quality improvement (QI) activities.
 - This process shall include a summary of provider network capacity issues by service and county, the MCE's remediation, and QI activities and targeted/actual completion dates for those activities.
- Demonstration of the MCE's efforts to develop an expanded network of community-based residential alternatives for *Indiana Pathways for Aging* members.
- The MCE must document all provider recruitment activities and capacity building on a quarterly basis.
- Description of the MCE's ongoing HCBS provider development activities taking into consideration identified provider capacity, network deficiencies, service delivery issues, and future growth in members needing LTSS.

The MCE must develop a comprehensive provider network. The MCE shall establish written agreements with all network providers. The MCE is required to have an open network for any willing provider for the first three years of *Indiana Pathways for Aging* implementation. After the first three years, the MCE is required to have an open network and accept any IHCP provider acting within their scope of practice until the MCE demonstrates that it meets the access requirements. The State reserves the right to delay initial member enrollment in the MCE's plan if the MCE fails to demonstrate a complete and comprehensive network.

The MCE must contract with its specialist and ancillary provider network, including LTSS and HCBS providers, before receiving enrollments. The State reserves the right to implement corrective actions and assesses liquidated damages, as described in the *Indiana Pathways for Aging* scope of work if the MCE fails to meet and maintain the specialist and ancillary provider network access standards. The State's corrective actions may include, but are not limited to, withholding, or suspending new member enrollment from the MCE. The State monitors the MCE's specialist and ancillary provider network to confirm the MCE is maintaining the required level of access to specialty care. The State reserves the right to increase the number or types of required specialty providers at any time.

6.b.2 Culturally and Linguistically Competent Providers

The MCE must ensure that all its contracted providers are IHCP providers and can respond to the cultural, racial, and linguistic needs of its member populations. Cultural and linguistic competence includes providers who serve members of different races, ethnicities, color, national origins, sexes, sexual orientations, gender identity, abilities (including members with cognitive impairments, visual impairments, hearing impairment, and/or who use sign language or an alternative mode of communication), and those with limited English proficiency. The MCE is required to participate in any State efforts to promote the delivery of covered services in a culturally and linguistically competent manner.

The MCE must 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.b.3 Network Composition Requirements

In compliance with 42 CFR 438.207, the MCE must:

- serve the expected enrollment,
- demonstrate an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled,
- establish a sufficient, mix, and geographic distribution of providers, and
- have appropriate agency staffing for providers that contract to render statewide services.

At the beginning of its contract with the State, the MCE must submit regular network access reports, as directed by the State. After the MCE demonstrates compliance with the State's access standards as determined by the State, the MCE must submit network access reports for all providers annually, and for HCBS providers specifically every six months, and any time the provider network changes substantially (such as the MCE no longer meets the network access standards). The State reserves the right to expand or revise the network requirements after the first three years upon program implementation, as it deems appropriate. The MCE must not discriminate with respect to participation, reimbursement, or indemnification as to any provider that is acting within the scope of the provider's license or certification under applicable state law, solely on the basis of such license or certification, as stated in 42 CFR 438.12. If the MCE declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision and notify the State of its decision. This requirement does not require the MCE to contract with providers beyond the number necessary to serve the members' needs with exception of the first three years of the program contract term. The MCE is not precluded from establishing any measure designed to maintain quality and control costs consistent with the MCE's responsibilities.

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

1. Establish mechanisms to ensure compliance by providers.
2. Implement the State's HCBS provider compliance framework to monitor provider quality. The MCE shall conduct compliance reviews.
3. Take corrective action for failure to comply. For HCBS providers, corrective action shall be in accordance with 455 IAC 2-6-4.
4. Provide the State written notice at least 90 calendar days in advance of the MCE's inability to maintain a sufficient network in any county.

For purposes of the following subsections, *urban areas* are counties not designated by the State and approved by the CMS as rural counties. *Rural areas* are those areas designated by the State and approved by the CMS as rural counties.

The MCE must meet or exceed the following network composition requirements:

Table 2- Network Composition Requirements

Provider Type	IHCP Enrollment Type/Specialty	Requirement
Acute Care Hospitals	Type 01 (Hospital) Specialty 010 (Acute Care)	• Must contract with a minimum of 90% of IHCP enrolled providers located in the State

Provider Type	IHCP Enrollment Type/Specialty	Requirement
Federally Qualified Health Centers	Type 08 (Clinics) Specialty 080 (FQHC)	Must contract with a minimum of 90% of IHCP enrolled providers located in the State
Rural Health Clinics	Type 08 (Clinics) Specialty 081 (RHC)	Must contract with a minimum of 90% of IHCP enrolled providers located in the State
Community Mental Health Centers	Type 11 (Behavioral Health) Specialty 111 (CMHC)	Must contract with a minimum of 90% of IHCP enrolled providers located in the State
Primary Medical Providers (PMPs)	Type 09 (APRN) Type 10 (Physician Assistant) Type 31 (Physician)	Must meet or exceed 1:1000 provider-to-member ratio
Behavioral Health Providers (excluding physicians, community mental health centers, and inpatient facilities)	Type 11 (Behavioral Health)	Must meet or exceed 1:1000 provider-to-member ratio
Gynecologists	Type 31 (Physician) Specialty 328 (OB/GYN)	Must meet or exceed 1:2000 provider-to-member ratio
Dentists	Type 27 (Dentist)	Must meet or exceed 1:2000 provider-to-member ratio
Specialists	All Type 31 (Physician)	Must meet or exceed 1:5000 provider-to-member ratio
Anesthesiologists	Specialty 311	Must meet or exceed 1:5000 provider-to-member ratio
Cardiologists	Specialty 312	Must meet or exceed 1:5000 provider-to-member ratio
Endocrinologists	Taxonomy Code 207RE0101X	Must meet or exceed 1:5000 provider-to-member ratio
Gastroenterologists	Specialty 317	Must meet or exceed 1:5000 provider-to-member ratio
Geriatricians	Specialty 320	Must meet or exceed 1:5000 provider-to-member ratio
Nephrologists	Specialty 323	Must meet or exceed 1:5000 provider-to-member ratio
Ophthalmologists	Specialty 330	Must meet or exceed 1:5000 provider-to-member ratio
Orthopedic surgeons	Specialty 331	Must meet or exceed 1:5000 provider-to-member ratio
General surgeons	Specialty 319	Must meet or exceed 1:5000 provider-to-member ratio
Pulmonologists	Specialty 340	Must meet or exceed 1:5000 provider-to-member ratio
Rheumatologists	Taxonomy Code 207RR0500X	Must meet or exceed 1:5000 provider-to-member ratio
Psychiatrists	Specialty 339	Must meet or exceed 1:5000 provider-to-member ratio

Provider Type	IHCP Enrollment Type/Specialty	Requirement
Urologists	Specialty 340	• Must meet or exceed 1:5000 provider-to-member ratio
Infectious disease specialists	Taxonomy Code 207RI0200X	• Must meet or exceed 1:5000 provider-to-member ratio
Otolaryngologists	Specialty 332	• Must meet or exceed 1:5000 provider-to-member ratio
Oncologists	Specialty 329	• Must meet or exceed 1:5000 provider-to-member ratio
Dermatologists	Specialty 314	• Must meet or exceed 1:5000 provider-to-member ratio
Physiatrists	Specialty 336	• Must meet or exceed 1:5000 provider-to-member ratio
Extended Care Facilities	Provider Type 03 (Extended Care Facility), Specialty 030 (Nursing Facility)	• Must meet or exceed 1:400 provider-to-member ratio • Must ensure network coverage of at least one facility in each county in the State of Indiana (<i>unless there is no facility located in a particular county</i>)
Home Health Agencies	Provider Type 05 (Home Health)	• Must meet or exceed 1:150 provider-to-member ratio • Must ensure network coverage of service with at least two providers servicing each county
Hospice Agencies	Provider Type 06 (Hospice)	• Must meet or exceed 1:400 provider-to-member ratio • Must ensure network coverage of service with at least two providers servicing each county
Agencies Certified to Provide Home and Community-Based (HCBS) Services	Provider Type 32 (Waiver)	• As of March 2023 this information is not available, and will be updated once deployable.
Adult Day Care	Specialty 350 (AD Waiver) Secondary Specialty A00, A01, A02 Specialty 356 (TBI Waiver) Secondary Specialty B00, B01, B02	• Must contract with a minimum of 90% of IHCP enrolled providers located in the State
Adult Family Home	As of March 2023 this information is not available, and will be updated once deployable.	• Must contract with a minimum of 90% of IHCP enrolled providers located in the State
Assisted Living	Specialty 350 (AD Waiver) Secondary Specialty A04 Specialty 356 (TBI Waiver) Secondary Specialty B25	• Must contract with a minimum of 90% of IHCP enrolled providers located in the State

Provider Type	IHCP Enrollment Type/Specialty	Requirement
Attendant Care	Specialty 350 (AD Waiver) Secondary Specialty A05 Specialty 356 (TBI Waiver) Secondary Specialty B04	• Must meet or exceed 1:400 provider-to-member ratio • Must ensure network coverage of service with at least one provider servicing each county
Structured Family Care	Specialty 350 (AD Waiver) Secondary Specialty A21	• Must meet or exceed 1:400 provider-to-member ratio • Must ensure network coverage of service with at least one provider servicing each county
Personal Emergency Response	Specialty 350 (AD Waiver) Secondary Specialty A19 Specialty 356 (TBI Waiver) Secondary Specialty B14	• Must meet or exceed 1:400 provider-to-member ratio • Must ensure network coverage of service with at least one provider servicing each county
Integrated Healthcare Coordination	Specialty 350 (AD Waiver) Secondary Specialty A09	• Must meet or exceed 1:300 provider-to-member ratio • Must ensure network coverage of service with at least one provider servicing each county
Home Delivered Meals	Specialty 350 (AD Waiver) Secondary Specialty A10 Specialty 356 (TBI Waiver) Secondary Specialty B10	• Must meet or exceed 1:200 provider-to-member ratio • Must ensure network coverage of service with at least one provider servicing each county
Home Modifications	Specialty 350 (AD Waiver) Secondary Specialty A08 Specialty 356 (TBI Waiver) Secondary Specialty B08	• Must meet or exceed 1:400 provider-to-member ratio • Must ensure network coverage of service with at least one provider servicing each county
Home & Community Assistance	Specialty 350 (AD Waiver) Secondary Specialty A11	• Must meet or exceed 1:400 provider-to-member ratio • Must ensure network coverage of service with at least one provider servicing each county
Community Transportation	Specialty 350 (AD Waiver) Secondary Specialty A17 Specialty 356 (TBI Waiver) Secondary Specialty B23	• Must meet or exceed 1:200 provider-to-member ratio • Must ensure network coverage of service with at least one provider servicing each county
Nutritional Supplements	Specialty 350 (AD Waiver) Secondary Specialty A12 Specialty 356 (TBI Waiver) Secondary Specialty B12	• Must meet or exceed 1:400 provider-to-member ratio • Must ensure network coverage of service with at least one provider servicing each county

Provider Type	IHCP Enrollment Type/Specialty	Requirement
Pest Control	Specialty 350 (AD Waiver) Secondary Specialty A13 Specialty 356 (TBI Waiver) Secondary Specialty B15	• Must meet or exceed 1:400 provider-to-member ratio • Must ensure network coverage of service with at least one provider servicing each county
Respite	Specialty 350 (AD Waiver) Secondary Specialty A14 Specialty 356 (TBI Waiver) Secondary Specialty B18	• Must meet or exceed 1:150 provider-to-member ratio • Must ensure network coverage of service with at least one provider servicing each county
Specialized Medical Equipment	Specialty 350 (AD Waiver) Secondary Specialty A16 Specialty 356 (TBI Waiver) Secondary Specialty B19	• Must meet or exceed 1:200 provider-to-member ratio • Must ensure network coverage of service with at least one provider servicing each county
Vehicle Modification	Specialty 350 (AD Waiver) Secondary Specialty A18 Specialty 356 (TBI Waiver) Secondary Specialty B24	• Must meet or exceed 1:200 provider-to-member ratio • Must ensure network coverage of service with at least one provider servicing each county

For LTSS providers (nursing facilities, home health agencies, hospice) and HCBS providers:

- The MCE must enter into contracts with a robust number of such providers within each county. For the first three years of the program, the MCE must accept into their network any LTSS or HCBS provider that agrees to the MCE's standard provider agreement and meets all applicable state and federal participation requirements. The MCE must provide a hands-on approach to supporting new HCBS providers in managed care with questions on certification, billing, prior authorization, data collection, etc. The MCE will work and support HCBS providers into being sustainable entities.

6.b.4 Acute Care Hospital Facilities

The MCE must provide a sufficient number and geographic distribution of acute care hospital facilities to serve the expected enrollment. The transport distance to a hospital from the member's home shall be the usual and customary, not to exceed 30 miles in urban areas and 60 miles in rural areas. Exceptions must be justified and documented to the State on the basis of community standards for accessing care. Inpatient services are covered when such services are prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.

The MCE is strongly encouraged to contract or enter into business agreements with any acute care hospital facility that is recognized as an Age-Friendly Health System. The MCE can locate a list of health systems recognized as Age-Friendly Health Systems through the Institute for Healthcare Improvement at the following webpage: <https://www.ihl.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/recognized-systems.aspx>.

6.b.5 Preferred Medical Provider (PMP) Requirements

Providers may contract as a PMP with one or multiple MCEs. A PMP may also participate as a specialist with another MCE. The PMP may maintain a patient base of non-Indiana Pathways for Aging members (such as commercial, traditional Medicaid, Hoosier Healthwise, HIP, or Hoosier Care Connect members). An MCE may not prevent the PMP from contracting with other MCEs.

The MCE must ensure that each member has a PMP who is responsible for providing an ongoing source of primary care appropriate to the member's needs. PMPs must coordinate each member's physical and behavioral healthcare and make any necessary referrals. In *Indiana Pathways for Aging*, a referral from the member's PMP is required when the member receives physician services from any provider other than his or her PMP, unless the service is a self-referral service.

The State requires the MCE to provide access to PMPs within at least 30 miles of the member's residence. Providers that may serve as PMPs include the following:

Table 3- Providers that may Service as PMPs

Provider	Provider Type	Provider Specialty
Internal medicine physicians	31	322 / 344
General practitioners		318
Family medicine physicians		316
Pediatricians		335 / 345
Gynecologists		328
Endocrinologists (if primarily engaged in internal medicine)		322 / 344
Geriatricians		320
Advanced practice registered nurses	09	090 / 091 / 092 / 093 / 095
Physician assistants	10	All

An important State goal is to ensure members have quality access to their PMPs. The State expects that access, quality, and clinical outcomes are monitored to validate proper and equitable access.

The MCE's PMP contract must state the PMP panel size limits, and the MCE must assess the PMP's non-*Indiana Pathways for Aging* practice when assessing the PMP's capacity to serve the MCE's members. The fiscal agent maintains a separate panel for PMPs contracted with more than one MCE. The State monitors the MCE's PMP network to evaluate its member-to-PMP ratio. The MCE must have a mechanism in place to ensure that contracted PMPs provide or arrange for coverage of services 24 hours a day, seven days a week and that PMPs have a mechanism in place to offer members direct contact with their PMP, or the PMP's qualified clinical staff person, through a toll-free telephone number 24 hours a day, seven days a week.

Each PMP must be available to see members at least 3 days per week for a minimum of 20 hours per week at any combination of no more than 2 locations. The MCE must also assess the PMP's non-*Indiana Pathways for Aging* practice to ensure that the PMP's *Indiana Pathways for Aging* population is receiving accessible services on an equal basis with the PMP's non-*Indiana Pathways for Aging* population.

The MCE must ensure that the PMP provides live-voice coverage after normal business hours. After-hour coverage for the PMP may include an answering service or a shared-call system with other medical providers. The MCE must ensure that members have telephone access to their PMP (or appropriate designate, such as a covering provider) in English and Spanish 24 hours a day, 7 days a week.

The MCE must ensure that PMPs are maintaining the PMP medical care standards and practice guidelines detailed in the applicable Provider Reference modules according to practice type. The MCE must monitor medical care standards to evaluate access to care and quality of services provided to members, and to evaluate providers regarding their practice patterns.

Full Panel Add Requests

When an MCE receives a full panel add request for a member who is not on its 834 file, the MCE must deny the request. The denial must be sent with a message indicating that the full panel add submitted cannot be processed because the MCE does not have this member on file. If the member is enrolled in another MCE or has traditional Medicaid, the member must be instructed to contact the enrollment broker to pursue additional

education and information on how to change MCEs, if applicable. Neither the State nor the enrollment broker accepts or processes any paperwork from the PMP or the MCEs requesting a member be added to a full panel. The enrollment broker will handle calls from members requesting a plan change if the member qualifies. If the member does not qualify, the request is handled via the normal just cause change process with a referral back to the MCE.

If the member is eligible to change MCEs, the PMP may pursue sending the full panel add with the MCE at that time. The MCEs must have a procedure in place for processing the full panel add after the member joins the MCE via the 834 file confirmation.

Additionally, when a PMP changes MCEs their members are allowed to follow them to the PMP's new MCE if they choose. The enrollment broker accepts and processes a member's request to change MCEs because of the member's PMP change. This change is allowed regardless of whether the member is currently in an open enrollment status, and there is no referral back to the MCE. The enrollment broker confirms that the PMP did change plans before allowing the change. A just cause reason code (PMP changed plans) is used for such changes. The MCE is responsible for letting the PMP know that the full panel add request cannot be processed because the member is not connected to that MCE.

6.b.6 Specialist and Ancillary Provider Network Requirements

In addition to maintaining a network of PMPs, the MCE must provide and maintain a comprehensive network of IHCP provider specialists and ancillary providers. As with PMPs, specialist and ancillary providers are not limited to serve in only one MCE network. In addition, physicians contracted as a PMP with one MCE may contract as a specialist with other MCEs.

The MCE must ensure that specialists are maintaining the medical care standards and practice guidelines detailed in the [Provider Enrollment](#) provider reference module and other applicable provider reference modules according to practice type. The State requires the MCE to monitor medical care standards to evaluate access to care and quality of services provided to members, and to evaluate providers regarding their practice patterns.

The MCE must develop and maintain the comprehensive network of specialty providers listed below.

- For providers identified with an asterisk (*), the MCE must provide at least two specialty providers within **60 miles of the member's residence**.
- For providers identified with two asterisks (**), the MCE must provide at least one specialty provider within **90 miles of the member's residence**.

Table 4 – Network Specialty Providers

Specialties	Ancillary Providers
• Anesthesiologists* • Cardiologists* • Cardiothoracic surgeons** • Dentists* • Oral Surgeons* • Dermatologists** • Endocrinologists* • Gastroenterologists* • General surgeons* • Geriatricians** • Hematologists • Infectious disease specialists** • Interventional radiologists**	• Diagnostic testing* • Durable Medical Equipment (see below) • Home Health (see below) • Prosthetic suppliers**

Specialties	Ancillary Providers
• Nephrologists* • Neurologists* • Neurosurgeons** • Nonhospital-based anesthesiologist (such as pain medicine)** • OB/GYNs* (must also ensure coverage of at least one practitioner within 30 miles of a member's residence) • Occupational therapists* • Oncologists* • Ophthalmologists* • Optometrists* • Orthodontists* • Orthopedic surgeons* • Orthopedists • Otolaryngologists • Pathologists** • Physical therapists* • Psychiatrists* • Pulmonologists* • Radiation oncologists** • Rheumatologists** • Speech therapists* • Urologists*	

The MCE must meet the following network access standards for **home health** agencies:

- Must meet or exceed 1:150 provider-to-member ratio
- Must ensure network coverage of service with at least two providers servicing each Indiana county

The MCE must meet the following network access standards for **durable medical equipment (DME)** providers:

- Must ensure network coverage of service with at least two providers servicing each Indiana county

In addition, the MCE must demonstrate the availability of providers with training, expertise, and experience in providing tobacco dependence treatment. Evidence that providers are trained to provide tobacco dependence treatment must be available upon request.

The MCE must contract with the Indiana Hemophilia and Thrombosis Center or a similar State-approved, federally recognized treatment center. This requirement is based on findings of the Centers for Disease Control and Prevention (CDC), which illustrate that persons affected by a bleeding disorder receiving treatment from a federally recognized treatment center require fewer hospitalizations, experience fewer bleeding episodes, and experience a 40% reduction in morbidity and mortality. This provider is identified by the following enrollments:

Provider ID	Provider Type
200184210A	Clinic
200375510A	Pharmacy
200375510B	Pharmacy

The MCE must arrange for laboratory services only through IHCP enrolled laboratories with Clinical Laboratory Improvement Amendments (CLIA) certificates.

6.b.7 Pharmacy Services

The MCE must establish a network of pharmacies. The MCE or its pharmacy benefit manager (PBM) must provide at least two pharmacy providers within 30 miles or 30 minutes from a member's residence in each county, as well as at least two durable medical equipment providers servicing each county.

6.b.8 Non-Psychiatrist, Non-Substance User Disorder (SUD), and Behavioral Health Providers

In addition to the access requirement for psychiatrists, the MCE must establish a network that includes other behavioral health providers. The following list represents behavioral health providers that must be available in the MCE's network:

Provider	Provider Type	Provider Specialty
Outpatient behavioral health clinics	11	110
Community mental health centers		111
Health services providers in psychology (HSPPs)		114
Licensed psychologists		616
Licensed clinical addiction counselors (LCAC)		617
Licensed clinical social workers (LCSW)		618
Licensed marital and family therapists (LMFT)		619
Licensed mental health counselors (LMHC)		620
Advanced practice nurses (APN) under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center	09	090 / 091 / 092 / 093 / 095

The MCE is required to contract with all Division of Mental Health and Addiction (DMHA) certified community mental health centers (CMHCs). If all CMHCs are not included in the provider network, the MCE must demonstrate that this does not prevent coordination of care with MRO and 1915(i) State Plan services. Further, the MCE must, at a minimum, establish referral agreements and liaisons with contracted and non-contracted CMHCs, and must provide physical health and other medical information to the appropriate CMHC for every member.

The DMHA conducts regular annual Consumer Service Reviews to evaluate the quality of care provided in the CMHCs. In addition to the regular oversight that the MCE provides for contracted CMHCs, the MCEs must use the results of the DMHA's review to inform contracting decisions, to monitor contracted CMHCs, and to develop improvement plans with contracted CMHCs.

The MCE must meet the following network composition requirements for non-psychiatrist behavioral health providers:

- In urban areas, the MCE must provide at least one behavioral health provider within 30 minutes or 30 miles from the member's home.
- In rural areas, the MCE must provide at least one behavioral health provider within 45 minutes or 45 miles. Access and availability of professionals will vary especially in rural areas. The MCE must demonstrate assertive outreach to members in rural areas where behavioral health services may be less available.

The MCE also must monitor utilization in rural and urban areas to ensure equality of service access and availability.

6.b.9 Inpatient Psychiatric Facilities (Provider Type 01, Specialty 011)

The MCE must provide a sufficient number and geographic distribution of inpatient psychiatric facilities to serve the expected enrollment. The MCE must contract with at least 90% of all IHCP enrolled inpatient geriatric psychiatric facilities in Indiana. A list of Indiana behavioral health inpatient facilities (including

those with a geriatric unit) is available through the Division of Mental Health and Addiction (DMHA): https://www.in.gov/fssa/dmha/files/DMHA_Indiana-Behavioral-Health-Inpatient-Facilities.pdf.

The transport distance to an inpatient psychiatric facility from the member's home must be the usual and customary distance, not to exceed 60 miles. Exceptions must be justified and documented to the State on the basis of community standards for accessing care.

6.b.10 Substance Use Disorder (SUD) Providers (Provider Type 11)

The MCE must establish a network of SUD treatment providers that provide the continuum of the American Society of Addiction Medicine (ASAM) levels of care. The provider network must reflect the following levels of treatment:

- Early intervention
- Outpatient
- Intensive outpatient
- Partial hospitalization
- Clinically managed low-intensity residential (ASAM Level 3.1)- Provider Type 11, Specialty 836
- Clinically managed high-intensity residential (ASAM Level 3.5)- Provider Type 11, Specialty 836
- Medically managed inpatient

The MCE should contract with all available IHCP enrolled SUD treatment providers. The MCE must include a network of providers who are authorized to provide medication-assisted treatment (MAT), including buprenorphine. A list of practitioners authorized to treat opioid dependency with buprenorphine is available through the Substance Abuse and Mental Health Services Administration at https://www.samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator?field_bup_state_value=18.

The MCE must ensure the availability of a MAT provider within 30 miles of a member's residence.

The MCE will receive a list of the IHCP approved ASAM Level 3.1 and ASAM Level 3.5 providers on a monthly basis through their State contract compliance officers.

6.b.11 Dental Providers (Provider Type 27)

The MCE must ensure the availability of a dentist practicing in general or family dentistry within 30 miles of the member's residence. This network requirement can include IHCP enrolled dentists who are associated with a federally qualified health center (FQHC). The MCE must ensure availability of specialty dentists within 60 miles of the member's residence.

6.b.12 Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHCs) (Provider Type 08, Specialties 080 and 081)

The MCE is encouraged to contract with all IHCP enrolled FQHCs and RHCs that meet all of the MCE's requirements regarding the ability of these providers to provide quality services. The MCE must reimburse FQHCs and RHCs for services at no less than the level and amount of payment that the MCE would make to a non-FQHC or non-RHC provider for the same services.

For any services provided to an American Indian/Alaskan Native IHCP member at an out-of-network Indian healthcare provider that is an FQHC, the MCE must pay a rate equal to the amount of payment that the MCE would pay to an in-network FQHC that is not an Indian health care provider for the same services. *Section 5006(d) of ARRA* requires that the State provide a supplemental payment to non-FQHC Indian healthcare providers for covered services provided to AI/AN enrollees. The amount of the supplemental payment is the difference, if any, of the rate paid by the MCE for the services and the rate that applies to the provision of such services under the State Plan, which is the encounter rate determined by IHS in the annual federal

register notice. To the extent the State requires utilization and/or reimbursement data from the MCE to make a supplemental payment to an Indian healthcare provider, the MCE must provide the requested data within 30 calendar days of the request.

The State will make supplemental payments to FQHCs and RHCs that subcontract (directly or indirectly) with the MCE. These supplemental payments represent the difference, if any, between the payment to which the FQHC or RHC would be entitled for covered services under the Medicaid provisions of the Medicare, Medicaid, and *SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)* and the payments made by the MCE.

The MCE must identify any performance incentives it offers to the FQHC or RHC. The State must approve any performance incentives. The MCE must report all such FQHC and RHC incentives which accrue during the contract period related to the cost of providing FQHC-covered or RHC-covered services to its members along with any fee-for-service and/or capitation payments in the determination of the amount of direct reimbursement paid by the MCE to the FQHC or RHC. If the incentives vary between the MCE's lines of business, the MCE must specify in its reporting to the State.

The MCE must perform quarterly claim reconciliation with each contracted FQHC or RHC to identify and resolve any billing issues that may impact the clinic's annual reconciliation conducted by the State.

The MCE must provide its utilization and reimbursement data for each FQHC and RHC in each month of the reporting period. The MCE must provide this information in the form and manner set forth in the MCE Reporting Manual, which is updated annually.

The submitted FQHC and RHC data must be accurate and complete. The MCE must pull the data by NPI or LPI. The MCE must establish a process for validating the completeness and accuracy of the data, and a description of this process must be available to the State upon request. The claims files must not omit claims for practitioners rendering services at the clinic nor should the files contain claims for practitioners who did not practice at the clinic.

The MCE must maintain and submit records documenting the number and types of valid encounters provided to members each month to the State.

Capitated FQHCs and RHCs must submit encounter data (e.g., in the form of shadow claims to the MCE) each month. The number of encounters will be subject to audit by the State or its representatives.

The MCE must work with each FQHC and RHC in assisting the State and/or its designee in the resolution of disputes concerning year-end reconciliations between the federally required interim payments (made by the State to each FQHC and RHC on the basis of provider reported encounter activity) and the final accounting that is based on the actual encounter data provided by the MCE.

6.b.13 Indian Healthcare Providers

Section 5006 of ARRA provides certain protections for Indian health care providers in Medicaid. An Indian health care provider means a health care program, including providers of contract health services, operated by the Indian Health Service (IHS) or an Indian Tribe, Tribal Organization or Urban Indian Organization (I/T/U) as defined in section 4 of the *Indian Health Care Improvement Act (25 U.S.C. 1603)*. The MCE must offer to enter contracts with Indian health care providers participating in Medicaid that reflect the provisions in this Section.

In accordance with *section 5006(d) of ARRA*, the MCE must:

- Permit any American Indian or Alaskan Native (AI/AN) enrollee who is eligible to receive services from a participating Indian healthcare provider to choose to receive covered services from that Indian healthcare provider, and if that Indian healthcare provider participates in the network as a PMP (if applicable), to choose that Indian healthcare provider as their PMP, as long as that Indian healthcare provider has the capacity to provide the service;
- Demonstrate that there are sufficient Indian healthcare providers in the MCE's network to ensure timely access to services available under the contract for AI/AN enrollees who are eligible to receive services

from such providers. The MCE must be held to standards issued by CMS regarding sufficiency of Indian healthcare providers in states like Indiana where few Indian healthcare providers are available. In accordance with 42 CFR §438.56(c) and §457.1212, if timely access to Indian healthcare providers in network cannot be guaranteed due to few or no network participating Indian healthcare providers, the adequacy standard is satisfied if:

- AI/AN enrollees, living on or off tribal lands, are permitted by the MCE, to access out-of-state Indian healthcare providers; or
- This circumstance is deemed a good cause reason under the managed care plan contract for AI/AN enrollees to disenroll from the managed care program into fee-for-service.

In accordance with 42 CFR §438.14(b)(3), the MCE must:

- Not require any Service Authorization or impose any condition for an AI/AN enrollee to access services at such facilities. This includes the right of the AI/AN enrollee to choose an Indian healthcare provider as a primary care provider if the Indian healthcare provider is a network provider.

In accordance with section 5006(d) of ARRA, the MCE must:

- Reimburse Indian healthcare providers, whether in-or out-of-network, for covered services provided to AI/AN enrollees who are eligible to receive services from such providers either at a rate negotiated between the MCE and the Indian healthcare provider, or if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the services were provided by an in-network provider that is not an Indian healthcare provider.
- Make prompt payment to all Indian healthcare providers as set forth in Section 9.7.3 of the *Indiana Pathways for Aging* scope of work; and
- Not reduce payments to Indian healthcare providers, or other providers of contract health services under referral by an Indian healthcare provider, for covered services provided to an AI/AN enrollee by the amount of a copayment or other cost-sharing that would be due from the AI/AN enrollee if not otherwise prohibited under Section 5006(a) of ARRA.

When a physician in an Indian Healthcare facility refers an AI/AN enrollee to a network provider for services covered under the contract, the MCE must not require the member to see a Primary Care Provider prior to the referral. The network provider to whom the Indian healthcare physician refers the member may determine that services are not medically necessary or not covered.

The MCE will accept the results of home care service assessments, waiver assessments, reassessments and the resulting care plans developed by tribal assessors for AI/AN enrollees as determined by the tribe. Referrals to non-tribal providers for services resulting from the assessments must be made to providers within the MCE's network. This applies to services requested by AI/AN enrollees residing on or off tribal land.

The MCE must work cooperatively with the State, other MCEs under contract with the State, and tribal governments to find mutually agreeable mechanisms to implement this section including, but not limited to, a common notification form by which tribal governments may report referrals to the MCE.

6.b.14 County Health Departments (Provider Type 13)

The MCE is strongly encouraged to contract or enter into business agreements with any IHCP enrolled county health departments that are willing to coordinate with the MCE and can meet the MCE's credentialing and service delivery requirements.

6.b.15 Urgent Care Clinics (Provider Type 08)

The MCE must affiliate or contract with urgent care clinics. Urgent care clinics must be made available no less than 11 hours each day, Monday through Friday, and no less than five hours each day on the weekend. In addition, the State strongly encourages the MCE to affiliate or contract with nontraditional immediate care

clinic including retail clinics. The State will continue to monitor the MCE's access to primary and urgent care.

6.b.16 Dialysis Treatment Centers (Provider Type 30)

The MCE must ensure the availability of one dialysis treatment center within 60 miles of the member's residence. The MCE must prioritize the transportation of members to dialysis when scheduling non-emergent medical transport.

6.b.17 Non-Emergency Medical Transportation Providers (Provider Type 26)

In accordance with 42 CFR 440.170 the MCE must provide an appropriate means of NEMT for individuals who have no other means of transportation available and must address the safety needs of the person with disabilities and/or special needs.

6.b.18 Physician Extenders

Physician extenders are health care professionals who are licensed to practice medicine under the supervision of a physician. Physician extender types, Advanced Practice Nurses (APN) and Physician Assistants (PA), may perform services per BT201584 and BT201743. Additionally, State Medicaid programs are required to make nurse practitioner services available to Medicaid recipients in accordance with 42 CFR 441.22.

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

- Advanced practice nurses, including nurse practitioners, nurse midwives and clinical nurse specialist,
- Physician assistants, and
- Certified registered nurse anesthetists (not in capacity of a PMP).

6.b.19 Skilled Nursing Facilities (Provider Type 03)

The MCE must maintain the adequacy of its provider network to provide enrollees with reasonable choice within each county provided that each Network Provider meets all applicable state and federal requirements for participation in the program. For the first three years of the program, the MCE must accept into their network any skilled nursing facility that agrees to the MCE's standard provider agreement and meets all applicable state and federal participation requirements.

6.b.20 Telehealth Providers

Telehealth is defined as healthcare services delivered via asynchronous (store and forward), remote patient monitoring, teledentistry, or telehealth (live interactive audio and video). The MCE must promote the use of telehealth to support an adequate provider network and meet the needs of members.

Telehealth must not replace provider choice and/or member preference for physical location of services. The MCE must be responsible for the oversight, administration, and implementation of telehealth services in compliance with state and federal laws, and other State guidance and references. The MCE must ensure that telehealth is available and utilized when appropriate to ensure geographic accessibility of services to members. The MCE is responsible for developing and expanding the use and availability of telehealth services and educating providers and members.

6.c Workforce Development

The MCE must 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 MCE must develop and implement

a workforce development strategy that is consistent with and complementary to the State's workforce plan (the Indiana Direct Service Workforce Plan or "the plan") and make that plan available to the public. The MCE must conduct efforts in support of the State's workforce plan.

The State plan is an evolving statewide initiative focused on the recruitment, training, retention, and support of home and community-based direct service workers. All MCE workforce development strategies and initiatives must align with the State plan and contain current and future plan-driven action areas. Action area examples include wages and benefit, training and career planning, promotion (i.e., marketing, and data collection and reporting. MCEs are required to develop community-facing materials that outline proposed and current direct service workforce strategies and initiatives, and implement a process to collect and respond to stakeholder feedback on strategies and implementation. All community facing materials must be pre-approved by the State.

MCEs will be active contributors in developing and refining the State plan through March 31, 2025. All MCE Workforce Development Administrators must participate in shared learning opportunities including convenings with other MCEs, the Indiana Direct Service Workforce Advisory Board, community partners, FSSA contractors (both internal and external), and other stakeholders as identified by the State. The MCE Workforce Development Administrators, as the primary contacts, will meet with the FSSA Chief Advocacy Officer routinely through July 1, 2024 to ensure continuity and alignment with current and future direct service workforce strategies and implementation.

All MCEs must utilize data-driven, community-informed strategies to assess and forecast direct service workforce capacity at a county level on a quarterly basis at minimum. The State reserves the right to require additional reporting.

All MCE direct service workforce programs, initiatives, and worker-centered services and supports must advance the missions of the State Office of the Chief Equity, Inclusion and Opportunity Officer and the FSSA Office of Healthy Opportunities.

The MCE must collaborate with the State and other agencies on any workforce development activities. The MCE must develop and deploy data collection and information processing resources for assessing the current level of workforce capacity. Additionally, MCE must identify strengths and deficits as well as forecasting and planning strategies that will address future workforce requirements.

6.d Provider Policies and Procedures Manual

The MCE will develop and maintain a provider policies and procedures manual for use by the MCE's network of *Indiana Pathways for Aging* providers. The provider policies and procedures manual must be available (without cost) both electronically and in hard copy, upon request, to all network providers when providers are initially enrolled, when there are any changes in policies and procedures, and/or upon a provider's request. Training and education must be offered to providers to request at their discretion.

Refer to section 6.11.2 of *Indiana Pathways for Aging* scope of work for minimum content requirements.

Updates or changes in operation that require revisions to the provider policies and procedures manual shall be submitted to the State for review and approval.

6.d.1 Provider Accessibility

The MCE must implement policies and procedures related to network provider accessibility as required below. These policies and procedures must be submitted to the State for review and approval.

- Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Traditional Medicaid if the provider serves only Medicaid enrollees.
- Make services included in the contract available 24 hours a day, seven days a week when medically necessary.

The MCE must require its network providers to meet standards for timely access to care and services taking into account the urgency of the need for services as required herein.

Standards for Timely Access to Care and Services

Service	Timely Standard
Urgent care appointments for physical or behavioral illness injuries that require care immediately but do not constitute emergencies	Appointments within 24 hours
Routine care with physical or behavioral symptoms	Appointments within 1 week or 5 business days whichever is sooner
Routine care without physical or behavioral symptoms	Appointments within 30 calendar days
Aftercare appointments	Appointments within 7 calendar days of hospital discharge
Requests for durable medical equipment	Delivered no more than 30 business days from the date of service order
Requests for highly specialized equipment and supplies	Delivered no more than 120 business days from the date of service order
Environmental accessibility adaptations / home modifications	Delivered no more than 90 business days from the date of service approval
Consultative clinical and therapeutic services for informal caregivers	Provided no more than 60 business days from the date of service approval

The health plan must have policies and procedures in accordance with these appointment and service standards. Methods for educating both the providers and the members about appointment and service standards must be addressed in these policies and procedures. The health plan must monitor compliance with these State established standards and must have a corrective action plan when appointment and service standards are not met.

6.e Provider Agreements

The MCE must have a process in place to review and authorize all network provider contracts. The MCE must submit a model or sample contract of each type of provider agreement to State for review and approval at least 60 calendar days before the MCE's intended use. The MCE must maintain a specific model contract to be used with HCBS providers.

The MCE must include in all its provider agreements provisions to ensure continuation of benefits. The MCE must 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 must agree that the applicable terms and conditions set out in the *Indiana Pathways for Aging* scope of work, 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 that subcontracts indemnify and hold harmless the State of Indiana do not extend to the contractual obligations and agreements between the MCE and healthcare providers or other ancillary medical providers that have contracted with the MCE.

In addition to the applicable requirements for subcontracts in Section 5.4 of the *Indiana Pathways for Aging* scope of work in the MCE's contract with the State, the provider agreements must meet the following requirements:

- Demonstrate 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.
- Require each provider to submit all claims that do not involve a third-party payer for services rendered to the MCE's members within 90 calendar days or fewer from the date of service. The MCE must waive the timely filing requirement in the case of claims for members with retroactive coverage.

- Require each provider to use the Indiana Health Coverage [Programs Prior Authorization Request Form](#), available IN.gov/Medicaid, for submission of prior authorization requests to the MCE.
- Include a termination clause stipulating that the MCE must terminate its contractual relationship with the provider as soon as the MCE has knowledge that the provider's license or IHCP provider agreement has terminated.
- Terminate the provider's agreement to serve the MCE's *Indiana Pathways for Aging* members at the end of the contract with the State and ensure safe member transition to enrolled providers without gaps in service.
- Monitor providers and apply corrective actions for those who are out of compliance with the State's or the MCE's standards.
- Obligate the terminating provider to submit all encounter claims for services rendered to the MCE's members while serving as the MCE's network provider and provide or reference the MCE'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 MCE. Said advance notice must not have to be more than 90 calendar days.
- Provide a copy of a member's medical record at no charge on 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 must not seek payment from the State for any service rendered to an *Indiana Pathways for Aging* 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 before discharge. This treatment must be provided within seven calendar days from the date of the member's discharge.

The MCE must 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.f Provider Network Participation Requests

6.f.1 Network Participation Process

A network participation request is when the provider makes a formal request to enter into a new agreement/contract with the MCE. This includes the mechanism utilized by the MCE to receive the request from the provider or group to join the MCE's network as a contracted provider. The network participation request must include at a minimum the information/fields outlined on the IHCP MCE Practitioner and IHCP MCE Hospital/Ancillary Provider Enrollment and Credentialing Forms and any supporting documentation required from providers for the MCE to enroll, credential and initiate contracting with the provider. MCEs may not require a signed contract in order for a network participation request to be considered complete as it's only the information necessary to begin processing the request.

The MCE must display on their public facing website and other written materials a clearly defined, step-by-step process for how providers submit a network participation request. The information and steps need to include all the information that is required from the provider and any differences by provider type. The information should clearly define for providers what would be considered a complete network participation request. The MCEs may visualize the network participation request using a workflow document, but this is not required.

Providers need to understand the different processes within network participation and understand the unique processes conducted within each of the processes (i.e., enrollment, credentialing, and contracting). State definitions for each of the processes that should be displayed on the MCE website and utilized by the MCEs are below:

- **Enrollment** - the process of loading a contracted and credentialed provider to all MCE internal systems, loading for claims payment, and loading to the provider directory (if applicable).
- **Credentialing** - the process of reviewing the qualifications and appropriateness of a provider to join the MCE's network. Credentialing requirements and processes will follow NCQA guidelines.
- **Contracting/Negotiating**- the process of the provider and MCE formally executing an agreement for the provider to deliver medical services that outlines reimbursement rates, scope of services, etc.

The MCEs are welcome to include additional information to describe each process, but the meaning of each term shall remain consistent with the State's definitions.

The network participation process information should also outline for providers how to submit any additional supporting documentation. Multiple methods should be offered to providers for submitting supporting documentation. The supporting documentation may include but is not limited to:

- W-9
- Debarment Form
- Credentialing Attestation/Information
- Proof of Certification
- Policies and Procedures required in Indiana Code
- Site visit certification tool for congregate settings

MCEs must notify providers when an incomplete network participation request is received and work directly with the provider to become compliant. Notification of an incomplete network participation request will be sent to providers within five business days after receipt of initial request. An incomplete network participation request is a request that the MCE cannot fully process because there is missing documentation, information needed to write a contract, etc.

MCEs must also include the most common mistakes providers make during network participation request process on the MCE website. The MCE will demonstrate how this information will be used as education for providers on what common issues are seen so they avoid making them and ensure their network participation process is most efficient. This information can be posted directly to the MCE website or in a supporting document posted to the website.

MCEs must outline for providers the information necessary, and steps required to be credentialed with the MCE. MCEs must confirm what provider types require credentialing and which do not. This must be communicated with providers via the MCE website and in direct correspondence with providers.

6.f.2 Provider Network Participation Request Forms

As part of the step-by-step instructions provided on the website, the MCE must clearly outline the forms to be completed. This includes whether the MCE Network Participation Request or the IHCP Enrollment Forms should be submitted and the method for submitting.

If an online form is available for providers to submit the network participation request, the MCE must include an instructions of proper form completion. MCE must ensure link and online form completion working and functional.

MCE Network Participation Request forms must include all the IHCP MCE Practitioner Enrollment Form and IHCP MCE Hospital/Ancillary Provider Enrollment Form fields to allow for efficient data capture and prevent providers from having to submit multiple network participation request forms. If the MCE utilizes an online form or other MCE generated form, the MCE must include all fields found on the IHCP Enrollment Forms. The MCE Network Participation Request forms must be approved by the State prior to implementation.

The use of additional network participation request forms to gather information not included on the IHCP Enrollment Forms is permitted so long as the MCE specifies in the step-by-step network participation process exactly which forms are required.

6.f.3 HCBS-Specific Network Participation Requirements

The MCE must make a unique network participation request form (or modify an existing network participation request form) specifically for HCBS providers wishing to participate with the health plan. This unique (or modified) form must be available both electronically and by paper. This form should remove any request for data points that are not applicable to an HCBS provider. Examples of these data points not applicable to this provider type are Individual/Group NPI Number, Taxonomy Code, CAQH Number, and DEA Number.

Providers will be required to provide a copy of their HCBS certification from the appropriate division within the State. In addition to standard provider enrollment data, the State will supply the MCE with a nightly data file of all HCBS certified providers. If the MCE does not have a provider's certification (and it was not supplied by the provider agency), the MCE can request a copy of the provider agency's certification through the State.

An HCBS provider who wishes to participate with a health plan must follow a specific process. The MCE is required to assist in this process as identified below:

1. A potential HCBS provider will contact the State and submit a formal application to be certified by the appropriate State division.
2. Upon successful certification from the appropriate State division, an HCBS provider will receive a certification letter outlining the services and service areas approved, and the provider will be directed to enroll with the Indiana Health Coverage Programs (IHCP).
3. Upon successful enrollment with the IHCP, providers will be directed to contact the *Indiana Pathways for Aging* managed care entities for network participation.
 - On Monday of each week, the State (through Gainwell Technologies) will provide each managed care entity a list of newly certified providers with the expectation that managed care entities will outreach to these providers to build network capacity.
 - The MCE will assign staff to review the weekly report of newly IHCP enrolled HCBS providers and conduct outreach to those providers to build network capacity. Reviews and outreach should be conducted and tracked weekly within 72 hours of receipt of report.
 - The MCE will ensure staff accessibility and knowledge to answer provider network participation inquiries before and during the network participation process. MCE staff will respond to network participation inquiries within 24 hours or same day (if impacted by a non-business day or holiday). The required turnaround times for responses help reduce provider capacity by partnering with the provider to deliver services as quickly as possible.
4. The managed care entity will conduct outreach within 24 hours to any provider that has an identified incomplete application. The managed care entity will not delay the process of outreach if the 24 hour timeframe intersects with a non-business day or holiday. In this scenario, the MCE should make an attempt at outreach to the provider the same day. Upon successful receipt of network participation request, the MCE will ensure staff provide notice to HCBS providers of MCE network approval within 24 hours upon MCE staff approving the provider's application.
 - The MCE will continuously conduct outreach to HCBS providers about the network participation process and portal accessibility. Through these surveys and listening sessions with HCBS providers, managed care entities will identify abrasion points, develop and implement a plan for correcting the abrasion points and communicating those changes with providers.

The State has an expectation that the MCE will process a provider's network participation request within 30 days from the date of a completed clean request.

To be considered for initial participation in an *Indiana Pathways for Aging* network, an MCE must require the provider to complete and submit the following documentation:

- An application either electronically or by paper
- A copy of the provider's HCBS certification letter from the State identifying the HCBS waiver services the provider is approved to render. This letter serves as State program and Medicaid approval for HCBS providers, and MCEs are required to accept such certification letters. This letter accounts for all provisions required in 455 IAC 2-6-1; IC 12-9.1-2-3; 455 IAC 2-6-3; 455 IAC 2-8-2; 455 IAC 2-9-1; 455 IAC 2-9-5; 455 IAC 2-10-1; 455 IAC 2-11-1; 455 IAC 2-12-1; 455 IAC 2-14-1; 455 IAC 2-15-3 and site visits related to Federal Settings Rule compliance for congregate settings.
 - In order to remove duplicative efforts for providers in the certification process, the MCE may require the provider to submit the above documents provided to the State Medicaid Office but must accept the original documents submitted by the provider to the State without requiring amendments.
 - The MCE shall not require any HCBS provider to have separate credentialing (such as NCQA) to participate with a health plan's network.

The State requires MCEs to make network participation as streamlined and simple for HCBS providers as possible with the primary goal to reduce burden. As part of the managed care entities network participation process, the MCE may require HCBS providers to submit additional documentation supporting the provider's certification, but that documentation shall not duplicate the State's certification process.

Examples of additional documentation may include provider agency staffing models and number of FTEs; quality measures; data reporting; specific areas for training and education of agency staff; HCBS Settings Rule requirements, etc. These areas are not covered as part of the State's provider certification process.

Each MCE shall outline its network participation requirements, including documentation requirements to be submitted by providers, and a detailed description of the documentation requirement for additional provider clarification. This information shall be posted on the MCE's website in an easily identified location. Additionally, the MCE shall provide the name and contact information for its provider representatives to assist providers during the application process.

6.f.4 Network Participation Effective Dates

MCEs must follow the following network effective date policy for all network participation requests. This effective date should be followed for all provider types. The same effective date policy will be in place regardless of whether the network participation request is for a hospital/ancillary provider or a practitioner. Providers must be fully enrolled and effective as an IHCP provider prior to becoming effective with an MCE.

Providers will be effective with an MCE on the first of the month following the receipt of a complete network participation request or contract execution as outlined in the additional guidance below.

- A brand-new provider that is not part of an existing contract with the MCE will be effective the first of the month following receipt of the network participation request from the provider or the contract execution. It is at the discretion of the MCE to decide which effective date will be utilized.
 - The network participation receipt date is the date the MCE receives the provider's complete network participation request electronically via an online portal, email, postal mail, or fax. All required fields must be completed, required supporting documentation provided, etc. for the network participation request to be considered complete.
 - If the MCE uses the contract execution date, the new provider will be effective the first of the month following the contract execution date.
 - The effective date utilized must be followed for all brand new provider network participation requests.
- A provider that is being added to an existing contract will be effective the first of the month following receipt of the network participation request from the provider. The network participation receipt date is the date the MCE receives the provider's complete network participation request electronically via an

online portal, email, postal mail, or fax. All required fields must be completed, required supporting documentation provided, etc. for the network participation request to be considered complete.

- In order to be able to render services, the contract or contract amendment must still be executed by both parties.
- MCEs are encouraged to use the standard out of network process for services rendered by providers prior to the effective date if needed for member access to care.
- The MCE network effective date must also be after the IHCP effective date. Providers must be enrolled and effective with IHCP prior to being effective with an MCE.
- The effective date will be the first of the month following the receipt of a complete network participation request, regardless of the contract execution date or credentialing completion date. In some cases, the effective date may be retroactive back to the first of the month following receipt of the complete network participation request since providers will not be fully effective until they are credentialed by and have a signed contract or contract amendment with the MCE.
 - After three years of contracting with any willing LTSS provider, if a provider is unable to be credentialed with the MCE, the provider will not be effective with the MCE.
 - If a provider and MCE cannot come to terms with a contract, the provider will not be effective with the MCE.
- Providers should hold all claims until the final welcome letter from the MCE is received confirming that they are effective with the MCE network. MCEs and providers are expected to complete all pieces of the network participation process timely. However, in instances where the network participation process extends for a time period longer than the standard timeframe, MCEs will not hold providers to the timely filing limit for claims rendered before the provider was confirmed effective.
- The State will allow the MCEs flexibility to deny the provider participation request if the contracting phase cannot be completed in an acceptable timeframe that is no more than 60 days. This will allow the effective date policy to remain consistent but also hold all parties accountable for the turnaround of necessary items for the network participation process. It is important that the MCEs educate providers on the significant impact any delay in signing a contract will have and that if they do not meet the timeframe their request will be denied.
 - This provision does not apply to HCBS providers – MCEs must continue to pursue a provider participation request even if it exceeds 60 days.
- The State will provide MCEs with flexibility to negotiate an appropriate retroactive effective date with a provider in the following situations:
 - When the retroactive date is in the best interest of member care.
 - When the retroactive date is in the best interest of the provider's ability to serve the member.
 - In situations involving changes of ownership, including provider mergers, acquisitions, or tax identification changes.
 - In situations where a provider has a preexisting contractual relationship with an MCE and has sought a change in their provider enrollment type or classification with the IHCP (i.e., when a provider was enrolled as a Billing provider but has decided to enroll as a Group provider).
- Upon request from providers in federally qualified health centers (FQHCs) or rural health clinics (RHCs).

Network Participation Effective Date Communications

The MCE must outline the network effective date policy in all written policy and procedures.

The MCE must make the network participation effective date policy readily available to all provider types. The policy should be posted to the MCE's public facing website. The MCE must also include the effective date policy and the specific effective date on the provider welcome letter so that the provider understands how the effective date was calculated.

6.f.5 Network Participation Provider Welcome Letter

The MCEs must include the standard language provided by the State in all provider welcome letters. The standard language includes things such as network effective date, effective date policy, and reference to provider materials. The MCE may add additional language at the discretion of and approval by the State.

MCEs are required to send out the provider welcome letter, either by mail or email, within five business days of the network participation process completion. The completion date for the network participation process is defined as all components of the network participation process being completed including:

- enrolling the provider
- credentialing the provider, if applicable
- contracting with or executing an amendment to add the provider
- provider is loaded into all systems and can submit claims for services rendered
- provider has been added to the provider directory, if applicable

The welcome letter may not state that there are further steps in the network participation process. The welcome letter should be the final confirmation that the provider is fully enrolled in the MCE network and able to render services.

The MCEs must modify the welcome letter language if they will use the first of the month following the contract execution as the effective date for brand new providers.

Network Participation Provider Welcome Letter Standard Language

Welcome to the <MCE> provider network. Please review all this information carefully.

Your effective date with our network is: MM/DD/YYYY. You are now fully enrolled and may render services to members. <MCE may add specific program or network name as applicable.>

Your effective date was assigned following the Indiana Medicaid network effective date policy. The effective date policy is as follows and can be found on our website.

- Providers will be effective with an MCE first of the month following the receipt of a complete network participation request.
- The effective date will be no sooner than the IHCP effective date.
- A brand-new provider that is not part of an existing contract with the MCE will be effective the first of the month following receipt of the network participation request from the provider. The network participation receipt date is the date the MCE receives the provider's complete network participation request electronically via an online portal, email, postal mail, or fax. All required fields must be completed, required supporting documentation provided, etc. for the network participation request to be considered complete.
- A provider that is being added to an existing contract will also be effective the first of the month following receipt of the network participation request from the provider. The network participation receipt date is the date the MCE receives the provider's complete network participation request electronically via an online portal, email, postal mail, or fax. All required fields must be completed, required supporting documentation provided, etc. for the network participation request to be considered complete.
- To be able to render services, the contract or contract amendment must still be executed by both parties.

We encourage you to visit our website at <enter MCE website> for resource materials and regular updates. In particular,

- Provider Manual
- Provider Portal
- Claims Submission Information and Instructions

- Forms
- Clinical Practice Guidelines
- Member Rights and Responsibilities
- Health and Wellness Materials

If you need to contact us for any reason, <MCE enter steps for how providers can contact someone to help answer questions> (this should include a link to the name and contact information for the MCE's provider relations field representatives).

6.f.6 Provider Network Participation Documentation

Network Participation Request Status Updates

The MCE must provide a portal for providers seeking network participation that will allow the provider to communicate with the MCE, submit their required network participation documentation, and see the status of their network participation request.

The MCE must assign for each network participation request a unique identifier that will confirm receipt of the network participation request and that providers can reference when checking the status of their request. The unique identifier should be provided to the provider at time of the network participation request submission either electronically, via email or via postal mail. Providers should be able to use this identifier when checking the status of all components of the network participation process, including credentialing, enrollment, and contracting. The MCE may utilize additional internal identifiers if necessary for internal use only.

In the event there is a request for a provider to be added to multiple locations that are tied to the same tax identification number, only one unique identifier may be used for that request. If a provider is requesting to be added to multiple locations that have different tax identification numbers, it is expected that a unique identifier will be used for each location.

The MCE must clearly identify on their website and on any initial network participation request receipt confirmations how providers can check the status of their request. This can include but is not limited to the ability to check the status of a request online, by calling the provider service helpline, or by contacting specific provider specialists at the MCE.

The MCE is required to notify providers when an incomplete network participation request is received. Notification of an incomplete network participation request must be sent to a provider within five business days after receipt of the initial request. An incomplete network participation request is a request that the MCE cannot fully process because of missing documentation, information to begin generating a contract, incomplete credentialing information, or other issues.

The MCE is required to conduct outreach to any HCBS provider who does not submit a completed application to outline the documentation needed by the managed care entity to complete the entirety of the application. Given HCBS workforce capacity shortages, the MCE shall conduct the outreach within 24 hours upon identifying an incomplete provider application. If the incomplete application is identified on a day prior to a non-business day (including a holiday), the managed care entity shall conduct outreach on the same day as the incomplete application is identified to avoid delays in the certification process.

Each MCE will conduct provider outreach on the effectiveness and accessibility of the portal, including process and timeliness of the application review on a monthly basis. The MCE will report the findings to the State, including any problems with the portal and the steps taken to address HCBS provider abrasion with the portal, including timeline of corrections. This information shall also be shared by each MCE to the HCBS provider network to build a relationship of trust between provider and MCE.

Central Repository for Network Participation Documentation and Correspondence

The MCE must have a central repository solution for all documentation and correspondence that is related to and occurs during the provider network participation process. MCEs must retain the request for participation

form, all supporting documents submitted by the provider, all credentialing files, and contract related documents. Written correspondence and email correspondence that occurs with providers and provider groups related to the network participation process should also be stored in the repository.

The State always reserves the right to audit the provider network participation process and view all correspondence that has occurred regarding a specific network participation request. The MCE must be able to provide copies of all correspondence during an audit or upon an inquiry request. The central repository should be used to store all network participation request communications.

6.f.7 Network Participation Annual Audit

The MCE must conduct an annual internal review of the network participation process and determine if there are key inefficiencies that need to be addressed. This includes a review of all components of the provider network participation process and timeliness to complete provider requests. MCEs should identify if there are frequent issues or questions raised by providers and work to resolve the process to address those. MCEs should also identify if there are manual components of the process that need to be refined.

After issues or key inefficiencies are identified, MCEs should work to implement process improvements to address and correct these inefficiencies.

The State will conduct an annual review of the MCE Provider Network Participation Process to validate compliance with these requirements. The annual review will include auditing all to specific components of the Provider Network Participation Process as well as auditing random provider participation experiences. The MCEs must report on their annual assessment and improvements that were made to address inefficiencies during the State annual compliance review.

The annual compliance review will evaluate the following requirements:

- Network Participation Request Forms
- Network Participation Process
- Network Effective Date Policy
- Provider Notifications
- Repository of Correspondence

The findings from the annual review will be provided in writing to the MCE in a scorecard. MCEs will receive an Overall Status which will indicate if there are Minor Concerns, Moderate Concerns or Major Concerns. An MCE will be found to be non-compliant if one or more of the requirements have not been met. An MCE will be found to be compliant if all the requirements have been met. The following overall status score will be applied to an MCE based upon the following definitions:

- **Minor Concerns** - the MCE was compliant with the requirements but has some items that could be improved to continue enhancing the provider experience.
- **Moderate Concerns** - the MCE was found non-compliant on one of the requirements and improvements must be made.
- **Major Concerns** - the MCE was found non-compliant on more than one of the requirements, and there are major concerns identified that need to be escalated and resolved immediately; or the MCE was found non-compliant on more than two of the requirements and improvements must be made.

MCEs shall engage in process improvements to address any concerns identified and areas of non-compliance. The timeline for the annual compliance review will be communicated by the State.

6.g HCBS LTSS Provider Qualifications and Standards

For HCBS providers, the MCE must not conduct a traditional NCQA credentialing process. The MCE must ensure these providers are compliant with the following requirements:

- Must be IHCP enrolled at the beginning of the network participation process,
- Must be certified by the appropriate State division (Division of Aging or Office of Medicaid Policy and Planning), and
- Must meet all provider qualification requirements established in [455 IAC 1-3](#)

The MCE will receive a weekly report (*PRV-0205-W Waiver Provider Extracts*) from Gainwell Technologies that provides all the latest enrollment activity pertaining to HCBS providers. The MCE must utilize this information to conduct outreach to new providers.

6.h Provider Credentialing and Recredentialing Policies and Procedures

The MCE must have written credentialing and recredentialing 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 MCE's credentialing and recredentialing process for all contracted providers (excluding HCBS providers) must meet the National Committee for Quality Assurance (NCQA) guidelines. The same provider credentialing standards must apply across *Indiana Pathways for Aging* program.

The MCE must use the IHCP MCE Practitioner Enrollment form / the IHCP MCE Hospital/Ancillary Enrollment form or gather the information identified on the forms during the provider network participation request process. The IHCP Practitioner Enrollment Form and the IHCP Hospital/Ancillary Enrollment Form can be found on the IHCP Provider Enrollment Transactions page at in.gov/medicaid/providers. The MCE must ensure that providers agree to meet all the State's and the MCE's standards for credentialing PMPs and specialists, and maintain IHCP manual standards, including:

- Compliance with State recordkeeping requirements
- The State's access and availability standards
- Other quality improvement program standards

As provided in *42 CFR 438.214(c)*, the MCE's provider credentialing and selection policies must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The MCE must not employ or contract with providers that have been excluded from participating in federal healthcare programs under Section 1128 or Section 1128A of the *Social Security Act*. The MCE must notify the State of any credentialing applications that are denied because of program integrity-related issues.

6.h.1 Credentialing Timeframe

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

6.h.2 Credentialing Requirements

The MCE must have written policies and procedures for credentialing healthcare professionals it employs and with whom it contracts. The MCE must have documented plans to periodically review and revise policies and procedures. If the MCE contracts with a hospital that conducts the MCE's credentialing activity, the MCE must have access to the hospital's credentialing files and audit the hospital's credentialing files as required by NCQA. At minimum, the MCE must obtain and verify the following:

- A current and valid Indiana license to practice.
- Status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility.

- Current and valid Drug Enforcement Administration (DEA) or controlled-substance registration (CSR) certificate, as applicable (DEA certificates are not applicable to chiropractic settings).
- Education:
 - Proof of graduation from medical school and completion of a residency, or board certification for Doctor of Medicine (MDs) and Doctors of Osteopathy (DOs), as applicable since the last time the provider was credentialed or recredentialed.
 - Proof of graduation from a chiropractic college for Doctor of Chiropractic Medicine (DC).
 - Proof of graduation from podiatry school and completion of residency program for Doctors of Podiatric Medicine (DPMs).
 - Proof of graduation from accredited and master's degree program for APRNs or physician assistants.
- Work history that includes a minimum of five years on the curriculum vitae (the MCE is not required to verify work histories).
- Current, adequate malpractice insurance, according to the MCE's policies.
- History detailing any pending professional liability claims and claims resulting in settlements or judgments paid by or on behalf of the practitioner.
- Proof of board certification if the practitioner states he or she is board certified.
- Verification of IHCP enrollment.
- For a group enrollment, verify that the provider is linked appropriately to the group, and that the provider is enrolled at the appropriate service locations.
- Verification that the provider, or an agent or managing employee of the provider, is not debarred, suspended, or otherwise excluded by Federal agencies or from participating in any contract paid with Federal funds.

The credentialing policies and procedures must specify the professional criteria required to participate in the MCE. Each practitioner's file must contain sufficient documentation to demonstrate that these criteria are evaluated. Primary sources used by the MCE to verify credentialing information must be included in its policies and can include using external agencies, such as county medical societies, hospital associations, or private verification services.

As outlined in the Provider Network Participation Request section, MCEs must outline for providers the information necessary, and steps required to be credentialed with the MCE. MCEs must confirm what provider types require credentialing and which do not. This information must be communicated with providers via the MCE website and in direct correspondence with providers.

6.h.3 Credentialing and Recredentialing Mechanisms

The MCE must document the mechanism for credentialing and recredentialing providers that fall under the MCE's scope of authority and action, and with whom it contracts or employs to treat members outside the inpatient setting. This documentation includes, but is not limited to, the following:

- Scope of practitioners covered.
- Criteria and the primary source verification of information used to meet these criteria.
- Process used to make decisions.
- Extent of any delegated credentialing or recredentialing arrangements.

Policies and procedures must specify the requirements and processes used to evaluate practitioners. Selection decisions must be based on the network needs of the MCE and on practitioners' qualifications.

Selection decisions cannot be based solely on a practitioner's membership in another organization, such as a hospital or medical group.

Policies and procedures must include specific details regarding the physicians and other licensed independent practitioners who are subject to these policies, and criteria to reach a decision.

The MCE must have a process in place for receiving advice from participating practitioners in credentialing and recredentialing to ensure that procedures are followed consistently. MCEs must seek practitioner expertise on current practice in the medical community and advice on modifying the criteria, as appropriate. This expertise can be obtained from a committee with participating practitioner representation or from consultation with participating practitioners.

Participating practitioners must complete applications for membership on such a committee. Through the application process, the practitioner discloses information about health status and history of issues with licensure or privileges that may require additional follow-up. A signed attestation statement on the application ensures that the practitioner has completed it in good faith.

Before making a credentialing decision, the MCE must have the following information about the practitioner:

- Information from the National Practitioner Data Bank (NPDB). NPDB is not applicable to chiropractors and podiatrists.
- Information about sanctions or limitations on licensure from the State Board of Medical Examiners, Federation of State Medical Boards, or the Department of Professional Regulations, if available.
- Information from the State Board of Chiropractic Examiners or the Federation of Chiropractic Licensing Boards.
- Information from the State Board of Podiatric Examiners.
- Previous sanction activity by Medicare and the IHCP.

Evidence indicating that the MCE has obtained information from the previously designated organizations must be included in the credentialing file.

6.h.4 Credentialing Site Visits (non-HCBS providers)

NCQA no longer requires initial provider credentialing visits for certain provider types. However, the State continues to require that the MCE credentialing process include an initial visit to the offices of all potential primary medical providers (PMPs), including all obstetricians and gynecologists (OB/GYNs). There must be a structured review that evaluates the site against the MCE standards. The initial site visit must also document evaluation of the medical recordkeeping practices at each site to ensure conformity with the maintenance of medical records. See [Member Services](#) for additional information.

6.h.5 Recredentialing (non-HCBS providers)

The MCE must have a formal recredentialing process that verifies credentialing information subject to change over time. The recredentialing process must be organized to verify the information through a primary source on the current standing of items listed in this section, such as member complaints, quality reviews, utilization management, and member satisfaction. The description of the recredentialing process must include data from at least three of the following six sources:

- Member complaints
- Quality reviews (practice-specific)
- Utilization management (profile of utilization)
- Member satisfaction (practice-specific)
- Medical record review
- Practice site reviews

The recredentialing process must use this data as objective evidence when reappraising professional performance, judgment, and clinical competence. The MCE must demonstrate it has taken action based on the data. Examples of action taken include continuation in the MCE, required supervision or participation in continuing education, evidence that the MCE has drawn up a clear plan for the practitioner's/provider's improvement, evidence of changes in the scope of practice, verification that correction led to provider compliance or termination of the practitioner from the MCE. The correction plan and final findings after education of the non-compliance must be delivered via U.S. Mail and email to the individual provider designee within 60 days of the provider's recredentialing.

While HCBS providers do have a formal credentialing/recredentialing process, the MCE should utilize the following data when assessing a provider's continued participation in the health plan's network:

- HCBS utilization management
- HCBS provider satisfaction scores
- HCBS setting rule site visit reviews

6.h.6 Recredentialing Site Visits

The MCE must conduct an on-site visit at the time of recredentialing to determine if there have been changes in the facility, equipment, staffing, or medical recordkeeping practices that would affect the quality of care or services provided to members of the MCE. Primary medical providers, OB/GYNs, and other high-volume specialists must be included in this site visit. The MCE is responsible for determining which high-volume specialists are subject to this visit based on its own experience with the specialist.

6.h.7 Credentialing for Healthcare Delivery Organizations

The MCE must have policies and procedures for credentialing healthcare delivery organizations including but not limited to hospitals, home health agencies, freestanding surgical centers, laboratories, and subcontracted networks of providers.

Every three years after the initial contract, the MCE must confirm the following:

- The organizations are in good standing with state and federal regulatory bodies.
- The organizations have been reviewed and approved by an accreditation body before contracting with the MCE.
- The organizations conform to the previously mentioned requirements.

The MCE must also develop standards of participation and assess these providers accordingly if the provider has not received accreditation.

6.h.8 Re-certification for HCBS Providers

HCBS providers are not familiar with credentialing practices as they have been trained on the State's re-certification process. *Credentialing* means something different to HCBS providers than *re-certification*. HCBS providers are not prepared to go through a process (even if implemented by the MCE) that mirrors NCQA. The MCE should work with this provider group toward a process that mirrors NCQA, but should ensure providers are prepared and successful in the process. MCEs are required to use the State's re-certification process for HCBS providers. The State's provider re-certification process can be found in the provider manual for the MCE.

6.h.9 Altering Conditions of Provider Participation

MCEs must have plans for developing and implementing policies and procedures for altering conditions of a provider's participation with the MCE because of quality of care and service issues. These policies and procedures must specify actions the MCE takes before terminating the provider's participation with the MCE. Policies and procedures must have mechanisms in place for reporting serious quality deficiencies to

the State that could result in a provider's suspension or termination. These policies and procedures must specify how reporting occurs and the individual staff members responsible for reporting deficiencies.

The policies and procedures must include explicit appeals process for instances in which the MCE decides to alter the provider's condition of participation because of quality of care or service issues. The MCE must ensure that providers are aware of the appeals process. Policies and procedures must include mechanisms to ensure that providers are treated fairly and uniformly.

6.i Provider Enrollment

The MCE components of *Indiana Pathways for Aging* are subprograms of the IHCP in CoreMMIS. As such, participating providers must be IHCP enrolled. The MCE is responsible for ensuring that all its providers are IHCP enrolled at the service location where they wish to participate as a PMP. The MCE is also responsible for ensuring that there are sufficient providers to adequately serve enrolled members.

Provider enrollment activities are governed by the following criteria:

- MCE provider outreach personnel assume responsibility for education of providers enrolled in the MCE and must implement any educational material provided by the State to the MCE. State-contracted provider personnel from the enrollment broker or the fiscal agent can also provide general information about the *Indiana Pathways for Aging* program.
- After enrolled in the IHCP, PMPs contract with the MCEs. PMPs are allowed to enroll with multiple MCEs and maintain member enrollment in each MCE and program.
- PMPs determine the maximum panel limits of *Indiana Pathways for Aging* members for each MCE. The State monitors each MCE's PMP network to evaluate its member-to-PMP ratio on at least a quarterly basis.

6.i.1 IHCP Provider Enrollment

Providers must first be enrolled with the IHCP to participate as a provider in the MCE's *Indiana Pathways for Aging* program. A provider is enrolled in the IHCP when all the following conditions have been met:

- The provider is duly licensed, registered, or certified by the appropriate professional regulatory agency pursuant to State or federal law, or otherwise authorized by the State.
- The provider has completed, signed, and returned an IHCP Provider Agreement, and any other forms required by the IHCP.
- The provider has been assigned a provider identification number (also known as a Legacy Provider Identifier).
- Practitioners must be actively enrolled at the service location where they wish to practice as a PMP before enrolling as a PMP at that location.

The IHCP recognizes four provider classifications for enrollment purposes:

- **Billing** - a practitioner operating as an individual or sole practitioner, or an organization operating as a business entity, billing for services at a distinct location, with no rendering providers linked to the practice or entity.
- **Group** - a practice or business entity operating at a distinct service location with one or more practitioners (rendering providers) linked to a common taxpayer identification number (TIN) for billing. Group providers must ensure that rendering providers are linked to each service location where they render services for the group practice.
- **Rendering** - a practitioner or other provider performing services for a group practice and linked to a common TIN. A provider enrolled as a rendering provider under one or more groups at one or more service locations may also enroll as a billing provider at a different service location.
- **Ordering, Prescribing, or Referring (OPR)** - practitioners who do not bill the IHCP for services rendered but may order, prescribe, or refer services or medical supplies for IHCP members. These non-billing

providers are required by the Affordable Care Act (42 CFR Parts 405, 447, 455, 457, and 498) to enroll in the Medicaid program to participate as an OPR provider.

A complete list of all IHCP-allowed provider types and specialties, including LTSS providers, is available at the [IHCP Provider Enrollment Type and Specialty Matrix](#).

The IHCP provider enrollment procedures are designed to ensure timely, accurate, and efficient processing of provider enrollment applications. This procedural base is the focus of provider participation and is critical for accurate claim processing. It is the MCE's responsibility to ensure that any network providers delivering services to members in the *Indiana Pathways for Aging* program are enrolled as IHCP providers. Providers are encouraged to use the [IHCP Provider Healthcare Portal](#) to apply and maintain their enrollment profiles as IHCP providers.

Detailed information about the IHCP provider enrollment process is found on the [Become a Provider](#) page at [in.gov/medicaid/providers](#). Providers may also contact the fiscal agent's Provider Enrollment by telephone at 800-457-4584 to request enrollment applications and to get answers to questions about IHCP provider enrollment.

IHCP Electronic Provider Files

IHCP provider extract files are posted to the IHCP file exchange for the MCEs' use. Provider files list all actively enrolled IHCP providers in *CoreMMIS*, regardless of PMP status.

MCEs use this information to pay out-of-network providers for carved-out and any other services rendered to their members in and out of network. Files include address and service locations, provider NPI crosswalk data and revalidation information.

The list of IHCP provider extract files and their frequencies can be found in [Appendix B](#). The file layouts are posted to the [MCE Secure Landing](#) page at [in.gov/medicaid/partners](#).

Paper File Submission

MCEs are encouraged to use the portal for submitting enrollments. If the MCE is unable to access the web, they may submit forms to the State fiscal agent at the address or fax below. Paper submission should be addressed to the attention of Care Programs Enrollment Unit. MCEs must use this option only when the portal access is unavailable for more than 24 hours Monday – Friday, or other extenuating circumstances agreed to by the fiscal agent and the State. The form for enrolling a PMP in the MCE may be found in **Provider Healthcare Portal > PMP Enrollment** and at the [MCE Secure Landing](#) page at [in.gov/medicaid/partners](#).

Username is **MCEhealthplans**

This site is password protected. MCEs can obtain the password by contacting their State contract compliance officer.

IHCP Provider Enrollment Unit
P.O. Box 7263
Indianapolis, IN 46207-7263
Fax: 317-488-5020

The following procedure for manual enrollment submissions readily identifies submissions as belonging to an MCE and confirms to MCEs that the enrollments have been processed:

1. The PMP enrollment requests must be sent with a cover letter containing the MCE's name, the signature of the MCE provider representative, MCE fax number and an itemized list of the enrollment forms submitted. The itemization must include fields for the following information:
 - o PMP name
 - o Provider identification number
 - o Effective date

2. The MCE must complete the PMP name and provider identification number.
3. On receipt of the MCE's PMP enrollment forms, the PMP enrollment coordinator enters the data into CoreMMIS, verifying the following information:
 - Valid IHCP numbers
 - IHCP eligibility
 - Valid PMP provider type and specialty
 - Valid IHCP service location
 - Valid group and individual relationships
 - Number of PMP service locations
 - Acceptable panel size
4. The PMP enrollment coordinator annotates the MCE cover letter to indicate the effective date or the reason the enrollment could not be processed.
5. The PMP enrollment coordinator confirms the disposition of the enrollments by sending an email confirmation to the submitter.

Because PMP enrollment in the MCE is a manual process, no exception reports are generated.

6.i.2 MCE Pre-Enrollment Provider Education

The MCEs can educate practitioners interested in becoming PMPs, as well as HCBS providers, about the *Indiana Pathways for Aging* program through face-to-face training sessions, brochures, informational guidance documents and videos. The State must pre-approve all education and outreach materials designed for distribution to providers.

Before enrolling providers in the MCE program, MCEs are encouraged to educate providers about the following:

- Indiana Pathways for Aging program goals.
- Member PMP selection and the PMP change process within their plans and programs.
- Practice requirements of a PMP include 24-hour access standards
- Provider disenrollment.
- Preventive health standards and requirements.
- Referral standards (for example, referrals for continuity of care).
- Quality improvement requirements (including EPSDT).
- Expectations of HCBS providers related to business acumen (certification, re-certification, adding a new service, changing provider demographic information in the MCE portal, data collection, quality measures, incident reporting, service planning, service delivery, prior authorization,
- Self-referral services.
- Billing and reimbursement practices, including MCE portal training and education.
- Covered and excluded services and referral practices for *Indiana Pathways for Aging*, and interpretation and implementation of HCBS waiver services
- Other relevant MCE-specific information.

Note: All prospective PMPs must first be enrolled in the IHCP at the service location at which they want to be enrolled as PMPs. MCEs must verify IHCP enrollment with prospective PMPs before enrolling them using the portal. If the prospective PMP is not IHCP enrolled, the MCE must advise the practitioner to contact the fiscal agent for an enrollment packet, or the practitioner (or employer) can download the appropriate information from the [Complete an IHCP Provider Enrollment Application](#) page at in.gov/medicaid/providers.

6.i.3 Post-Enrollment Provider Education

As part of the enrollment process for health plan PMPs, the MCE must educate PMPs about the following:

- How PMPs are notified about panels – MCEs provide member enrollment roster information to their contracted network PMPs.
- Universally accepted standards of preventive and other care – these standards are determined by the MCE. MCEs are strongly encouraged to employ the practice standards. Practice standards are updated as needed.
- Medical records retention and availability – This information is described in [Maintenance of Medical Records](#).
- PMP authorization requirements – This information is described in Authorization of Services and Notice of Actions.
- IHCP-covered but MCE-excluded services – This information is described in IHCP-Covered Services Excluded from *Indiana Pathways for Aging*.
- Provider claims dispute – These procedures are developed by the MCE. Minimum requirements are described in [Provider Dispute Procedures](#).
- Provider helpline – MCEs must offer a telephone helpline to providers. The MCE must report provider helpline performance statistics, as described in the *MCE Reporting Manual*. The MCE helpline staff must be prepared to respond to provider concerns including, but not limited to, the following:
 - Enrollment and disenrollment from the MCE
 - Provider grievances and claim disputes
 - Covered services
 - Self-referral services
 - Provider network development as described in this section
 - Quality improvement requirements as described in [Quality Improvement and Utilization Management](#)
 - Billing requirements
 - Eligibility issues
 - Preventive health standards and requirements (including EPSDT)
 - Encounter data requirements as described in the [Information Systems](#) section of this manual
 - Reassignment of a member to another PMP – this process, as initiated by the provider, is described in [Member Enrollment](#) section of this manual.

6.i.4 Preferred Medical Providers (PMP) Enrollment

MCEs must verify that a practitioner is IHCP enrolled before submitting a PMP enrollment via the portal. PMPs participating with an MCE can have service locations in any Indiana county that the MCE's State contract allows. Physicians can download the IHCP application from in.gov/medicaid/providers.

PMP Enrollment MCE Steps

All MCEs have the capability to establish PMP networks for the *Indiana Pathways for Aging* program and enroll their PMPs accordingly in the Portal. MCEs also have the ability to disenroll their PMPs from networks using the portal.

MCEs specify the network's name, effective dates, and four-digit ID. After the fiscal agent enters the networks under the applicable MCE and region in CoreMMIS, MCEs can see the networks that are available in the region for the PMP service location being enrolled in the lower portion of the enrollment window. The following PMP-network functions are available:

- Link an existing PMP service location to a network
- Link a PMP service location to a network as part of the initial enrollment
- End-date a network affiliation for a PMP service location

PMP-network effective and end-dates must be greater than or equal to the processing date. The PMP's network name, when applicable for the date of service, appears in eligibility verification responses after the MCE name and telephone number.

MCEs can submit individual PMP enrollments for their *Indiana Pathways for Aging* plan through the Portal. MCEs can also update the existing PMP's scope of practice, network, panel-hold status, and panel-size information. Panel size and network updates require effective dates that are the day after data entry or a future date. Updates to the panel size are viewable the day after data entry or when the change becomes effective. Updates to the panel-hold and scope-of-practice information are processed the day the update is completed in PMP Update using the Portal. Panel hold and full status are used for information purposes in CoreMMIS and are viewable in the Portal > Provider Profile.

All MCEs must enroll in the Portal as group administrators and establish user IDs and passwords to access the Portal. MCE group administrators can assign users and enable them with appropriate access to the Portal.

When users log on to the Portal, they must click the Provider Profile link. Then they have the option to view the provider profile, enroll a PMP, update PMP information, view a list of the fiscal agent's provider field consultants, and download the PMP enrollment, update, and other program enrollment forms. Only users who are assigned access to the PMP Enrollment Membership task see the Enroll a PMP, Update PMP, or the PMP Enrollment and Update Forms section on the provider profile menu. Users also can access help text to assist them with PMP enrollments and updates. The MCE must log in as the MCE ID of the program where they intend to enroll the PMP so that CoreMMIS can differentiate between the two programs when establishing the PMP service location.

MCEs must complete the selection process by entering the IHCP group or billing ID, selecting a service location and, if a group provider, selecting the applicable rendering provider. After the selection process is finished, the MCE must enter the 24-hour telephone number, scope-of-practice information, panel size, and network information, if applicable. After the MCE's data entry is complete and has passed the system cross-editing, the MCE must click Submit. A confirmation web page appears, stating that the PMP enrollment has been successfully processed. The window also includes the submission date, enrollment date, MCE name, provider ID number, group number, and alpha service location ID. MCEs can print the confirmation web page for PMP enrollment tracking purposes.

6.i.5 PMP Scope of Practice Changes

PMPs may request changes to their scope-of-practice information by contacting their affiliated MCEs. The scope of information includes the following:

- Admit Privileges – Options: Relationship or Privileges
- Delivery Privileges – Options: Yes or No
- Age Restrictions – Options: None, 0-2 years of age, 0-12 years of age, 0-17 years of age, 0-20 years of age, 13-17 years of age, 13-20 years of age, 21 years of age and older, 3 years of age and older, 17 years of age and older, 13 years of age and older
- 24-Hour Telephone Number and Extension
- Accept Obstetrics – Options: Yes or No
- Accepts All Women – Options: Yes or No
- Panel Size
- Panel Size Hold
- Panel Size Hold Removal
- Gender – Options: Male, Female, Male/Female

PMP Scope of Practice Change MCE Steps

On receipt of a change request from a PMP, the MCE can perform a change through the Portal > Provider Profile: Update a PMP. If the Portal is not available, the MCE can submit the MCE Network PMP Panel Size/Panel Hold Request Form to the fiscal agent PMP enrollment specialist, who updates the PMP's record in CoreMMIS.

6.j Provider Disenrollment or Treatment Termination

The MCE must adhere to the following requirements around specific provider disenrollment or treatment termination:

- **Change in PMP**

- The MCE must immediately provide written notice to a member when the MCE changes the member's PMP. The notice must be issued in advance of the PMP change when possible or as soon as the MCE becomes aware of the circumstances necessitating a change.

- **Physical/Behavioral Health Providers Providing Ongoing Treatment Termination**

- If a member is in a prior authorized ongoing course of treatment with any other contract provider who becomes unavailable to continue to provide services to such member and the MCE is aware of such ongoing course of treatment, the MCE must provide written notice to each member as soon as possible but no less than 30 calendar days prior to the effective date of the termination and no more than 15 calendar days after receipt or issuance of the termination notice. The requirement to provide notice 30 calendar days prior to the effective date of termination must be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide 30 calendar days advance notice to the MCE, the provider moves from the service area and fails to notify the MCE or a provider fails credentialing, and instead must be made immediately upon the MCE becoming aware of the circumstances.

- **Non-PMP Termination**

- If a non-PMP provider, including but not limited to a specialist or hospital, ceases participation in the MCE, the MCE must provide written notice to members who have been seen and/or treated by the non-PMP provider within the last six months. Notice must be issued no less than 30 days prior to the effective date of the termination of the non-PCP provider when possible or immediately upon the PMP becoming aware of the termination.

- **LTSS Provider Termination**

- If an LTSS provider ceases participation in the MCE, the MCE must provide written notice as soon as possible, but no less than 30 calendar days prior to the effective date of the termination and no more than 15 calendar days after receipt or issuance of the termination notice, to each member who has chosen or is authorized to receive LTSS services from that provider. Notices regarding termination by a facility must comply with state and federal requirements. The requirement in this section to provide notice 30 calendar days prior to the effective date of termination must be waived in instances where a provider becomes physically unable to care for members due to illness, a provider dies, the provider fails to provide 30 calendar days advance notice to the MCE the provider moves from the service area and fails to notify the MCE or a provider fails credentialing, and instead must be made immediately upon the MCE becoming aware of the circumstances. In their contracts with LTSS providers the MCE must require LTSS providers to adhere to the transition requirements in 455 IAC 2-8-4. See 4.12 Transitions, in the *Indiana Pathways for Aging* scope of work, regarding requirements for transitioning from a terminating provider to a new provider.

- **Hospital Termination**

- Termination of the MCE's provider agreement with any hospital, whether or not the termination is initiated by the hospital or by the MCE, must be reported by the MCE in writing to the State no less than 30 calendar days prior to the effective date of the termination.

- **Identified Network Deficiency**

- Upon notification from the State that a corrective action plan designed to remedy a network deficiency has not been accepted, the MCE must immediately provide written notice to members living in the affected area of a provider shortage in the MCE's network.

- **Any Other Provider Termination**

- The MCE must notify the State of any provider termination and must submit an Excel spreadsheet that includes the provider's name, IHCP provider identification number, NPI number, and the number of members affected within five business days of the provider's termination. If the termination was initiated by the provider, the notice to the State must include a copy of the provider's notification to the MCE. The MCE must maintain documentation of all information, including a copy of the actual member notice(s), on-site. Upon request, the MCE must provide the State a copy of the following: one or more of the actual member notices mailed, an electronic listing in Excel identifying each member to whom a notice was sent, a transition plan for the members affected, and documentation from the MCE's mail room or outside vendor indicating the quantity and date member notices were mailed as proof of compliance with the member notification requirements.

If termination of the MCE's provider agreement with any provider, whether or not the termination is initiated by the provider or by the MCE, places the MCE out of compliance with the network requirements, the MCE must provide a written plan to come into compliance and must submit GeoAccess reports in the manner and timeframe required by the State.

6.j.1 PMP Provider Disenrollment

A PMP can be disenrolled from the *Indiana Pathways for Aging* program for various reasons. MCEs are responsible for reassigning members assigned to PMPs disenrolling from their plan. MCEs must have a policy and procedure in place to identify these members and ensure that they are enrolled in a new PMP in a timely manner. MCEs are required to end-date disenrolling *Indiana Pathways for Aging* PMP service locations in CoreMMIS, so this information is available for reporting and available for the enrollment broker.

MCEs disenroll their own PMP service locations using the Portal. Access is similar to the procedure used by the MCEs to enroll PMP service locations. MCEs must enroll in the Portal as group administrators and establish user IDs and passwords to access the Portal. MCE group administrators can assign users and enable them with appropriate access.

PMP Provider Disenrollment Steps

The following are steps for disenrolling a PMP from an MCE:

1. Log into Access the Portal.
2. Click **Provider Profile**. A new selection appears under the Managed Care section, titled *Disenroll a PMP*.
3. Click **Disenroll a PMP**. A new page appears, titled *PMP Disenrollment*.
4. Search for the desired provider location by entering the PMP's group or NPI or Provider ID and the MCE ID.
5. Click **Select Service Location**. A new page appears; all service locations for the group are selected.
6. Select the disenrolling location using the radio buttons.
7. Type the effective date of disenrollment and choose the disenrollment reason from the drop-down list. Disenrollment reasons are as follows:
 - PMP no longer practices at this location
 - PMP no longer contracted with MCE
 - PMP no longer in managed care at this location

- PMP deceased

8. The date must be the current date or a future date except for death of PMP. Web editing prevents entry of a past date except when the reason code is *PMP Deceased*.

9. Click **Save** and **Close** to complete the process.

Immediate PMP terminations (such as a PMP's death) that are the result of IHCP terminations are carried out by the fiscal agent's Provider Enrollment Unit. The fiscal agent's Provider Enrollment Unit notifies the MCE when one of the MCE's PMPs has been disenrolled. PMPs terminated by the fiscal agent are disenrolled using the reason code, IHCP termed.

With the exception of an emergency event, such as the PMP's death, the fiscal agent's Provider Enrollment Unit notifies the MCE that the MCE has five business days to disenroll the PMP through the Portal. If the PMP is not disenrolled after five business days, the Provider Enrollment Unit disenrolls the PMP and notifies the PMP's MCE. MCEs use the PMP disenrollment reason codes available to them through the Portal disenrollment process (reason codes listed previously in step 5).

The Provider Enrollment Unit team members have the ability to retroactively end-date a PMP's eligibility with an MCE, with the approval of the fiscal agent's Managed Care Unit. An example of a retroactive end date is a PMP's date of death when received by Provider Enrollment Unit one week after the PMP actually died.

6.k Out of State Providers

To enhance access to primary care in areas with an inadequate number of PMPs, the State permits out-of-state PMPs to enroll in the program in areas where limited access has been identified. The State developed criteria to determine which areas would most benefit from additional PMPs with out-of-state locations, permitting these enrollments on a case-by-case basis according to predetermined access measures. PMPs with out-of-state service locations are available for voluntary selection by members. See the Out-of-State Provider module for more information, <https://www.in.gov/medicaid/providers/files/modules/out-of-state-providers.pdf>

The IHCP designates providers located in the following counties (*located within metropolitan statistical areas of major cities within or bordering Indiana*) as "in-state" for prior authorization requirements:

City/State	Counties
Chicago, Illinois	• Cook • Dekalb • DuPage • Grundy • Kane • Kendall • Lake • McHenry • Will
Cincinnati, Ohio	• Boone • Bracken • Brown • Butler • Campbell • Clermont • Gallatin • Grant

City/State	Counties
	• Hamilton • Kenton • Pendleton • Warren
Louisville, Kentucky	• Bullitt • Henry • Jefferson • Oldham • Shelby • Spencer • Trimble
Evansville, Indiana	• Henderson (KY)
South Bend, Indiana	• Cass (MI)

Additionally, the IHCP allows newly enrolling providers that are located out-of-state (not in one of the aforementioned counties) to request in-state status when applying for IHCP enrollment. Providers may qualify for in-state status based upon one of the following circumstances:

- Enrollment increases access to medically necessary services in areas where the distance to an in-state provider would subject a member, or a member's family, to significant financial hardship or create an unnecessary significant burden on a member.
- Enrollment allows a member to retain a primary medical provider, or to obtain specialty services from a provider (such as centers for excellence) when the same care may not be available from an in-state provider or would place a significant hardship on a member due to the geographic location of the in-state specialty care provider.
- Transportation to an appropriate in-state provider would cause significant undue expense or hardship on a member or the office.
- Enrollment addresses an emergency health crisis.

Durable medical equipment and home medical equipment providers are allowed to request in-state status by answering yes to all of the following questions:

- Do you maintain an Indiana business office, staffed during regular business hours, with telephone service?
- Do you provide service, maintenance, and replacements for IHCP members whose equipment has malfunctioned?
- Do you qualify with the Indiana Secretary of State as a foreign corporation?
- Do you anticipate at least 70% of your Indiana business to be rendered by mail order or online purchases?

All providers designated as in-state for prior authorization purposes will be given a State county designation on their IHCP provider profile.

6.1 Residency Programs

To promote long-term relationships for managed care members, physicians practicing in group residency programs are not eligible to enroll as PMPs in the *Indiana Pathways for Aging* program. The frequent turnover of physicians in a residency program disrupts the continuity of care essential to a managed care program. Residents can provide care to *Indiana Pathways for Aging* members only if the residency program's faculty physicians are participating PMPs and are enrolled in *CoreMMIS* in the same billing group as the resident physicians. The PMP or faculty physician retains responsibility for the care provided to

patients and must provide oversight to the resident physician consistent with the residency program's stated procedures.

6.m Provider Referrals

The MCE is required to make arrangements with or referrals to, a sufficient number of qualified physicians, facilities, and HCBS and social support providers to ensure that the services under the contract can be furnished promptly and without compromising the quality of care in accordance with *42 CFR 438.3(q)(1)* and *42 CFR 438.3(q)(3)*. In addition to the requirements pertaining to referrals as described throughout the MCE *Indiana Pathways for Aging Policies and Procedures Manual*, the MCE must have adequate written policies and procedures regarding referrals to specialists and provide education to members and/or providers regarding referral procedures, to include, at a minimum, the following:

- The use of the MCE's referral process,
- Targeted education and training to ensure that primary care providers, other physical health providers and LTSS providers know the process to refer members to specialists and specifically behavioral health services,
- Targeted education to ensure behavioral health providers know the process to refer members to physical health services,
- Requirements for intake to ensure member access to behavioral health services,
- Process and requirements in place that ensures the member's Primary Medical Provider receives all specialist and consulting reports,
- Referral processes offered through the MCE helpline staff,
- Referral training for Care management and other appropriate MCE staff including how the MCE will notify the member if the referral is to a provider owned by the MCE,
- Process for providers to refer members to the MCE's care management program or to receive HCBS and other LTSS supports,
- Process to ensure the Primary Medical Provider follow-up of referrals for behavioral health services, and
- A referral plan for any member who is about to lose eligibility and who requests information on low-cost or no-cost health care services.

The MCE may not require a referral from a member's PMP for the member to obtain medical services from within the MCEs network or an out of network self-referral provider. This does not prohibit an MCE from requiring authorization on specific medical services.

6.m.1 Physician Extenders

Physician extenders are healthcare professionals who are licensed to practice medicine under the supervision of a physician. Physician extenders can perform some of the services that physicians provide per BT201584 and 201743.

Appropriate use of physician extenders can have a positive influence on cost, quality, and access. Physician extenders can perform routine or straightforward services at a lower cost than a physician, allowing physicians to focus on more complicated patient problems. Physician extenders also allow patients to be seen promptly for preventive visits or acute health problems, which improves access to care and may allow more Medicaid patients to be seen.

The following physician extenders are licensed to provide care in the State:

- Advanced practice nurses, including nurse practitioners, nurse midwives and clinical nurse specialists,
- Physician assistants, and
- Certified registered nurse anesthetists (not in capacity of PMP).

MCEs are required to implement initiatives that encourage providers to use physician extenders. Examples of these types of initiatives include:

- Educate providers about the benefits of physician extenders.
- Educate providers about reimbursement policies for physician extenders.
- Offer financial or nonfinancial incentives to providers who increase their use of physician extenders. Any financial incentives must be positive, not punitive.
- Collaborate with physician-extender training programs in Indiana. Collaboration could include providing internships or practicum for physician extenders, expanding the number of training slots for physician extenders, and so forth.

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

6.n Maintenance of Provider Medical Records

The MCE must assure that its records and those of its participating providers document all medical and personal care services that the member receives in accordance with the state and federal law. In accordance with 405 IAC 1-1.4-2 and section 6.10 of the *Indiana Pathways for Aging* scope of work, the provider's medical record must include, at a minimum:

- The identity of the individual to whom service was rendered,
- The identity, including dated signature or initials, of the provider rendering the service,
- The identity, including date signature or initials, and position of the provider employee rendering the service, if applicable,
- The date on which the service was rendered,
- The diagnosis of the medical condition of the individual to whom service was rendered; relevant to physicians, optometrists, and dentists only,
- A detailed the statement describing services rendered, including duration of services rendered,
- The location at which services were rendered,
- The amount claimed through Medicaid for each specific service rendered,
- Written evidence of physician involvement, including signature or initials, and personal patient evaluation will be required to document the acute medical needs,
- A current plan of treatment and progress notes, as to the medical necessity and effectiveness of treatment and ongoing evaluations as to assess progress and refine goals, if applicable, and

For example, pest control and home modification would not require a treatment plan.

- X-rays, mammograms, electrocardiograms, ultrasounds, and other electronic imaging records.

The MCE's providers must maintain members' medical records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. [42 CFR 438.208(b)(5)] Medical records must be legible, signed (manually or electronically) and dated and maintained for at least seven years as required by the state and federal regulations.

The MCE's providers must provide a copy of a member's medical record upon reasonable request by the member at no charge. [42 CFR 438.100(b)(2)(vi)] The provider must facilitate the transfer of the member's medical record to another provider at the member's request. The MCE must ensure that providers maintain and share a member health record in accordance with professional standards [42 CFR 438.208(b)(5)].

Confidentiality of, and access to, medical records must be provided in accordance with the standards mandated in the *Health Insurance Portability and Accountability Act (HIPAA)* and all other the state and federal requirements, including, but not limited to, 42 CFR Part 2 specific to the confidentiality of alcohol

and drug abuse records. See Section 2.10 of the *Indiana Pathways for Aging* scope of work or [Confidentiality of Members' Medical Records and other Information](#) for more information regarding the confidentiality of member medical records.

The MCE's providers must permit the MCE and representatives of the State to review members' medical records for the purposes of monitoring the provider's compliance with the medical record standards, capturing information for clinical studies, monitoring quality or any other reason, in accordance with 405 IAC 1-1.4-2. The failure of MCE and/or its participating providers to keep and maintain detailed and accurate medical records as required in this section may result in MCE and/or its participating providers repaying the State or MCE for amounts paid corresponding to the services rendered for which accurate and detailed medical records are not timely provided.

Records must be provided by MCE and/or its participating providers upon request within the timeframe identified in the request. The State in its sole discretion may authorize additional time for responding to medical records requests made by the MCE or the State. The failure of the MCE and/or its participating providers to submit records in a timely manner may result in the assessment of an overpayment and/or other non-compliance remedies. The State encourages MCEs to use technology, including participation in health information exchanges, where appropriate to transmit and store medical record data.

6.0 Provider Communications

All provider communication materials required in this section or otherwise developed by the MCE must be pre-approved by the State. The MCE must develop and include an MCE-designated inventory control number on all provider communications, including letters, forms, bulletins and promotional, educational, training, informational or other outreach materials, with a *date issued* or *date revised* and *date of last approval by the State* **clearly** marked. The purpose of this inventory control number is to facilitate the State's review and approval of all provider communications and documentation of its receipt and approval of original and revised documents.

The MCE must submit all provider communication materials designed for distribution to, or use by, contracted providers to the State for review and approval at least 30 calendar days before use and distribution. The MCE must also submit any material changes to previously approved provider communication materials to the State for review and approval at least 30 calendar days before use and distribution. When submitting documents for review the MCE must identify, to the State, that the document is for the *Indiana Pathways for Aging* program (as well as any other program(s), as applicable). Documents submitted for review must be as close to their final form as possible (e.g., no spelling, grammar, or formatting issues). The MCE must receive approval from the State before distribution or use of materials. The State's decision regarding any communication materials is final. The MCE must include the State program logos in their provider communication materials upon the State request.

The MCE must give providers at least 45 calendar days advance notice of material changes that may affect the providers' procedures such as changes in subcontractors, claims submission procedures or prior authorization policies. The MCE must post a notice of the changes on its website to inform both network and out-of-network providers and make payment policies available to non-contracted providers upon request.

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

All public facing communications from the MCE's subcontractors must be approved by the State and meet the same timeframe as the MCE's requirement.

The MCE must not refer to or use the FSSA, OMPP, or other State agency name or logo in its provider communications without prior written approval. The MCE must request in writing approval from the State for each desired reference or use at least 30 calendar days prior to the reference or use. Any approval given for the FSSA, OMPP, or other State agency name or logo is specific to the use requested and must not be interpreted as blanket approval.

All State-approved provider communication materials must be available on the MCE's provider website within three business days of distribution. The provider communication materials must be organized online in a user-friendly, searchable format by communication type and subject.

Any provider communications by a subcontractor to IHCP providers must comply with the provisions in the section, just as the MCE is required.

6.o.1 LTSS-Specific Provider Communication

The MCE must develop an education and training workplan for contracted providers regarding key requirements of the contract and the specific training requirements for providers of LTSS and HCBS as specified in this section. The education and training workplan must be submitted annually to the State as further described in the *MCE Reporting Manual*.

The MCE must maintain active communication and collaboration with all providers, including LTSS providers. The MCE must solicit and act on feedback from providers to continuously improve provider experience. The MCE will participate in a State facilitated LTSS provider forum as directed by the State. The frequency of the forum will be determined by the State. The MCE must develop and submit a LTSS provider engagement plan to the State for review and approval during Readiness Review and annually, to include but not limited to communication methods implemented to partner with providers, webinars, emails, phone calls, in-person meetings, attendance of association meetings. The engagement plan must also include identified trends in provider questions and concerns and action steps the MCE implemented to improve trends.

Education and training regarding the MCE-specific policies and procedures must occur for providers of LTSS no later than 30 days prior to implementation of the contract and ongoing upon initial provider contracting. The MCE must offer education and training regarding the MCE-specific policies and procedures for all contracted providers regarding provider requirements and responsibilities, the MCE's prior authorization policies and procedures, clinical protocols, caring for populations at greater risk for negative health outcomes, aging populations, person-centered standards, member's rights and responsibilities, claims submission process, claims dispute resolution process, pay-for-outcomes programs and any other information relevant to improving the services provided to the MCE's members.

The MCE will ensure that providers of long-term services and supports maintain a level of training appropriate to the services that they provide. The MCE will identify areas where the need for further provider training is evident and share information with providers about available resources and training. MCEs must ensure that providers have access to training programs. MCEs must 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.o.2 Provider Website

The MCE must develop and maintain a user-friendly website for network and out-of-network providers within six months of the effective date of the MCE's contract with the State. The website must be compliant with Section 508 of the *US Rehabilitation Act*. The State must pre-approve the information and graphic presentations on the MCE's website. The MCE may choose to develop a separate provider website or incorporate it into the home page of the member website.

To minimize download and wait times, the website must 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 MCE must date each web page, change the date with each revision, and enable users to print the information.

The provider website may have secured information available to network providers but must, at a minimum, have the following information available to all providers:

- MCE's contact information,
- MCE provider policy and procedure manual and necessary forms,
- All provider communication materials, organized online in a user-friendly, searchable format by communication type and topic,
- A link to the State's Preferred Drug List,
- Claim submission and denial information (including denial reason codes and other information),
 - Including, but not limited to, MCE submission and processing requirements, paper and electronic submission procedures, emergency room auto-pay lists, and frequently asked questions.
- Claims dispute resolution procedures for contracted and out-of-network providers,
- Prior authorization procedures, including a complete list of services that require prior authorization,
- Appeal procedures,
- Entire network provider listings,
- Links to the State's website for general IHCP and *Indiana Pathways for Aging* 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 network and be credentialed.

6.0.3 Provider Newsletters

The MCE must distribute provider newsletters not fewer than four times per year that provide updates related to provider services, and policies and procedures specific to the *Indiana Pathways for Aging* program. The newsletters must be publicly posted on the MCE's website and able to be subscribed to by providers, associations, the State, and other members of the public. The MCE must notify their contracted providers to changes such as to policy, procedures, contact information, and medical necessity criteria via the MCE's newsletter.

6.0.4 Provider Services Helpline

The MCE must 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) must be dedicated and specially trained to assist the needs of LTSS and HCBS providers. With the exception of the holidays listed below, the MCE must staff the telephone provider helpline with personnel trained to accurately address provider issues during (at a minimum) a 12- hour business day, from 8 a.m. to 8 p.m. Eastern Standard Time (EST), 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 4)
- Labor Day
- Thanksgiving
- Christmas

The MCE may request that additional days, such as the day after Thanksgiving, be authorized for limited staff attendance. This request must be submitted to the State at least thirty 30 calendar days in advance of the date being requested for limited staff attendance and must be approved by the State. For all days with a closure, early closing or limited staff attendance, there must be a process for providers to process emergency

prior authorizations as needed. Call center closures, limited staffing or early closures must not burden a member's access to care.

The MCE must maintain a system for tracking and reporting the number and type of provider calls and inquiries. The MCE must monitor its provider helpline and report its telephone service performance to the State each quarter as described in the MCE Reporting Manual.

6.o.5 IHCP Workshops and Seminars

The State fiscal agent sponsors workshops and seminars for all IHCP providers. The MCE must participate in the workshops and attend the provider seminars. An MCE representative must be available to make formal presentations and respond to questions during the scheduled times. The MCE is also encouraged to set up an information booth with a representative available during the provider seminars.

6.p Provider Dispute Process

The MCE must have written Provider Claims Dispute Resolution policies and procedures for responding to claims disputes for both in-network and out-of-network providers, in accordance with the rules for the claims dispute resolution process for non-contracted providers outlined in Indiana law, 405 IAC 1-1.6. Failure to comply with any of these provisions may result in the imposition of sanctions.

The MCE's Provider Dispute Resolution process must comply with the following provisions including but not limited to:

- The Provider Claims Dispute Policy must accept and use the *MCE Reporting Manual* definitions of Informal and Formal Disputes and address provider claims disputes at the lowest level and a formal process for provider appeals.
- The Provider Claims Dispute Policy must specify the timelines and process for submission of the Informal and Formal Disputes challenging claim payments, denials or recoupments of a timely claim submission. The MCE must allow this timeline for submission of a claim dispute to be waived in the event of a retroactive eligibility posting affecting the processing of the original submitted claim or for other events affecting the dispute submission that are out of the provider's control.
- Specific qualified individuals must be appointed with authority to require corrective action and with requisite experience to administer the claims dispute process.
- The MCE must develop and maintain a tracking log for all claims disputes containing sufficient information to identify the provider's name, date of objection, nature of the objection, disposition of the claim dispute, and the date of resolution.
- The MCE must submit quarterly reports regarding the number and type of provider objections and appeals as described in the *MCE Reporting Manual*.
- Claims disputes must be thoroughly investigated using the applicable statutory, regulatory, contractual and policy provisions, ensuring that relevant facts are obtained from all parties.
- All documentation received by the MCE during the claim dispute process must be dated upon receipt.
- All claim disputes are filed in a secure designated area and are retained for the appropriate time period following the MCE's decision or close of the claims dispute, whichever is later, as required by federal or State law.
- The decision for both an informal and formal claims dispute (appeal) must include and describe in detail the following:
 - The nature of the claim dispute.
 - The specific factual and legal basis for the dispute, including but not limited to, an explanation of the specific facts that pertain to the claim dispute, the identification of the member's name, pertinent dates of service, dates and specific reasons for the MCE denial/payment of the claim, and whether or not the provider is a contracted provider.

- An explanation of 1) how the MCE applies the relevant and specific facts in the case to the relevant laws to support the MCE's decision and 2) the applicable statutes, rules, contractual provisions, policies, and clinical basis. Reference to general legal authorities alone is not acceptable.
- The provider's right and the timeline to request an appeal (formal dispute) of the initial dispute (informal dispute) resolution by filing a written request to the MCE.
- Formal claim appeals must be reviewed by an MCE panel and meet the requirements of *405 IAC 1-1.6-3*.
- If a claim dispute is overturned at any level, in full or in part, the MCE must reprocess and pay the claim(s) in a manner consistent with the Decision, along with any applicable interest, within 30 business days of the date of the Decision.
- If the MCE upholds a claim dispute and a request for binding arbitration or other next level review of the decision is subsequently filed, the MCE must review the matter to determine why the request for hearing was filed and resolve the matter or the cause of the matter when appropriate.
- If the MCE reverses a decision to deny, limit or delay services not furnished during the claim dispute or the pendency of the hearing process, the MCE must authorize or provide the services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives the notice reversing the determination [*42 CFR 438.424*]. Services must be authorized within the above timeframe irrespective of whether the MCE contests the decision.
- In compliance with Indiana law, *IAC 1-1.6-4*, binding arbitration must be conducted in accordance with the rules and regulations of the American Health Lawyers Association, pursuant to the *Uniform Arbitration Act* as adopted in the State of Indiana at *Indiana Code 34-57-2-1 et. seq.*, unless the provider and the MCE mutually agree to an alternative binding resolution process.
- Timely processes for reporting Provider dispute data and decisions to the MCE Administration, Quality Management, Provider Relations and other affected MCE staff for consideration and resolution of claims processing or dispute process issues.

6.q Provider Directory

The MCE must develop a provider directory consistent with the requirements of *42 CFR 438.10(h)* and this contract. The MCE must develop and maintain a searchable electronic provider directory and a paper provider directory. The electronic directory on the MCE's website must be searchable by county and updated at least every two weeks. The paper directory must be updated at least monthly if the MCE does not have a mobile-enabled, electronic directory; or quarterly if the MCE has a mobile-enabled electronic directory. Copies of the provider directory in the format requested by the individual must be available upon request to:

- Members
- Members' Informal Caregivers
- FSSA staff
- Care planning and care coordination staff
- Interdisciplinary care team members.

The MCE may use the same provider directory for all of its Indiana Medicaid programs as long as the directory clearly designates which population(s) the provider serves. The provider directory must include providers that are under contract with the MCE including physicians, hospitals, pharmacies, behavioral health providers, specialists, specialty providers such as Community Mental Health Clinics, and LTSS/HCBS providers. The provider directory must include the following information for providers under contract with the MCE:

- Provider name as well as any group affiliation (individual practitioner, clinic or agency as appropriate) including primary care physicians, specialists and hospitals,
- Provider's practice setting street address(es), telephone number(s), website URL, (as appropriate), and for LTSS service providers, the service area,

- Services furnished by the provider,
- Provider specialty (as appropriate),
- The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract,
- Whether the provider is accepting new members. If a preferred provider is not accepting new members, the MCE must assist the member in obtaining an alternate provider,
- The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training, and
- Accessibility of the provider's premises (if the member will be receiving services at the provider's premises), including offices, exam rooms and equipment according to state and federal standards.

6.r Provider Education

The MCE must educate its contracted providers, including behavioral health providers, about provider requirements and responsibilities, the MCE's prior authorization policies and procedures, clinical protocols, member's rights and responsibilities, claim dispute-resolution process, pay-for-performance programs, and any other information relevant to improving services.

The MCE must provide ongoing education to the provider network on the *Indiana Pathways for Aging* program as well as MCE-specific policies and procedures. In addition to developing its own provider education and outreach materials, the MCE must coordinate with the State-sponsored provider outreach activities upon request. The MCE must educate its contracted providers regarding:

- Provider requirements and responsibilities
- Prior authorization policies and procedures
- Clinical protocols
 - If the MCE chooses to produce clinical practice guidelines (CPG) as education for providers on specific medical topics, they must limit those CPGs to a maximum of four every two years. These CPG are distinct from medical policy and utilization management (UM) criteria that inform UM decisions.
- Caring for vulnerable populations
- Member's rights and responsibilities
- Claims submission process
- Claims dispute resolution process
- Pay-for-outcomes programs
- Any other information relevant to improving the services provided to the MCE's *Indiana Pathways for Aging* members.

6.s Provider Complaint Resolution

- **Core Values**
 - Providers are service partners in *Indiana Pathways for Aging*
 - Accessible information on where providers submit complaints
 - Accountability in responding timely to providers with a complaint resolution
 - Personal level customer service to providers

The State requires *Indiana Pathways for Aging* MCEs to respond to complaints from providers concerning operational and claims disputes in a timely manner. The State uses information regarding disputed claims and other MCE operations to monitor and examine *Indiana Pathways for Aging*'s MCE compliance.

Provider complaints, whether submitted to the managed care entity from a provider, or from a member about a provider, present in different avenues:

- Procedures for credentialing with the State or the MCE
- Claim disputes from providers including denials, payment accuracy and timeliness
- Utilization disputes from providers
- System disputes from providers
- Inability to contact or obtain assistance from the MCE
- Miscommunication or confusion around MCE policy and procedures
- Lack of transparency from the MCE in requirements and expectations of providers

6.s.1 Complaints Received by MCE

The MCE must maintain a system for tracking and reporting the number and type of provider calls and inquiries. As part of the MCEs' Provider Feedback and Technical Assistance plan (outlined in section 7.5 of the *Indiana Pathways for Aging* scope of work), the MCE is required to submit reports on provider complaints outlining:

- date complaint was submitted to the MCE,
- name of submitting provider agency,
- complaint reason and narrative,
- date reviewed by the MCE,
- investigation activities performed by the MCE, and
- complaint resolution and date of resolution.

The State requires the MCE to provide training and technical assistance to MCE staff and providers about any change in policy/procedure that results from resolution of the complaint and provide this detail in the MCE's feedback report and quality improvement strategy submitted quarterly to the State. Training must occur upon provider onboarding as well as at least annually, or as needed to address provider questions or issues.

6.s.2 Complaints Received by the State About an MCE

The State will forward the complaint to the MCE for investigation and response. The State will send the Provider written notification of this referral. The MCE is required to respond in writing to both the Provider and the State by the State's set deadline to avoid assessment of liquidated damages.

The State will require the MCE to show proof that the MCE has done what it promised to avoid assessment of liquidated damages.

6.s.3 MCE Failure to Resolve

If the MCE fails to comply with any resolutions because of a provider complaint, providers will be instructed to notify State in writing. The State will require the MCE to demonstrate proof that the MCE has resolved the concern to avoid potential assessment of liquidated damages.

6.t Provider Qualifications and Standards

The MCE 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.u Practice Standards

There must be evidence that the MCE further enhances quality of service to its *Indiana Pathways for Aging* members by requiring PMPs to adhere to nationally accepted standards or guidelines for preventive care for women and adults.

The MCE must use or develop preventive health guidelines based on reasonable medical evidence and national guidelines. Guidelines adopted by the MCE must include those endorsed by the following:

- American Academy of Family Physicians (AAFP)
- American Society of Internal Medicine (ASIM)
- American College of Physicians (ACP)
- American College of Obstetrics and Gynecology (ACOG)
- U.S. Preventive Services Task Force
- American College of Surgeons
- National Cancer Institute (NCI)
- American Cancer Society

The MCE must provide evidence that it reviews the guidelines and scientific literature incorporated into the MCE's preventive health guidelines. Guidelines must be shared with the MCE's Quality Improvement Committee (QIC) and subcommittees, if any, and must include provider participation. The QIC and subcommittees must have opportunities to review, comment, and make modifications reasonable for local practices.

The guidelines must be appropriate for the full spectrum of the *Indiana Pathways for Aging* populations enrolled in the MCE. Primary and secondary prevention must be addressed for populations identified as high risk. Practice guidelines must include areas of study, methodology, indicators, analysis, plans for corrective action, follow-up, and assessment of effectiveness.

The MCE must provide evidence that supports how it shares preventive health guidelines with MCE providers, including new and existing providers. There must also be evidence that the MCE has plans for sharing new and revised guidelines. Communications can include provider newsletters, mailings, and provider manuals.

The MCE must establish mechanisms to monitor and review provider compliance and consistency in following preventive care guidelines. Barriers to treatment must be identified.

MCEs must publicize to members the availability of preventive health services, guidelines for these services and the recommended frequency or conditions under which prevention activities are required. MCEs may inform members through member newsletters, member orientation packets, member handbooks and targeted mailings.

Note: Additional evidence-based clinical practice guideline information is available at the [National Guideline Clearinghouse](#) website.

6.u.1 Additional Standards

MCEs are expected to have detailed practice standards for other patient conditions including the following:

- Breast cancer and mammography
- Cervical cancer and pap smears
- Human immunodeficiency virus/Acquired Immune Deficiency Syndrome (HIV/AIDS)
- Asthma
- Diabetes
- Hypertension
- Sexually transmitted diseases

- Cholesterol screening
- Prevention of influenza
- Tobacco dependence treatment
- Immunizations
- Domestic violence
- Autism Spectrum Disorder (ASD)

These standards are developed by the State's QIC, based on consultation with and recommendations from the following:

- IHCP physician providers
- Indiana medical community at large
- External Quality Review Organization (EQRO) and the Healthcare Effectiveness Data and Information Set (HEDIS)
- Federal Agency of Health Care Policy and Research (AHCPR)
- Centers for Disease Control and Prevention (CDC)
- IHCP Coordinated Care Technical Assistance Group (TAG)
- Other Department of Health and Human Services (DHHS) collaborative TAG committees.

A medical director and one other person knowledgeable about managed care, quality improvement, and data analysis represents MCEs on the QIC committee. MCEs must have practice standards in place for any of the previously listed or other conditions and must make these standards available to *Indiana Pathways for Aging* enrollees after review and approval by the State.

6.v Billing and Reimbursement Policies and Procedures

The MCEs and providers in their networks negotiate billing and reimbursement arrangements. These arrangements must support the MCE's general encounter data, utilization and other reporting requirements described in [Information Systems](#).

The MCE must pay providers for covered medically necessary services rendered to the MCE's members in accordance with standards set forth in *IC 12-15-13-1.6* and *IC 12-15-13-1.7* unless the MCE and provider agree to an alternate payment schedule and method. The MCE must pay or deny all electronically filed clean claims within 21 calendar days of receipt, with the exception of HCBS claims. The MCE must pay HCBS related electronically filed clean claims within seven calendar days of receipt. With regards to paper claims, the MCE must pay both HCBS related and non-HCBS related clean paper claims within 30 calendar days of receipt. If the MCE fails to pay or deny a clean claim within these time frames, but subsequently pays the claim, the MCE must also pay the provider interest, as required under *IC 12-15-13-1.7(d)*. A definition of a *clean claim* is set forth in *IC 12-15-13-0.6*. These standards apply to out-of-network claims for which the MCE is responsible and to any other claims submitted by providers that have not agreed to alternate payment arrangements.

While the MCE may choose to subcontract claim processing functions, or portions of those functions, with a State-approved subcontractor, the MCE must demonstrate that the use of such subcontractors is invisible to providers, including out-of-network and self-referral services, and does not result in confusion in the provider community about where to submit claims for payments.

For example, the MCE may elect to establish one post office box for submission of all out-of-network provider claims. If different subcontracting organizations are responsible for processing those claims, the MCE must ensure that the subcontracting organizations forward claims to the appropriate processing entity. Use of a method such as this does not lengthen the timeliness standards discussed in this section.

In this example, the definition of date of receipt is the date of a claim's receipt at the post office box.

6.v.1 Interest Payments to Noncontracted Providers

MCEs are financially responsible for interest payments on clean claims billed by noncontracted providers. The requirement ensures timely payment of claims for services provided to *Indiana Pathways for Aging* enrollees. Interest is payable in accordance with provisions set forth in *IC 12-15-13*. Claims for services rendered by providers contracted with the MCE are not subject to this provision.

6.v.2 Billing and Balance Billing IHCP Enrollees

IHCP and federal regulations specifically prohibit providers from charging IHCP enrollees for covered services, except in specific, limited circumstances. IHCP enrolled providers are required to accept the IHCP's determination of payment for covered services as payment in full, except for copayments and any other patient liability payment as authorized by law. The provider must maintain documentation that the member voluntarily chose to receive the service, knowing it was not covered by the program.

The [Provider and Member Utilization Review](#) provider reference module contains detailed information about billing IHCP members. Generally, IHCP enrolled providers can bill members only under the following conditions:

- The service is not covered under the IHCP (for example, cosmetic procedures).
- The member has exceeded the program limitation for a particular service.
- The member understands that the IHCP does not cover the service and accepts financial responsibility before receiving a service that is not covered by the program.
- The services provided are covered or noncovered embellishments or enhancements to covered services. These services can be considered and billed separately from the basic service only if a separate procedure, revenue, or National Drug Code (NDC) exists for the enhancement. Otherwise, a service in its entirety is considered covered or noncovered.
- The provider has taken appropriate action to identify a responsible payer, and the enrollee has failed to inform the provider of IHCP eligibility before the filing limit established by the MCE.

MCE contracted providers, as IHCP-enrolled, are subject to the same policy outlined previously. While the State and the Centers for Medicare & Medicaid Services (CMS) recognize that there may be circumstances unique to the managed care environment in which billing members may be appropriate, the State discourages this practice. If an MCE elects to permit its contracted providers to bill members under any circumstance, the MCE must do all the following:

- Develop sufficient safeguards to ensure that members can access medically necessary services.
- Ensure that members are not subject to any coercive practices.
- Ensure that members are informed of their right to file grievances.

The MCE can permit a provider to bill members for services that require authorization, but for which authorization is denied, if certain safeguards are in place and are followed by the provider. MCEs must establish, communicate, and monitor compliance with procedures that include at least the following:

1. The provider must establish that authorization has been requested and denied before rendering the service.
2. The provider can request MCE review of the authorization decision. The MCE must inform providers of the contact person, the means for contact, the information required to complete the review and procedures for expedited review, if necessary.
3. If the MCE maintains the decision to deny authorization, the provider must inform the member that the service requires authorization, and that the authorization has been denied. Covered services may be available without cost in the MCE if authorization is provided.
4. The member must be informed of the right to contact the MCE to file an appeal if the member disagrees with the decision to deny authorization.

5. The providers must inform members of member responsibility for payment if the member chooses to or insists on receiving the service without authorization.

If the provider chooses to use a waiver to establish member responsibility for payment, use of such a waiver must meet the following requirements:

- The waiver is signed only after the member receives the appropriate notification stated in requirements 3 and 4.
- The waiver does not contain any language or condition to the effect that if authorization is denied, the member is responsible for payment.
- Providers must not use nonspecific patient waivers. A waiver must be obtained for each encounter or patient visit that falls under the scenario of noncovered services.
- The waiver must specify the date the services are provided and the services that fall under the waiver's application.
- The provider must have the right to appeal any denial of payment by the MCE for denial of authorization.

6.v.3 Future Recovery Effort Due to Retroactive Medicare Eligibility

The MCEs must include the language below in any future recovery effort due to retroactive Medicare eligibility. This ensures providers are aware of their rights when billing Medicare beyond Medicare's standard timely filing limits and has helped Traditional Medicaid cut down on provider complaints.

Medicare regulations 42 C.F.R. §424.44(b) allows for exceptions to the one calendar year time limit for filing Medicare claims. Retroactive Medicare entitlement involving the State Medicaid Agencies, where a State Medicaid Agency recoups payment from a provider or supplier 6 months or more after the date the service was furnished to a dually eligible beneficiary, is an allowed exemption. Refer to Chapter 1, subsection 70.7 of the [Medicare Claims Processing](#) manual for qualifying exceptions and associated billing instructions.

Section 7: Quality Improvement and Utilization Management

7.a Quality Improvement

The State has established three overarching program quality goals for the *Indiana Pathways for Aging* program:

Indiana Pathways for Aging Program Quality Goals

Goal 1: Person-Centered Services and Supports

Develop service plans and deliver services in a manner that is person-centered, member-driven, holistic, involves caregivers, and addresses SDOH.

Goal 2: Ensuring Smooth Transitions

Ensure continuity of care and seamless experiences for members as they transition into the *Indiana Pathways for Aging* program or among providers, settings, or coverage types.

Goal 3: Access to Services (Member Choice)

Assure timely access to appropriate services and supports to enable members to live in their setting of choice and promote their well-being and quality of life.

Refer to 1.b for additional details [Program Quality Goals](#).

Because the State requires the MCEs to make ongoing investments to achieve lasting progress toward improved outcomes, the State is committed to maintaining the above goals for the first contract term and potential contract term extension years of the *Indiana Pathways for Aging* program.

The MCE must design its quality program in a manner that supports these goals to increase the likelihood that the MCE and the overall program will be successful. MCEs must develop and implement initiatives across the MCE's operational areas that will improve performance in the goal areas. Examples include the following:

- Member outreach and education campaign including targeted initiatives
- Education campaigns for provider organizations and for direct care providers
- Member and provider incentive programs
- Confidential provider performance reporting and feedback as well as technical assistance and, as needed, corrective actions
- Analyses of provider network composition and use of creative provider network recruitment and services
- Pulse surveys or check-ins with members to gauge their experience
- Use of robust and frequent data analysis to detect access concerns, disparities, underutilization, overutilization, at-risk individuals, and other opportunities to improve performance.

It is the State's expectation that the MCE as a whole – not solely the MCE's quality team – will understand these program goals and work cohesively to achieve these program goals. Furthermore, the MCE will be required to actively collaborate with the State and other *Indiana Pathways for Aging* MCEs to design and implement initiatives and interventions that support these overarching goals. This collaboration will be achieved through participation in formal committees and workgroups facilitated by the State, as well as by the execution of common strategies across MCEs. MCEs will be expected to share insights and best practices, and to actively participate in and contribute to these quality improvement activities.

7.a.1 Quality Program Expectations

The MCE must monitor, evaluate and take effective action to support the identified [Program Quality Goals](#) and address any needed improvements in the quality of care delivered to members in the *Indiana Pathways for Aging* program by all providers in all types of settings. In compliance with state and federal regulations, the MCE must submit quality improvement data, including data that meets Healthcare Effectiveness Data and Information Set (HEDIS) standards for reporting and measuring outcomes, that includes the status and results of performance improvement projects to the State. The MCE is required to submit accurate and timely data and reports, and to respond to any questions or address any reporting deficiencies identified by the State within three business days. Additionally, the MCE must submit information requested by the State to complete the *State's Annual Quality Assessment and Improvement Strategies Report* and *annual Core Set measures* to the Centers for Medicare & Medicaid Services (CMS).

The MCE's medical director must be responsible for the coordination and implementation of the QMIP. The program must have objectives that are measurable, realistic, and supported by consensus among the MCE's medical and quality improvement staff. Through the QMIP, the MCE must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to members. As a key component of its QMIP, the MCE will develop incentive programs for both providers and members, with the intent of encouraging appropriate utilization of healthcare resources and improving health outcomes of *Indiana Pathways for Aging* members. The MCE may establish different provider and member incentives for its *Indiana Pathways for Aging* populations to achieve these goals. All incentives must be submitted to the State for review and approval through the document review process.

As a part of the MCE's QMIP, the MCE must participate in the State's annual performance improvement program and other State directed quality activities. These can include meetings, reports, quality improvement measures and studies, and surveys.

The MCE must meet the requirements of *Code of Federal Regulations 42 CFR 438 subpart E* and the National Committee for Quality Assurance (NCQA), including but not limited to the following requirements, in developing its quality management program. The quality management program must ensure that it addresses the following:

- Assess quality and appropriateness of care provided to members with special health care needs and enrollees using long-term services and supports, including assessment of care between care settings and a comparison of services and supports received with those set forth in the enrollee's treatment/service plan.
- Complete performance improvement projects in a reasonable time to allow information about the success of performance improvement projects.
- Produce new information on quality of care at least annually.
- Collect and submit performance measurement data as required by this policy.
- Establish mechanisms to detect both the underutilization and overutilization of services.
- Participate in efforts by the State to prevent, detect, and remediate critical incidents.
- Participate in an annual review performed by a qualified external quality review (EQR) organization.

The MCE's Quality Management and Improvement Committee, in collaboration with the MCE's medical and pharmacy directors, must develop, approve, monitor, and evaluate the QMIP Description, Work Plan, and Annual Evaluation. Descriptions of these requirements are below:

- The *Quality Management and Improvement Program Description* will clearly outline an outcome- driven strategy for quality improvement. The strategy will include a detailed description of new goals and objectives based on findings from a variety of sources including but not limited to QI activities, EQR findings, Grievance and Appeals, survey results, and clinical and service quality indicators. The program description will clearly reflect alignment with the State's quality strategy with a focus on health equity and special populations. The MCE must also include its Quality Management and

Improvement Committee(s) structure(s) as part of the QMIP program description. The State will review the committee structure as part of the readiness review process to confirm that the MCE meets all committee requirements and has integrated committees into its larger quality infrastructure. The QMIP Description will be submitted to the State during readiness review and annually thereafter.

- The *Quality Management and Improvement Work Plan* is a working document that will track a broad range of activities and timelines as well as program goals and activities to support each goal. The work plan will be updated at least quarterly and will be submitted to the State quarterly. This document will include elements outlined by NCQA as well as line items to monitor activity and performance of closed and open quality improvement projects. The work plan must identify the MCE's quality management goals and objectives specific to *Indiana Pathways for Aging* and include a timeline of activities and assessments of progress toward meeting the goals. The MCE must be prepared to periodically report on its quality management activities to the State's Quality Strategy Committee.
- The *Quality Management and Improvement Program Evaluation* is an annual comprehensive quality program evaluation of the QI activities and goals related to the quality and safety of clinical care and services, and highlights gains in health outcomes over the year. It also documents areas where goals were not met and identifies barriers that contributed to unmet goals. The results of the QMIP Evaluation will drive updates to the subsequent year program description. The plan must meet NCQA standards for reporting and measuring outcomes.

7.a.2 Quality Management and Improvement Program (QMIP)

The MCE's QMIP shall address and support the *Indiana Pathways for Aging* Program Quality Goals, both for the pay-for-outcome (P4O) measures and any non-P4O focus areas, as a core component. The QMIP must also support quality improvement more broadly. To that end, the MCE must perform the activities listed below and must address each of these elements in its annual QMIP and QMIP work plan:

1. Measure and report to the State on its performance, using standard measures required or identified by the State or CMS, to determine the quality and appropriateness of care and services furnished to all enrollees. MCEs must capture all required measures as specified in the *MCE Reporting Manual*.
2. Complete up to three 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). This includes meeting requirements in the *MCE Reporting Manual* concerning demonstrating statistically significant improvement.
3. Implement up to three State-defined initiatives or interventions annually, in collaboration with other MCEs and in addition to those interventions implemented under QIPs', in support of the *Indiana Pathways for Aging* Quality Program Goals. This may include specific initiatives for Year 1, potentially including collaborative efforts among MCEs.
4. Design and implement at least one specific and measurable initiative, approved by the State, to support each of the State-defined *Indiana Pathways for Aging* 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 of the scope of work, each year to address equity. The initiative(s) must tie back to the State's equity strategies.
6. Actively participate in and contribute to program-wide quality improvement activities including the State's established quality improvement committees and to the design of quality improvement initiatives and interventions in collaboration with other MCEs 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. This shall include but not limited to survey data, call center data, complaint and grievance data, and input from the Member and Informal Caregiver Advisory Committee and the Health Equity and Cultural Competency Workgroup.

8. Produce all quality of care reports in the format and at the frequencies specified in the MCE Reporting Manual. This includes, but is not limited to:

- The required Prospective and Retrospective QMIP Report outlining the structure of all QIPs, outcomes, and outcomes of the three State-defined initiatives or interventions,
- The Performance Measure Monitoring Report outlining internal rates for each performance measure, identified barriers in meeting performance expectations, and a detailed analysis of MCE performance and trends, and
- Quality of care/service Investigations Report.

The MCE shall have a written document (updated and approved by the MCE Quality Committee at least annually) to describe its QMIP that clearly defines its quality improvement structures and processes and assigns responsibility to appropriate individuals.

The QMIP Description document shall be submitted to the State for approval during the readiness review process and then annually in advance of each contract year thereafter per the due dates established by the State. The plan must be pre-approved by the State before implementation each year.

The QMIP description shall include, at minimum, all minimum standards as defined in *42 CFR 438.330(b)*, and as follows:

- A written description of the annual and prospective quality goals and specific objectives for achieving those goals, the strategies and activities to be undertaken to support quality, and the procedures for monitoring results and assessing progress toward the goals
- Mechanisms to include member voice, needs, and wants in the development of the annual workplan including:
 - Developing and maintaining mechanisms, including but not limited to MCE's Member and Informal Caregiver Advisory Committee and Health Equity and Cultural Competency Workgroup, to solicit feedback and recommendations from members, family members, informal caregivers, and other key stakeholders, to monitor service quality and to develop strategies to improve member outcomes, health equity, and quality improvement activities related to the quality of care and system performance.
 - Procedures to conduct member and informal caregiver surveys as required and report these survey results to the State per the MCE Reporting Manual.
 - Procedures to develop and implement targeted strategies to improve health, functional, or quality of life outcomes. Procedures shall include specific mechanisms for correcting deficiencies, including the action to be taken, the timeframe, and the anticipated outcome.
 - Procedures to track, trend and address member, informal caregiver, and provider issues (e.g., call reasons, complaints, grievances, appeals, critical incidents, quality of care and service investigations, and claims disputes).
 - Other ways MCE will assess member experience and satisfaction, as applicable.
- Mechanisms to evaluate quality of care and utilization of services and supports including:
 - Detecting, at least on a quarterly basis, both underutilization and overutilization of services and supports, including service gaps for members receiving HCBS. This information should be reported in required service utilization reports as described in the *MCE Reporting Manual*.
 - Detecting, investigating, and tracking and trending potential quality of care and quality of service concerns
 - Assessing quality and appropriateness of care, including both physical and behavioral health as well as long-term services and supports for all members, with a special focus:
 - assessment of quality across care settings and a comparison of the services and supports actually received as set forth in the member's service plan. This also includes the timelines of service and support.

- Participation in State efforts to prevent, detect, and remediate critical incidents for members receiving HCBS. Efforts to manage and reduce critical incidents must be documented as required in the State's Critical Incident Management policy manual.
- Mechanisms to understand and assess members' social determinants of health (SDOH) and to promote connections with social services providers that will address member needs.
- Mechanisms to detect, evaluate, and address identified disparities in health care, service delivery, and outcomes. The MCE must describe its plans for addressing health disparities in its QMIP description, work plan, and evaluation. The MCE must include its approach for capturing and maintaining health equity information in its systems, including stratification by subpopulations (and including any specific subpopulations required by the State). Additional reporting requirements for health disparities may be implemented by the State in the future.
- An approach to monitor, evaluate and take effective action to identify and address any needed improvements in the quality of care delivered to members in the *Indiana Pathways for Aging* program by all providers in all types of settings, including but not limited to:
 - The identification of key measures of performance, discovery and data collection processes, identification and remediation of issues, and systems improvement activities. The MCE will be required to report on standard measures identified by the State.
 - Establishment of processes to measure, evaluate and improve provider network quality including but not limited to credentialing and recredentialing; provider performance on quality measures; network adequacy, variation in practice patterns and identification of outliers.
 - Mechanisms to take appropriate action to address service delivery, provider, and other quality management and improvement issues as they are identified, including but not limited to Performance Improvement Plan (PIP) and Quality Improvement Plans (QIP) as specified by the State and CMS.
 - Meeting the desired performance levels established by CMS upon release of the national performance measures, in accordance with 42 CFR 438.330(a), which allows CMS to specify measures and topics for performance improvement projects.
 - Analysis of the effectiveness of implemented interventions, to include targeted interventions, to address the unique needs of populations and subpopulations served, including a focus on equity across subpopulations.
- Data collection and monitoring efforts must, at a minimum:
 - Incorporate evidence-based clinical guidelines and use of Healthcare Effectiveness Data and Information Set (HEDIS) rate data, survey results, service plans, claims data, and data from other similar sources to periodically and regularly assess the quality and appropriateness of care provided to members.
 - Collect and analyze data on and by race, ethnicity, and language (REL), at a minimum as required by NCQA and State reporting requirements. As part of the program description, MCE shall include its efforts to identify and address health disparities, as well as outline the methodology utilized for collecting the data, as well as any interventions taken to enhance the accuracy of the data collected. The State may specify particular REL and other stratifications to be required.
- Collect measurement indicator data related to State-specified areas of clinical priority and quality of care, which the State will establish. Include procedures to report national performance measures developed by CMS, as well as other State-required performance measures, including member-specific data, as required by the State.
 - Incorporate to the extent possible all relevant data required in the State Medicaid Agency Contract (SMAC) for MCE's aligned Dually eligible Special Needs Plan (D-SNP) that would inform all State-defined goals and priorities outlined herein. This would include all CAHPS and HEDIS data collected as well as any additional quality data required by the State.

- Include procedures for collecting and assuring accuracy, validity and reliability of performance outcome rates that are consistent with protocols developed in the public or private sector. (The CMS website contains an example of available protocols.)
- Procedures to contract for an NCQA-accredited HEDIS audit.
- A plan and procedures to provide training and technical assistance to participating providers, including quality-related and data collection topics (i.e., to support HEDIS).
- Mechanisms to align provider and member incentives with *Indiana Pathways for Aging* Quality Goals, as well as (if desired) other MCE-defined goals as applicable:
 - Strategies designed to promote practice patterns, which shall be consistent with evidence-based practice guidelines through the use of education, technical assistance and financial incentives, and the plan should outline how the MCE will share any pay for outcomes (P4O) dollars with providers.
 - Procedures for a provider Value Based Payment program as required.
 - Procedures for provider and member incentive programs.
- Other structural components and identification of resources including, at a minimum:
 - The MCE's guiding philosophy and framework for quality management, including any nationally recognized, standardized approach that is used (e.g., PDCA, Rapid Cycle Improvement, FOCUS-PDCA, Six Sigma).
 - Written policies and procedures for quality improvement. Policies and procedures must include methods, timelines and individuals responsible for completing each task.
 - Devoted resources including staffing, data sources and analytical resources.
 - The mechanism within MCE's organization for the governing body to provide strategic direction for the QMIP, and for the QI program committee to communicate with the governing body.
 - Specific training about quality that shall be provided by MCE to staff serving in the QI program committee.
 - Quality Management and Improvement Committee structure, including development of subcommittees and task forces, and the committee's role in monitoring and evaluation of quality and appropriateness of care provided to enrollees.
 - A description of the MCE's quality committee structure, including committee governance. This includes the Quality Management and Improvement Committee, as well as the Member and Informal Caregiver Advisory Committee structure, approach to assuring the Committee membership is representative of MCE's *Indiana Pathways for Aging* membership, and the committee's role in reviewing and advising on quality and appropriateness of care, as well as MCE's approach to initiatives and interventions to improve quality.
 - As determined by the State, revisions to established standards and their respective elements that the State determines are necessary to ensure compliance with changes to federal or State statutes, rules, and regulations.

QMIP Work Plan Requirements

The MCE shall submit its QMIP work plan to the State during the readiness review. The initial work plan shall include start-up activities and processes that include ongoing monitoring and management, and rapid-cycle reporting, feedback loop, and meeting cadence with the State during the implementation phase. Annually thereafter and at least 45 days prior to each contract year, the MCE shall provide the State an annual written work plan, informed by the annual QMIP evaluation, that details the MCE's proposed quality assurance and performance improvement projects and initiatives for the year. The State retains the right of advance written approval and to review on an ongoing basis all aspects of the QMIP, including subsequent changes.

The plan shall identify MCE's quality management goals and objectives (which should be consistent with *Indiana Pathways for Aging* Quality Goals) and include a timeline of activities and assessments of progress

towards meeting those goals. The plan shall be specifically targeted for *Indiana Pathways for Aging* and shall not cover other states or lines of business and shall include prospective activities over a four-year period. The plan shall meet NCQA HEDIS standards for reporting and measuring outcomes, and shall include all of the following elements:

- Description of specific activities to support *Indiana Pathways for Aging* Quality Goals
- Identification of individuals responsible and timelines for each activity
- Demonstration of participation, as directed by the State, in collaborative efforts with the State and other *Indiana Pathways for Aging* MCEs
- Inclusion of objectives that are measurable, realistic, and supported by consensus among MCE's medical and quality improvement staff
- The MCE shall include program activities to improve disparities identified through data collection and make performance data available to providers, members, and informal caregivers
- Demonstration that its quality improvement program is integrated throughout the organization
- Efforts toward implementing enrollee-targeted programs that result from areas for improvement identified through readiness reviews, focused studies, and internal quality improvement efforts.

The program description, work plan, and program evaluation shall be exclusive to *Indiana Pathways for Aging* and shall not contain documentation from other State Medicaid programs or product lines operated by the MCE. However, the State reserves the right to add a requirement for a coordinated or combined quality work plan with MCE's D-SNP and Medicare Advantage plans.

If the State determines that the MCE is not in compliance with the expectations outlined in this policy for quality management, including but not limited to failing to supply the required work plan, submit data, or failing to maintain sufficient quality oversight, the MCE may be subject to a Corrective Action Plan (CAP) until the issues are satisfactorily addressed.

The *MCE Reporting Manual* contains additional specifications regarding the annual QMIP work plan and Quality Improvement Evaluation, which may be amended from time to time by the State. MCE shall provide quality program progress reports via Quality Improvement Workplan updates to the State on no less than a quarterly basis. The MCE must be prepared to periodically report on its quality management activities to the State's Quality Committee.

Annual QMIP Evaluation and Update

The MCE must conduct an annual evaluation of its QMIP consistent with state and federal regulations. This evaluation must review the impact and effectiveness of MCE's QMIP including performance on standard measures and MCE's performance improvement projects. This should include internal rates for each performance measure in accordance with measure specifications and an analysis of the results against performance standards and historical performance. The MCE must identify quality improvement activities that resulted in measurable, meaningful, and sustained improved health care outcomes for the *Indiana Pathways for Aging* population. The State will look for the MCE to show statistically significant improvement. The MCE will describe the quality strategies, including quantitative evidence of improvements, lessons learned, and how the quality improvement outcomes will influence future activities. To the extent provider and/or member incentives are utilized as a strategy to impact a quality goal, the evaluation should reflect the impact of the incentive toward achieving the goal. The MCE must submit the written evaluation to the State per the *MCE Reporting Manual*.

In addition to the required elements outlined in the *MCE Reporting Manual*, a complete evaluation should reflect key topics such as:

- Effectiveness of delegation oversight
- Monitoring of provider compliance
- Trends in quality-of-care concerns and how they are used in developing quality improvement initiatives

- Reporting of critical incidents and similar quality of care concerns
- Monitoring of long-term care facilities and other service sites
- Member experience
- Effectiveness of initiatives to improve health equity

The State expects the MCE to follow-up on EQR recommendations and demonstrate proof of follow-up via both the evaluation and the work plan.

The MCE must make a summary of its QMIP evaluation available on a public web page associated with MCE. The MCE must prominently feature the description of major workplan initiatives including at least one quality improvement activity each year that addresses equity. The web page must be updated annually by February 28 each contract year. The State holds the right to publish the website link on the State's public website and accept public comments. The MCE will be held responsible to respond to public comments within 30 days.

Staff and Delegation of Quality Program Activities

The MCE shall have qualified staff to manage quality program activities. The MCE shall establish minimum employment standards and requirements for employees who will be responsible for quality improvement (e.g., education, training, and experience). The MCE's Medical Director shall be responsible for the coordination and implementation of the QMIP. The MCE shall include at least one designated professional with expertise in the assessment and delivery of LTSS who will be substantially involved in the quality program.

Staffing requirements include the following expectations:

- The MCE shall maintain an organizational chart that states the employees responsible for quality improvement, their titles and responsibilities, and the time allotted to that employee. This organizational chart shall reflect all full and part time staff, as well as the reporting structure. This organizational chart shall also reflect the oversight role of the Medical Director.
- The MCE shall maintain a list of qualifications for each staff position, including, as identified above, education, training, and experience, and staff each role accordingly.
- The MCE shall ensure that the designated professional(s) with expertise in the assessment and delivery of LTSS are clearly identified.
- The MCE shall ensure that the designated quality professional(s) are skilled in Quality Improvement methodology. It is highly recommended that quality staff obtain a quality certification such as Certified Professional in Healthcare Quality or receive quality Improvement training such as that offered by the Institute for Healthcare Improvement.
- The MCE shall maintain a training plan for educating staff on how to identify quality of care issues and the process for escalating those concerns.
- The MCE retains responsibility for and provides oversight and evaluation of any delegated QI activities.

7.a.3 QMIP Committee and Peer Review Committee

The MCE's Medical Director, LTSS Program Manager, and Pharmacy Director shall be active members in MCE's *Indiana Pathways for Aging* Quality Management and Improvement Committee. The committee shall be representative of management staff, including provider relations, LTSS support staff, and other department heads, as well as include stakeholders such as members, aging and disability-led advocacy groups, medical and behavioral health providers, LTSS providers, community partners, advocates, caregivers, and subcontractors as appropriate. Subcontractors providing delegated direct services to members shall be represented on the committee.

The Quality Management and Improvement Committee shall meet at a minimum of quarterly or more frequently as needed. The responsibilities of the Committee include:

- Reviewing and approving any changes to the Quality Management program description, work plan, and/or evaluation,
- Monitoring and review of work plan execution, performance on quality and outcome measures, and progress towards goals and performance of QIP initiatives,
- Reviewing and approving any changes to quality management policies and procedures,
- Track and manage responsibilities of quality management staff and assess compliance with program expectations, and
- Manage the dissemination of information to providers regarding quality outcomes.

If the Committee identifies changes that must be made to quality management operations due to a deficiency, the meeting notes shall clearly note the issue and the accountability, timeframe, and steps taken to resolve it.

The Quality Management and Improvement Committee is one component of the MCE's committee structure. The MCE is expected to have a larger formal committee structure in place, including other committees, sub-committee, work groups, and task forces that support the achievement quality goals and objectives.

MCE shall notify the State of upcoming Quality Management and Improvement Committees 10 business days prior to the meeting date and submit the agenda. The MCE shall submit minutes of these meetings to the State within seven calendar days following each meeting. The State will maintain the option to attend any Quality Management and Improvement Committee meeting.

7.a.4 Waiver Assurances

The State must meet Federal requirements for the 1915(c) waiver(s) that provide authority to implement the *Indiana Pathways for Aging* program. Further State instructions will be communicated to the MCEs as reporting parameters are determined.

7.a.5 External Quality Review

Pursuant to federal regulation, the State shall arrange for an annual, external independent review of each MCE's quality of timeliness and adequate access to health care services. The MCE shall provide all information required for this review in the timeframe and format requested by the external quality review organization. The MCE shall cooperate with and participate in all external quality review activities.

As a distinct component of annual quality reporting, the MCE must detail its efforts in implementing the recommendations made in the EQR report. The MCE is also required to identify a list of best practices undertaken to improve care and outcomes. EQR recommendations must also be reported into the QIMP Committee.

7.a.6 Incentive Programs

The State requires MCEs to participate in a pay-for-outcomes program that focuses on rewarding MCEs' efforts to improve quality and outcomes for *Indiana Pathways for Aging* members. The State will provide, at minimum, financial performance incentives to MCEs based on performance targets in priority areas established by the State. The State reserves the right to revise measures on an annual basis and will notify the MCE of changes to incentive measures in advance. See Exhibit 2 for additional information.

Value-Based Payment

The State will use Value Based Payment (VBP) as a tool in *Indiana Pathways for Aging* quality framework to leverage the managed care model toward a health care system where members' experience and health outcomes are satisfactory and demonstrate improvement. Additionally, VBP is intended to hold health care providers accountable for cost and quality of care provided. This includes all provider types including nursing facilities and HCBS services. The State reserves the right to establish VBP methodologies that MCEs must implement. The MCE shall routinely collect, update, report, and reconcile to the State, data on

MCE's efforts and progress towards achieving the goals of the *Indiana Pathways for Aging VBP Program*. The MCE shall also submit reports for any additional MCE-defined VBP arrangements, as applicable. In addition to State requirements, the MCE shall establish internal procedures to assess VBP initiatives for effectiveness and equity.

The MCE shall support their respective providers with technical assistance to promote engagement and program success.

MCE Pay-for-Outcomes (P4O) Quality Incentive Programs

The State shall require MCEs to participate in a P4O program that focuses on rewarding MCEs' efforts to improve quality and outcomes for *Indiana Pathways for Aging* members. The P4O program will at a minimum incentivize objectives that support the Program Quality Goals but may be used to support additional State goals. Incentive payment performance may be made available to stakeholders and the public.

In Years 2 through 4, the State shall also have the right to require MCE to invest a portion of the P4O payment in infrastructure that supports the *Indiana Pathways for Aging* Quality Goals or to distribute a portion of the P4O payment to its network providers in support of the *Indiana Pathways for Aging* Quality Goals. The State will notify MCE of such requirements at least 180 days before their effective date.

If applicable, the MCE must also invest P4O payments as required in Exhibit 2 *Contract Compliance and Pay for Outcomes* policy in a manner that supports the *Indiana Pathways for Aging* Quality Goals through contributions to infrastructure or distribute a portion of the P4O payment to its network providers.

Provider Incentive Programs

MCEs must establish a performance-based incentive system for its providers. Different provider incentives may be established for the MCE's *Indiana Pathways for Aging* providers. The MCE will determine its own methodology for incenting providers. The MCE must obtain State approval 30 days prior to implementing its provider incentive program and before making any changes thereto. The State encourages creativity in designing pay for performance programs.

The MCE is encouraged to establish, at a minimum, one provider incentive program aligned with each of the *Indiana Pathways for Aging* Quality Goals. The MCE is also encouraged coordinate these incentives to align with program-wide initiatives and, potentially, with incentive programs employed by other *Indiana Pathways for Aging* MCEs to increase the likelihood of achievement of the *Indiana Pathways for Aging* Quality Goals.

If the MCE offers financial incentives to providers, these payments must be above and beyond the standard Medicaid fee-for-service Fee Schedule.

Section 1876(i)(8) of the *Social Security Act* and federal regulations 42 CFR 438.10(f)(3), 42 CFR 422.208 and 42 CFR 422.210 provide information regarding physician incentive plans. The MCE must comply with all federal regulations regarding the physician incentive plan and supply to the State information on its plan as required in the regulations and with sufficient detail to permit the State to determine whether the incentive plan complies with the federal requirements. The MCE must provide information concerning its physician incentive plan, upon request, to its members and in any marketing materials in accordance with the disclosure requirements stipulated in the federal regulations. Similar requirements apply to subcontracting arrangements with physician groups and intermediate entities.

Physician incentive plans must comply with the following requirements:

- The MCE will make no specific payment directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual member.
- The MCE meets requirements for stop-loss protection, member survey and disclosure requirements under 42 CFR 438.10(f)(3).

The MCE is required, for any provider incentives offered, to collect data and assess the impact of the incentives toward achieving their intended purpose. Results of the impacts achieved (including take-up rate) must be included in quality workplan updates and program reports to the State.

Member Incentive Programs

MCEs must establish member incentive programs to encourage appropriate utilization of health services and healthy behaviors. Member incentives may be financial or nonfinancial. The MCE will determine its own methodology for incenting members. For example, the MCE may offer member incentives for:

- Obtaining recommended preventive care (including dental)
- Completion of recommended treatment for a prevention and wellness program, care management or complex case management program
- Making healthy lifestyle decisions such as quitting smoking or losing weight
- Completing a health screening.
- Encouraging appropriate utilization of health care services and long-term services and supports
- Increasing adherence to keeping medical appointments
- Encouraging the receipt of health care services in the appropriate treatment setting

The MCE must establish, at a minimum, one member incentive program aligned with each of the *Indiana Pathways for Aging* Quality Goals. The MCE is encouraged coordinate these member incentives to align with program-wide initiatives and, potentially, with incentive programs employed by other *Indiana Pathways for Aging* MCEs. This will increase the likelihood of achievement of the *Indiana Pathways for Aging* Quality Goals.

The MCE may not offer gifts or incentives greater than \$300 for each incentive unless an exception is approved by the State. Incentives may not be disproportionate to the value of the service provided, as determined by the State. The MCE may petition the State for authorization to offer items or incentives greater than \$300. Additionally, MCEs must comply with requirements found in *42 CFR 1003.110* for *Indiana Pathways for Aging* materials that describe member incentive programs. MCEs must only advertise incentives to current members through mediums such as the member handbook or letters or telephone calls directed to current membership.

To obtain approval for any member incentive programs and all enhanced services proposals, MCEs must use the established Enhanced Services review process to facilitate the State's review. The MCE is responsible for describing the goals of the program, time frame, target population, program criteria, outreach methodology, incentives proposed, and monitoring and evaluation methods. Additionally, the MCE must demonstrate that the incentive proposed does not surpass the value of the preventive care service provided. Petitions to provide enhanced incentives for preventive care will be reviewed on a case-by-case basis and the State retains full discretion in determining whether the enhanced incentives will be approved.

In any member incentive program, the incentives must be tied to appropriate utilization of health services and/or health-promoting behavior. The MCE must comply with all marketing provisions in the *42 CFR 438.104*, as well as federal and State regulations regarding inducements. Examples of appropriate rewards include gift certificates for groceries or phone cards.

The MCE must obtain State approval before implementing its member incentive program and before making any changes. It is required that the MCE establish, at a minimum, one member incentive program aligned with each of the *Indiana Pathways for Aging* Program Quality Goals.

As with provider incentives, for any member incentives offered, the MCE is required to collect data and assess the impact of the incentives toward achieving their intended purpose or unintended consequences. Results of the impacts achieved (including take-up rate) must be included in quality workplan updates and program reports to the State.

The State reserves the right to prospectively end its approval of an MCE's member incentive program based on these results.

7.a.7 Critical Incidents

Critical incident management is an essential MCE responsibility to ensure the safety and welfare of *Indiana Pathways for Aging* members as well as the overall success of the program. The MCE is required to develop, maintain, and execute policies and procedures regarding reporting and management of critical incidents as outlined in the *Indiana Pathways for Aging* scope of work. Additionally, the State has published a Critical Incident Management policy manual for MCEs. The MCE shall ensure all policies are compliant with all State guidance including the documents forementioned, and Indiana Code and Indiana Administrative Code.

Critical incidents are categorized as **(1)** HCBS critical incidents, **(2)** Abuse, Neglect, and Exploitation (ANE) critical incidents, and **(3)** all other critical incidents. For all types of critical incidents defined by the State, MCEs are responsible for obtaining and complying with the most current information, including definitions, contact information, and details on relevant reporting processes.

The Critical Incident policy manual outlines expectations for the MCE to educate their staff, provider network, and members/caregivers about CIs and how to report them.

If the MCE perceives an immediate threat to the member's life or safety, it should follow emergency procedures which may include calling 911.

The MCE shall refer to the *Indiana Pathways for Aging* scope of work and the State's *Critical Incident Management* policy manual for full guidance and responsibilities for critical incident management.

7.a.8 Mortality Review Committee

The State shall create a mortality review committee to review circumstances of member deaths to explore root causes and identify interventions to prevent future deaths. The MCE is required to participate per State direction. Participation may include the MCE sharing member medical information, claims history, care management notes, and other pertinent documentation.

7.b Utilization Management Program

The MCE must operate and maintain its own utilization management program.

The MCE may place appropriate limits on coverage on the basis of medical necessity, provided the services furnished can reasonably be expected to achieve their purpose. The MCE 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 MCE 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 MCE shall not use improvement in function as a criterion for approving continuation of services that enable the member to maintain their health status or prevent the member from experiencing a more significant decline.

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

7.b.1 Utilization Management Staffing and Training

Utilization management (UM) staff must receive ongoing training regarding interpretation and application of the utilization management guidelines. The MCE must be prepared to provide a written training plan, which shall include dates and subject matter, as well as training materials, upon request by the State. The State reserves the right to standardize certain parts of the prior authorization reporting process across the MCEs,

such as requiring the MCEs to adopt and apply the same definitions regarding approved, pending, denied, or modified authorizations, etc. When adopted, these standards will be set forth in the *MCE Reporting Manual*.

The MCE shall staff and operate a utilization management helpline during business hours and, per NCQA standards, have a method to take in requests after normal business hours. The helpline staff shall be equipped to provide customer service to providers with authorization and coverage questions and authorize post-emergency department stabilization services.

When the MCE 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.

Licensed physicians or licensed doctorate-level behavioral health clinicians who have appropriate clinical expertise in the treatment of a member's condition or disease must make all medical necessity 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 MCE is required to have a full time Geriatrician (see Key Staff requirements) with oversight of utilization management to review all denials of prior authorization requests. Only physicians licensed in Indiana, or a licensed doctorate-level behavioral health clinician may deny a service authorization request based on medical necessity criteria.

The MCE shall not provide incentives to utilization management staff or to providers for denying, limiting, or discontinuing medically necessary services. The State may audit MCE denials, appeals and authorization requests. The MCE shall adhere to the requirements and timelines for prior authorization as described in Section 3.22 in the *Indiana Pathways for Aging* scope of work regarding transitions and continuity of care. The State 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 MCE may be required to comply with such waivers and will be provided with prior notice by the State.

7.b.2 Medical Service and Pharmacy Prior Authorization (Non-HCBS Services)

The MCE will ensure that the State's mandatory medical criteria hierarchy, pictured below and discussed in the following section, is utilized for all authorization review.

Figure 1 – Medical Criteria Hierarchy Pyramid

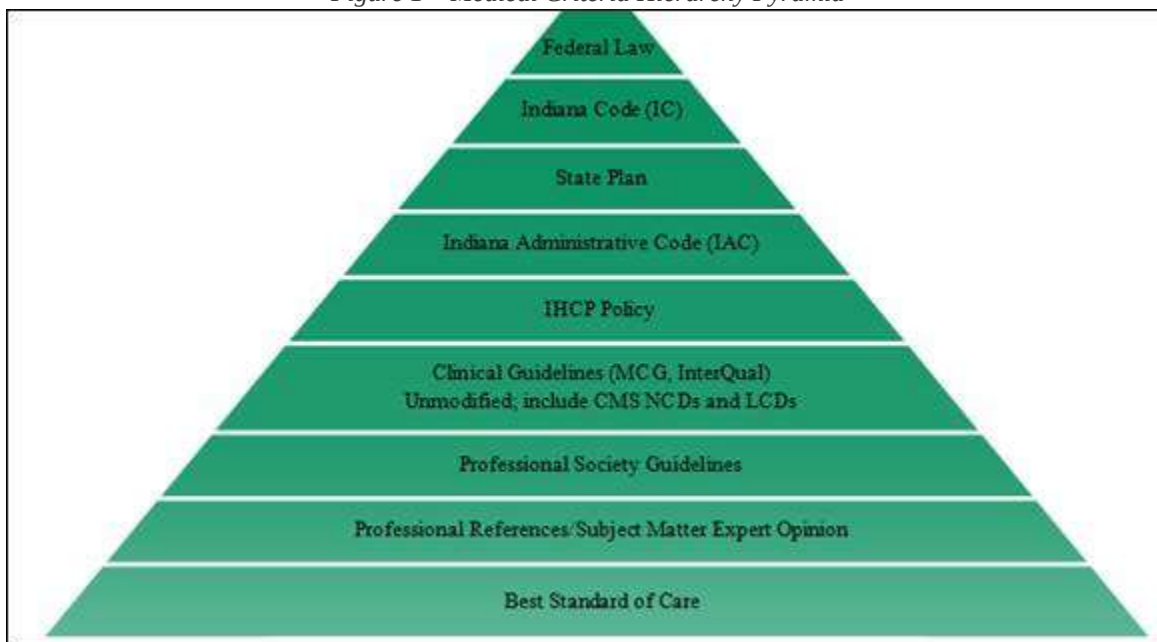


Image Alt Text: Figure 1 – Medical Criteria Hierarchy Pyramid (from top to bottom): 1. Federal Law, 2. Indiana Code (IC), 3. State Plan, 4. Indiana Administrative Code (IAC), 5. IHCP Policy, 6. Clinical Guidelines (MCG, InterQual) Unmodified; include CMS NCDs and LCDs, 7. Professional Society Guidelines, 8. Professional References/Subject matter Expert Opinion, 9. Best Standard of Care (End of list).

7.b.3 Mandatory Medical Criteria Hierarchy

The following utilization management medical criteria hierarchy is in effect for all managed care programs beginning April 1, 2023.

For select items, MCEs must use IHCP Policy as outlined below. For all other items where the State has criteria or guidelines in place, the MCE cannot have criteria or guidelines that are more restrictive. The MCE must use the full suite of non-company customized InterQual or Milliman Care Guidelines (MCG) clinical guidelines, inclusive of Medicare National Coverage Determinations and Medicare Local Coverage Determinations. For areas not addressed by IHCP Policy and MCG/InterQual, the MCE may develop their own prior authorization-medical necessity guidelines and criteria. In accordance with 438.210(b) the MCE must consult with contracting health care professionals when developing their own practice guidelines. All MCE developed prior authorization-medical necessity guidelines and criteria must be approved by the State and made available to the State prior to implementation of said guidelines and criteria. The hierarchy for clinical criteria and guidelines is outlined below.

Medical review criteria must follow the following hierarchy:

- 1. Federal law** – All review criteria must comply with federal law (if the Code of Federal Regulations has any Medicaid-specific requirements—Indiana Medicaid must comply)
- 2. Indiana Code**—All review criteria must comply with Medicaid-specific provisions of the Indiana Code
- 3. State Plan**—Review criteria are subject to the terms of the state plan (which is our agreement with CMS outlining the coverage and reimbursement of Indiana Medicaid services)
- 4. Indiana Administrative Code**—All review criteria must comply with Medicaid-specific provisions of the Indiana Administrative Code (which is given authority from the Indiana Code)
- 5. IHCP Policy**—This includes Provider Reference Modules, Bulletins, Banners.

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

- **ABA Therapy:** Bulletins
 - <http://provider.indianamedicaid.com/ihcp/Bulletins/BT201867.pdf>
 - <http://provider.indianamedicaid.com/ihcp/Bulletins/BT201953.pdf>
 - Module - <https://www.in.gov/medicaid/providers/files/behavioral-health-services.pdf>
- **Drug Testing:** Bulletins
 - <http://provider.indianamedicaid.com/ihcp/Bulletins/BT201846.pdf>
 - <http://provider.indianamedicaid.com/ihcp/Bulletins/BT202183.pdf>
 - Module - <https://www.in.gov/medicaid/providers/files/laboratory-services.pdf>
- **EndoPredict-Breast Cancer:** Bulletin
 - <http://provider.indianamedicaid.com/ihcp/Bulletins/BT202010.pdf>
- **Hysterectomies:** Bulletin
 - <http://provider.indianamedicaid.com/ihcp/Bulletins/BT201976.pdf>
 - Module - <https://www.in.gov/medicaid/providers/files/obstetrical-and-gynecological-services.pdf>

- **ReliZorb:** Bulletin
 - <http://provider.indianamedicaid.com/ihcp/Banners/BR202050.pdf>
 - **Speech Generating Devices:** Bulletin
 - <http://provider.indianamedicaid.com/ihcp/Bulletins/BT202012.pdf>
 - **Spinal Stenosis:** Bulletin
 - <http://provider.indianamedicaid.com/ihcp/Bulletins/BT2020111.pdf>
 - **Transplants:** Bulletin
 - <http://provider.indianamedicaid.com/ihcp/Bulletins/BT202019.pdf>
 - Module- <https://www.in.gov/medicaid/providers/files/surgical-services.pdf>
 - **Bariatric Procedures:** Bulletin
 - <http://provider.indianamedicaid.com/ihcp/Bulletins/BT202240.pdf>
 - Module - <https://www.in.gov/medicaid/providers/files/surgical-services.pdf>
 - **Oxygen Usage:** Bulletin
 - <http://provider.indianamedicaid.com/ihcp/Bulletins/BT202242.pdf>
 - Module - <https://www.in.gov/medicaid/providers/files/durable-and-home-medical-equipment-and-supplies.pdf>
- 6. Non-Customized National Clinical Guidelines** – The MCE may choose to use either InterQual or MCG but must use the full suite of review criteria in these platforms—including the Medicare National Coverage Determinations (NCDs) and the Medicare Local Coverage Determinations (LCDs).
- If an item is covered by MCG or InterQual—the MCE must use the applicable MCG or InterQual guideline in lieu of an MCE-derived guideline.
 - The MCG and InterQual guideline hierarchy is as follows:
 - Must use diagnosis or procedure-specific guidelines before more general guidelines.
 - Medicare (MCR) guidelines are to be used in this order: NCDs, then LCDs for Indiana
- 7. MCE-derived Guidelines** (must be pre-approved by the State)
- Professional Society Guidelines**—Guided by published peer-reviewed literature (can supersede National and MCE-derived guidelines if specifically called out to be used in the scope of work i.e., ASAM)
- 8. Professional References/SME**—Guided by published peer-reviewed literature
- 9. Best Standards of Care**—Guided by published peer-reviewed literature

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

7.b.4 Special Consideration for Long Term Services and Supports (LTSS) Service Authorization

The MCE 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 PASRR approval, the MCE will not deny an authorization for the member to receive necessary care in a nursing facility. Likewise, the MCE will 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.

Home and Community Based Services (HCBS) Service Authorization

The MCE'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 MCE's prior authorization processes will 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 MCE will 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 in the *Indiana Pathways for Aging Pathways* scope of work; additional information is also available in the *Indiana Pathways for Aging Care and Service Coordination Manual*. The MCE 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 request). The MCE 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.

Interdisciplinary Care Team (ICT) staff will prepare service authorizations in accordance with the MCE's approved service authorization policies and procedures and Section 7.8.1 of the *Indiana Pathways for Aging* scope of work. For LTSS and HCBS services, the MCE must seek State approval of its service authorization policies and procedures as part of its annual Care Coordination program plan.

For LTSS and HCBS services, the MCE shall authorize services and supports as determined through the Comprehensive Health Assessment Tool (CHAT), LTSS-specific assessment process, and person-centered service plan. If members have engaged in Care Coordination activities prior to meeting with their Service Coordinators, Service Coordinators must use any applicable information discovered during those Care Coordination activities, including member goals and/or preferences captured in Individualized Care Plans, to inform service plan development.

The Service Coordinator must obtain the electronic or written signatures of the member, member's designated representative (if applicable), providers, and any others involved in and/or responsible for the service planning process and its implementation. Signatures indicate the individuals participated in the process, they approve and understand the services outlined in the service plan as integrated into the ICP, and that services are adequate and appropriate to the member's needs. The service plan is not considered complete until all of the required signatures are received.

A member may also sign indicating disapproval of the service plan if the member disagrees with them service plan. When this occurs, the Service Coordinator must provide the member with a denial notice within two business days that includes their right to file a grievance and assist the member through the process as appropriate. A copy of the signed service plan is given to the member as well as all ICT participants.

The State reserves the right to require the MCE to submit service plans 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 or if a service plan is denied. **All service plan** submissions must include a copy of the denial letter, a copy of the care plan, a copy of the most recent Comprehensive Health Assessment Tool (CHAT), and any other MCE-specific assessments used.

The MCE must honor existing service plans for 180 days following implementation in alignment with continuity of care requirements stated in Section 3.22 in the *Indiana Pathways for Aging* scope of work, unless the member requires an increase in HCBS.

7.b.5 Established Utilization Management Policy

The MCE must have sufficient staff with clinical expertise and training to interpret and apply utilization management criteria to providers' requests for healthcare or service authorizations. Utilization management staff must receive ongoing training regarding interpretation and application of the utilization management

guidelines. The MCE must be prepared to provide a written training plan, which must include dates and subject matter, as well as training materials, upon request by the State.

If the MCE chooses to use separate medical policy for physical health and behavioral health services, the MCE must demonstrate that using separate policy would have no negative impact on members and would not otherwise violate the MCE's requirements under the *Mental Health Parity and Addiction Parity Act* (MHPAEA). Pursuant to 42 CFR 438.210(b), the MCE must consult with contracting healthcare professionals in developing medical policy; the MCE must also have mechanisms in place to ensure consistent application of review criteria for authorization decisions and must consult with the provider that requested the services, when appropriate. The MCE must conspicuously publish on their member and provider websites which national clinical policy (MCG or InterQual) they utilize for PA/UM adjudication.

MCEs must publish their prior authorization procedures on the MCE website at least 45 days before the effective date. Any updates must be published at least 45 days prior to the effective date. These procedures must include all information necessary for a provider to submit a prior authorization (PA) request. The State may waive certain administrative requirements, including prior authorization, to the extent that such waivers are allowed by law and are consistent with policy objectives. The MCE may be required to comply with such waivers and are provided with prior notice by the State.

The MCE shall require its providers to utilize the standardized IHCP Prior Authorization Request Form for the submission of all prior authorization requests. In addition, the State reserves the right to standardize certain parts of the prior authorization reporting process across the MCEs, such as requiring the MCEs to adopt and apply the same definitions regarding approved, pending, denied, suspended requests, etc.

The MCE shall include utilization management measurements in their Quality Management and Improvement Program Work Plan as set forth in Section 7.1.2 of the *Indiana Pathways for Aging* scope of work.

The MCE's utilization management program shall not be limited to traditional utilization management activities, such as prior authorization. The MCE 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 MCE's utilization management program must link members to prevention and wellness programs(s), care management, complex case management and service coordination as set forth in Section 4.0. of the *Indiana Pathways for Aging* scope of work and the *Indiana Pathways for Aging* Care and Service Coordination Manual. This includes, but is not limited to, integrating prior authorization requests for the identification of members with real-time clinical needs. The MCE's utilization management program must also encourage health literacy and informed, responsible medical decision making.

For example, MCEs should develop member incentives designed to encourage appropriate utilization of health care services, increase adherence to keeping medical appointments, and obtaining services in the appropriate treatment setting.

MCEs shall also be responsible for identifying and addressing social barriers which may inhibit a member's ability to obtain preventive care.

The MCE shall monitor utilization through retrospective reviews and will identify areas of high and low utilization and identify key reasons for the utilization patterns. The MCE must identify those members that are high utilizers of emergency room services and/or other services, including pharmacy, and perform the necessary outreach and screening to assure the member's services are coordinated and that the member is

aware of and participating in the appropriate prevention and wellness programs(s), care coordination or complex care management services. The MCE must also use this data to identify additional prevention and wellness programs that are needed. Any member with emergency room utilization must be outreached to again offer complex case management or care coordination. The MCE may use the Right Choices Program (RCP), as described in Section 4.2.4 in the *Indiana Pathways for Aging* scope of work, in identifying members to refer to prevention and wellness programs(s), care coordination or complex case management. The MCE must identify members with high utilization of controlled substances following the policies and procedures of the Right Choices Program (RCP), as described in Section 4.2.4 of the *Indiana Pathways for Aging* scope of work.

As part of its utilization review, the MCE shall monitor access to preventive care, specifically to identify members who are not accessing preventive care services in accordance with accepted preventive care standards. The MCE must develop education, incentives and outreach plans tailored to its member population to increase member compliance with preventive care standards.

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

The MCE must define service authorizations in a manner that at least includes members' requests for services. The MCE's utilization management policies and procedures must include time frames for the following:

- Completing initial requests for prior authorization of services
- Completing initial determinations of medical necessity
- Completing provider and member appeals and expedited appeals for prior authorization of service requests or determinations of medical necessity
- Notifying providers and members of the MCE's decisions on initial prior authorization requests and determinations of medical necessity
- Notifying providers and members of the MCE's decisions on appeals and expedited appeals of prior authorization requests and determinations of medical necessity

The MCE must also monitor the pharmacy utilization of its members.

To monitor under- or overutilization of behavioral health services, the State requires MCEs to provide separate utilization reports for behavioral health services. In particular, the MCE must monitor use of services for its members with special needs and those with diagnoses of severe mental illness or substance abuse. Reporting requirements are in the *MCE Reporting Manual*.

If the MCE chooses to use a list of diagnosis codes to initially determine whether a service may be an emergency, the MCE must, at a minimum, use the State's Emergency Department Autopay List, accessible from the Code Sets page at [in.gov/Medicaid/providers](https://www.in.gov/Medicaid/providers). The MCE must check at a minimum the diagnosis codes in fields 67 and 67A-E on the UB04 and 21A-F on the CMS 1500 against the emergency department autopay list.

7.b.6 Authorization of Service and Notice of Action

Physicians or doctorate-level behavioral health clinicians with clinical expertise in the treatment of a member's condition must make all medical necessity decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The MCE must not provide incentives to utilization management staff for denying, limiting, or discontinuing medically necessary services. The MCE must accept the universal prior authorization forms established by the State with no additional information besides clinical documentation necessary to make the determination. Additionally, providers must be able to submit prior authorization, concurrent reviews, retrospective reviews, and appeals

of decisions in an electronic format via a web-based system accessible through the MCE's website. The web-based system should mimic the fields on the universal prior authorization forms established by the State and not require additional information. The MCE's web-based system should use automation and built-in system logic (e.g., member information pre-population, and smart editing to reduce errors) to reduce administrative burden on providers.

As part of utilization management, the MCE must facilitate its PMPs' requests for authorizing primary and preventive care and must assist PMPs in providing referrals for specialty services. In accordance with federal regulations, the process for authorizing services must comply with the following requirements:

- **Second Opinions**

- In accordance with *42 CFR 438.206(b)(3)*, the MCE must comply with all member requests for second opinions from qualified professionals. If the provider network does not include a provider that is qualified to give a second opinion, the MCE must arrange for the member to obtain a second opinion from a provider outside the network at no cost to the member.

- **Special Health Care Needs**

- In accordance with *42 CFR 438.208(c)*, the MCE must allow members with special health care needs who require courses of treatment or regular care monitoring to directly access specialists for treatment via established mechanisms, such as standing referrals from the members' PMPs or an approved number of visits. Treatment provided by specialists must be appropriate for the member's condition and needs.

- **Women's Health**

- In accordance with *42 CFR 438.206(b)(2)*, the MCE must provide female members with direct access to a women's health specialist within the network to provide women's covered routine and preventive healthcare services. This is in addition to female members' designated sources of primary care (if those sources are not women's health specialists). The MCE must have an established mechanism, such as standing referrals from members' PMPs or an approved number of visits, to permit direct access.

The MCE must notify the requesting provider and provide written notice to members of any decisions to deny service authorization requests, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the member must be given within the time frames required in this section and in *42 CFR 438.404*. Notification must be made to the member by the last day of the decision time frame if a decision is still pending.

The MCE will establish 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 MCE's utilization management program policies and procedures must meet all state and federal regulations and current NCQA standards, and must include appropriate timeframes for:

- Completing initial requests for prior authorization of services,
- Completing initial determinations of medical necessity,
- Completing provider and member appeals and expedited appeals for prior authorization of service requests or determinations of medical necessity, per state law,
- Notifying providers and members in writing of the MCE's decisions on initial prior authorization requests and determinations of medical necessity following State forms and templates, and
- Notifying providers and members of the MCE's decisions on appeals and expedited appeals of prior authorization requests and determinations of medical necessity.

The MCE must notify members of standard authorization decisions as expeditiously as required by the member's health condition. For members enrolled in an aligned DSNP, the MCE 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 approved by the State and limited to a

fifth grade reading level. The notice must be given within the timeframes described in the following paragraphs:

- a. Unless otherwise provided in *405 IAC 5-3-14* or *42 CFR 438.210(d)(1)*, to require a shorter timeframe, the MCE 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 calendar days after the request for services. An extension of up to 14 calendar days is permitted if the member or provider requests an extension or if the MCE justifies to the State a need for more information and explains how the extension is in the member's best interest. The MCE will be required to provide its justification to the State 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 MCE fails to respond to a member's prior authorization request not pertaining to medications within seven calendar days of receiving all necessary documentation, the authorization is deemed to be granted.
- c. For authorizations originally approved by the MCE, if the MCE denies continuation of services with the skilled nursing facility or long-term attendant care the MCE must provide at least five 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 MCE 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 MCE shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 48 hours after receipt of the request for service. The MCE may extend the 48 hours by up to 14 calendar days if the member requests an extension or the MCE justifies a need for additional information and how the extension is in the best interest of the member. The MCE will be required to provide its justification.
- e. For requests related to HCBS, the MCE 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 MCE extend that timeframe.
- f. If the MCE 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. Concurrent requests are requests for authorization of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the MCE did not previously approve the earlier care. All concurrent authorization requests should be adjudicated within one business day of receiving all information, not to exceed 72 hours from the receipt of the request.
- h. For decisions to terminate, suspend or reduce previously authorized covered services because of probable member fraud that has been verified by the Indiana Office of the Inspector General or Attorney General, the MCE must provide notice five business days before the date that services would be terminated, suspended, or reduced.
- i. The MCE must adhere to exceptions detailed in *42 CFR 431.213* and *431.214*.
- j. Notice may occur no later than the date of the action in the event of the following circumstances:
 - o The death of a member,
 - o The MCE'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),
 - o The member's admission to an institution,
 - o The member's address is unknown, and mail directed to him/her has no forwarding address,
 - o The member's acceptance for Medicaid services by another local jurisdiction,

- The member's physician prescribes the change in the level of medical care,
- An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions, or
- 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 30 calendar days (applies only to adverse actions for nursing facility transfers).
- The MCE shall have staff available on weekends to ensure that utilization management decisions and notifications are delivered in the timelines required in this scope of work. MCE timeliness shall be an area of enhanced auditing by the State.

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

The MCE must submit all PA notification form letters to the State through the document review process. The letters must meet the requirements of *42 CFR 438.10(c) and (d)* and Section 7.3 of *Indiana Pathways for Aging* scope of work regarding language, oral interpretation, and format for member materials, and must clearly explain the following:

- qualifications of the reviewer,
- guidelines used and reason for denial or approval,
- action the MCE or its MCE has taken or intends to take,
- reasons for the action,
- member's right to file an appeal and the process for doing so,
- member's right to request a State hearing and the process for doing (if the member has exhausted the MCE's appeal process),
- circumstances under which expedited resolution is available and how to request, and
- member's right to have benefits continue until the resolution of the appeal, how to request continued benefits, and the circumstances under which the member may have to pay the costs of services.
- 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. Further that the provider has 15 business days to request a peer-to-peer conversation. A provider must have the right to schedule a specific date and time for the peer-to-peer conversation.

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

7.b.7 Requirements for Tracking Prior Authorization Requests

The MCE must track all prior authorization requests in their information system. All notes in the MCE's prior authorization tracking system must be signed by clinical staff and include the appropriate suffix, such as registered nurse (RN) and medical doctor (MD). For prior authorization approvals, the MCE must provide a prior authorization number to the requesting provider and maintain a record of the following information, at a minimum, in the MCE's information system:

- Name of requester
- Title of requester
- Date and time of request
- Prior authorization number

For all denials of prior authorization requests, the MCE must maintain a record of the following information, at a minimum, in the MCE's information system:

- Name of requester
- Title of requester
- Date and time of request
- Clinical synopsis inclusive of:
 - Time frame of illness or condition
 - Diagnosis
 - Treatment plan
- Clinical guidelines or other rationale supporting the denial (such as insufficient documentation)
- Denial notification letter for both members and providers
- Date and time of denial notification and the name of the individual notified of denial
- Evidence that the treating practitioner was notified of availability to discuss denial.

Additionally, the MCE must establish an electronic prior authorization look-up tool that provides verification of whether a service requires authorization. This look-up tool shall be easily accessible on the MCE's website and have open provider access without the need for an access account.

7.b.8 Objection on Moral or Religious Grounds

If the MCE elects not to provide, reimburse for, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover in accordance with *42 CFR 438.102(b)*. Any MCE policy regarding objections on moral or religious grounds must be submitted to the State for review and approval consideration. If approved, the MCE must serve notice to potential members before and during enrollment; and to members within 90 calendar days after adopting the policy with respect to any particular service, but at least 30 calendar days prior to the effective date.

7.b.9 Utilization Management Committee

The MCE must have a utilization management committee directed by the MCE's medical director. The committee is responsible for the following:

- Providing oversight of the MCE UM program and structure,
- Involvement of physician and behavioral health providers in the review, evaluation, and supervision of UM activities,
- Monitoring providers' requests for rendering medically appropriate and necessary healthcare services to its members,
- Monitoring the medical appropriateness and necessity of health care services provided to its members. (Ex over/under utilization of services),
- Reviewing the effectiveness of the utilization review process and making appropriate changes to the process,
- Review and approve written policies and procedures for utilization management that conform to industry standards,
- Oversees UM work plan including methods, timelines, and individuals responsible for completing each task,
- Annual review of UM Program description and program evaluation,
 - Confirming that the MCE has an effective mechanism in place to respond within one hour to all emergency department providers regardless of day or time. This includes responsiveness following a member's initial emergency department screening, and post stabilization as determined by the emergency department provider and necessary continued treatment to maintain stabilization.

7.c The Right Choices Program

The Right Choices Program (RCP) is Indiana's restricted card program. The purpose of the RCP is to identify members who use covered services more extensively than their peers and/or exhibit drug-seeking behaviors. The program, set forth in *405 IAC 1-1-2(c)* and *405 IAC 5-6*, is designed to monitor member utilization, and when appropriate, implement restrictions for those members who would benefit from increased care coordination.

The RCP follows the CMS design of a Patient Review and Restrict (PRR) program that is focused on behaviors of doctor shopping and excessive utilization of controlled substances, especially opioids. The MCE will provide appropriate prevention and wellness programs(s), care management, or complex case management services to the RCP members.

Program policies, set forth by the State for the RCP, are delineated in the Right Choices Program policy manual. The MCE shall be responsible for RCP duties for their members as following:

- Evaluate claims, medical information, referrals, and data to identify members to be enrolled in the RCP.
 - Before enrolling a member in the RCP, the MCE must ensure a physician, pharmacist, or nurse confirms the appropriateness of the enrollment,
- Enroll members in the RCP,
- Provide written notification of RCP status to such members and their assigned primary physicians and pharmacies,
- Intervene in the care provided to RCP members by providing, at minimum, enhanced education, case management, and care coordination with the goal of modifying member behavior,
- Provide appropriate customer service to providers and members,
- Evaluate and monitor the member's compliance with their treatment plan to determine if the RCP restrictions should terminate or continue,
- Notify the State of members that are being reported to the FSSA Bureau of Investigation for suspected or alleged fraudulent activities,
- Provide ad-hoc reports about RCP to the State upon request,
- Cooperate with the State in evaluation activities of the program by providing data and/or feedback when requested by the State,
- Meet with the State about RCP program implementation as requested by the State, and
- Develop and implement internal policies and procedures regarding the MCE's RCP program administration. MCE program policies and procedures must have State approval prior to utilization.

The State monitors the MCE's compliance with RCP duties set forth in the [Right Choices Program](#) provider reference module through its monthly on-site visits and/or external quality review activities. The MCE may be subject to noncompliance remedies if the MCE fails to comply with RCP duties set forth in the MCE's contract with the State and the provider reference module. The State reserves the right to review utilization data for the MCE's RCP membership, including the number of RCP members who have had more than one emergency department visit in a 30-calendar day period, in assessing the effectiveness of the MCE's RCP program.

Section 8: Program Integrity

The Indiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU) is the State agency responsible for the investigation of provider fraud in the Indiana Medicaid program.

The OMPP Program Integrity Unit (OMPP PI), is responsible for overseeing the integrity of all Medicaid payments issued by the State for services on behalf of Medicaid-eligible beneficiaries and referring cases of suspected fraud to the MFCU for investigation. The OMPP PI Unit identifies and recovers Medicaid waste and abuse.

The FSSA Bureau of Investigations evaluates and investigates reports of suspected fraud by recipients of assistance programs and both government and contract employees.

Pursuant to *42 CFR 438.608*, which sets program integrity requirements, the MCE must have an administrative procedure that includes a mandatory compliance plan that describes in detail the manner in which it will detect fraud and abuse.

8.a Program Integrity Plan

The Program Integrity (PI) *Plan* shall serve as MCE's compliance plan. The Program Integrity Plan shall be submitted annually and upon request by the OMPP Program Integrity (PI) Unit, and updated quarterly, or more frequently if required by the OMPP PI Unit and be submitted to the State. The PI Plan and/or updates to the PI Plan shall be submitted through the reporting process to the State, who shall forward to the OMPP PI Unit, 10 business days before scheduled meetings discussing the Plan. The Plan shall include in its PI Plan provisions enabling the efficient identification, investigation, and resolution of waste, fraud and abuse issues of MCE's providers, vendors, and subcontractors (including but not limited to Pharmacy Benefits Managers, vision, transportation, dental) and MCE itself, including:

- Written policies, procedures and standards of conduct that articulate the organization's commitment to comply with all applicable state and federal standards. This includes *42 CFR 438.610*, *42 CFR 455.104 – 106* and *42 CFR 1002*.
- Designation of a Special Investigation Unit Manager, a compliance officer and a Compliance Committee who are accountable to senior management. The compliance officer and SIU Manager must meet with the State's OMPP PI Section at a minimum of quarterly intervals and as directed by the OMPP PI Section.
- Type and frequency of training and education for the Special Investigation Unit Manager, compliance officer and the organization's employees charged with detecting fraud. Training must be annual and address the False Claims Act, Indiana laws and requirements governing Medicaid reimbursement and the utilization of services – particularly changes in rules, and other Federal and State laws governing Medicaid provider participation and payment as directed by CMS and the State.
- A risk assessment of the MCE's various fraud and abuse program integrity processes. A risk assessment shall also be submitted on an 'as needed' basis, or at a minimum of every 6 months. This assessment shall also include a listing of the MCE's top three vulnerable areas and must outline action plans mitigating such risks.
- An organizational chart and communication plan highlighting lines of communication between the Special Investigation Unit manager, the compliance officer, and the organization's employees.
- Provision for internal monitoring and auditing.
- Procedures designed to prevent and detect abuse and fraud in the administration and delivery of services under the contract.
- A description of the specific controls in place for the prevention and detection of potential or suspected fraud and abuse, including, but not limited to, a list of:
 - Automated pre-payment claims edits
 - Automated post-payment claims edits

- Types of desk audits on post-processing review of claims
- Reports for provider profiling and credentialing used to aid program and payment integrity reviews
- Surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services
- Provisions in the subcontractor and provider agreements that ensure the integrity of provider credentials
- References in provider and member material regarding fraud and abuse referrals
- Provisions for the confidential reporting of PI Plan violations to the designated person
- Provisions for the investigation and follow-up of any suspected or confirmed fraud and abuse, even if already reported, and/or compliance plan reports
- Provisions ensuring that the identities of individuals reporting violations of the MCE are protected and that there is no retaliation against such persons.
- Specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance PI Plan violations.
- Requirements regarding the reporting of any confirmed or suspected provider fraud and abuse under State or federal law to the OMPP PI Unit and pursuant to the [Program Integrity Operations](#) section of this manual.
- Assurances that no individual who reports MCE's potential violations or suspected fraud and abuse is retaliated against.
- Policies and procedures for conducting announced and unannounced site visits and field audits to providers defined as high risk (including, but not limited to, providers with cycle/auto billing activities, providers offering DME, home health, mental health, and transportation services) to ensure services are rendered and billed correctly.
- Provisions to ensure and verify that the MCE, managing employees, subcontractors, and providers are not affiliated with any organizations or individuals debarred, suspended, or otherwise excluded by federal agencies or from participating in any contract paid with federal funds.
- Provisions for maintaining fraud and abuse-dedicated hotlines, website or email addresses, mailing addresses, facsimile numbers, and internal mailboxes for members, providers, MCE staff, and the general public to report instances of suspected fraud and abuse.
- Provision for prompt response to detected offenses and for the development of corrective action initiatives.
- Program integrity-related goals, objectives and planned activities for the upcoming year.

On a quarterly basis, the MCE must submit a high-level progress report to the State, which:

1. Outlines the MCE's program integrity-related activities and findings
2. Identifies the MCE's progress in meeting program integrity-related goals and objectives
3. Identifies recoupment totals for the reporting period.

The MCEs must disclose healthcare-related criminal convictions from providers and all affiliated parties, as specified in the *42 CFR 455.106*, to the State and Medicaid Fraud Control Units (MFCU). MFCU will notify the Department of Health and Human Service Office of Inspector General (HHS-OIG).

In the event of provider fraud, the MCE must notify the State by contacting their State contract compliance officer and the Surveillance and Utilization Review Section (SURS). In the event of member fraud, the MCE must notify the State by contacting their State contract compliance officer and SURS with a copy to FSSA Bureau of Investigation.

8.b Additional Program Integrity Requirements

The MCE, its subcontractors and its providers (whether contract or non-contract), must comply with all federal requirements on disclosure reporting [42 *CFR Part 455*] to include business transaction disclosure reporting [42 *CFR 455.105*] and the full ownership and control information [42 *CFR 455.104*]. The MCE shall further provide any additional information necessary for the State to perform exclusion status checks pursuant to 42 *CFR 455.436*.

All tax-reporting provider entities that bill and/or receive Indiana Medicaid funds, as the result of the contract, must submit routine disclosures in accordance with time frames specified in 42 *CFR Part 455, Subpart B* and the terms of the contract (including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, at least once every three years, and at any time upon request from the State).

Pursuant to 42 *CFR 455.104-106*, the MCE must disclose, to the State and HHS-OIG, the following information on ownership, control, and persons convicted of crimes:

- The name and address of each person with an ownership or controlling interest in the MCE,
- The name and address of each person with an ownership or controlling interest in a subcontractor in which the MCE has direct or indirect ownership of 5% or more,
- Whether any person who has an ownership or controlling interest in the MCE and subcontractor are related to another as a spouse, parent, child, or sibling,
- Name of any other Medicaid provider in which a person with an ownership or controlling interest in the MCE also has an ownership or controlling interest,
- Name of any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because participation on any program established under titles V, XVIII, or XX of the *Social Security Act* in which a person with an ownership or controlling interest in the MCE also has an ownership or controlling interest,
- Any person with ownership or control interest in the MCE who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs,
- Any person who is an agent or managing employee of the MCE who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs,
- Any person with ownership or control interest in a provider contracted with an MCE who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs, and
- Any person who is an agent or managing employee of a provider contracted with an MCE who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs.

The MCE must develop policies and procedures for notifying the State of the aforementioned disclosures that includes procedures for providing quarterly updates and immediate updates, if any changes occur.

8.c Program Integrity Operations

The MCE must immediately report all suspected or confirmed instances of waste, fraud and abuse to the FSSA and the OMPP PI Section. The MCE must use the Reporting Forms provided by the State for all such reporting or such other form as may be deemed satisfactory. The MCE will be subject to non-compliance remedies, (Exhibit 2) for willful failure to report fraud and abuse by providers, Medicaid beneficiaries/members, or applicants to the OMPP PI Section as appropriate.

- The MCE must have surveillance and utilization control programs and procedures (42 CFR 456.3, 456.4, 456.23) to safeguard Medicaid funds against improper payments and unnecessary or inappropriate use of Medicaid.
- The MCE must have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected waste, fraud and abuse activities.
- MCE must have operations sufficient to enable the efficient identification, investigation, and resolution of waste, fraud and abuse issues of MCE's providers, vendors, and subcontractors (including pharmacy benefits managers) and MCE itself.
- The MCE must have provisions in its Program Integrity Plan to perform a coordinated audit of a sampling of home health, personal care, hospice, nursing facilities, and assisted living providers to ensure providers are only audited by one Managed Care Organization. The results of the audits will be submitted annually to the State with the Program Integrity Plan.

The MCE is required to conduct and maintain, at a minimum, the following operations and capabilities. The MCE shall conduct all operations and deploy all capabilities described below on a routine basis and as necessary for the effective reduction of Medicaid waste, fraud, and abuse.

- The MCE Special Investigation Unit must have the ability to make referrals to the OMPP PI Unit,
- The MCE Special Investigation Unit must have the ability to accept referrals from a variety of sources including directly from providers (either provider self-referrals or from other providers), members, law enforcement, government agencies, etc.,
 - The MCE must also have effective procedures for timely reviewing, investigating, and processing such referrals.
- The MCE will suspend all payments to a provider after the State determines that there is a credible allegation of fraud and has provided the MCE with written notice of a payment suspension,
- Data mining, analytics, and predictive modeling for the identification of potential overpayments and aberrant payments/providers warranting further review/investigation,
- Provider profiling and peer comparisons of all of MCE's provider types and specialties – at a minimum, annually - to identify aberrant service and billing patterns warranting further review/audit,
- Onsite Audit capability and protocols identifying how and when the Special Investigation Unit shall conduct such onsite audits of providers,
- Medical claim audit capabilities sufficient to enable the Special Investigation Unit to audit any payment issued to any provider (including utilizing medical record reviewers, clinicians, coding specialists, accountants, and investigators needed for review of payments to any provider/provider type),
- Member service utilization analytics to identify members that may be abusing services, and
- The MCE shall submit the criteria utilized for its review of its members and the referral of members to the *Right Choices Program* to the State for approval.

8.d Program Integrity Reporting

The MCE, and all subcontractors, must cooperate with all appropriate state and federal agencies, including the Indiana MFCU and the OMPP PI Unit, in investigating fraud and abuse. Cooperation includes making a timely referral of potential credible allegations of fraud as well as providing the OMPP PI Unit and the Medicaid Fraud Control Unit with any documentation requested, in a timely manner.

The MCE shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR 455.13, 455.14, 455.21). The MCE must provide an Audit Report to the State and the OMPP PI Unit. This report documents all provider and member-specific program integrity activities of the MCE (i.e., the specific application of the Program Integrity Plan provisions to identify specific provider and member waste, fraud and abuse).

8.d.1 Reporting Waste, Fraud and Abuse

The MCE must immediately notify the OMPP PI Unit when it has identified a provider with a potential credible allegation of waste, fraud and abuse.

- The MCE shall use the *Reporting Forms* provided by the State for all such reporting or such other form as may be deemed satisfactory
- The MCE shall be subject to non-compliance remedies for willful failure to report fraud and abuse by providers, Medicaid beneficiaries/members, or applicants to the OMPP PI Unit as appropriate
- All suspected cases of waste, fraud, and abuse must be discussed at the Managed Care-Program Integrity coordination meeting following the OMPP PI Unit's receipt of the report unless otherwise directed by the OMPP PI Unit

Investigation of Waste, Fraud and Abuse

1. The MCE must promptly perform a preliminary investigation of all incidents of suspected fraud and abuse and provide the results of its preliminary investigation to the OMPP PI Unit or to another agency designated by the OMPP PI Unit.
2. The MCE must cooperate fully in any further investigation, or prosecution, by any duly authorized government agency (e.g., administrative, civil, or criminal). Such cooperation shall include providing, upon request:
 - information,
 - access to records, and
 - access to interview MCE employees and consultants
 - including, but not limited to, those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.
3. As part of monitoring, auditing, and investigating network providers and subcontracted services to detect fraud, abuse, and improper payments, the MCE shall have mechanisms in place to review documentation maintained by providers of LTSS to ensure compliance with the billing requirements.
4. The MCE should ensure that if a home health, personal care, hospice, nursing facility, and/or assisted living provider is audited, that coordination has happened with other MCEs so only one MCE is currently auditing the provider. This allows the State to see the full scope of the fraud, waste, or abuse across a period of time.

Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the MCE **must not** take any of the following actions as they specifically relate to Indiana claims:

- Contact the subject of the investigation about any matters related to the investigation;
- Enter into or attempt to negotiate any settlement or agreement regarding the incident; or
- Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

Credible Allegation of Fraud

The MCE must comply with 42 C.F.R. § 455.23 by suspending all payments to a provider after the Agency determines that there is a credible allegation of fraud and has provided the MCE with notice of a payment suspension.

Audit Report

On a quarterly basis, and as otherwise directed by the OMPP PI Unit, the MCE must submit a detailed Audit Report to the State which outlines the MCE's program integrity-related activities, as well as identifies the

MCE's progress in meeting program integrity-related goals and objectives. The *Audit Report* documents all provider and member-specific program integrity activities of MCE (for example, the specific application of Program Integrity Plan provisions to identify the specific provider and member waste, fraud, and abuse), as documented in the following:

- The *Audit Report* shall specify current audits, reviews, claim denials, and investigation activity of the unit, a summary of the reason for the audit/investigative activity, the disposition of any such completed activity (including detailed overpayment amounts identified or recouped), and projected upcoming activity for the following quarter.
- The *Audit Report* must specify individual provider recoupment, repayment schedules, and actions taken for each audit or investigation. The quarterly progress report must identify recoupment totals for the reporting period. In accordance with the *Affordable Care Act* and State policy and procedures, the MCE shall report overpayments made by the State to the MCE as well as overpayments made by the MCE to a provider and/or subcontractor.
- Recoupment totals and summaries for each reporting period (quarterly unless otherwise specified by the OMPP PI Unit) must also be submitted in the *Audit Report*.
- The *Audit Report* shall identify projected upcoming activity, including the top 20 providers on MCE's list for audit, and the types of audits envisioned
- In accordance with 42 CFR 438.608(d)(3), the MCE must report, annually to the State, on the recoveries of overpayments.

The OMPP PI Unit will review and approve, approve with modifications, or reject the *Audit Report* and specify the grounds for rejection.

HIPAA or Other Security Breach

The MCE must notify the State within one business day upon discovery of a HIPAA or other security breach.

8.e Program Integrity Overpayment Recovery

The MCE has primary responsibility for the identification of all potential waste, fraud and abuse associated with services and billings generated as a result of this contract. In cases involving wasteful or abusive provider billing or service practices (including overpayments) identified and recovered by MCE.

The MCE will have policies and procedures in place to fully comply with 42 CFR 438.608. The MCE must maintain relevant documentation for a minimum of seven years. Quarterly and annual reporting of recoveries will be made in accordance with the guidance in the *MCE Reporting Manual*.

In cases involving wasteful or abusive provider billing or service practices (including overpayments) identified by the OMPP PI Unit, the State may recover any identified overpayment directly from the provider or may require MCE to recover the identified overpayment and repatriate the funds to the State Medicaid program as directed by the OMPP PI Unit. The OMPP PI Unit may also take disciplinary action against any provider identified by MCE or the OMPP PI Unit as engaging in inappropriate or abusive billing or service provision practices.

If a fraud referral from the MCE generates an investigation and/or corresponding legal action results in a monetary recovery to IHCP, the reporting MCE is entitled to share in such recovery following final resolution of the matter (settlement agreement/final court judgment) and following payment of recovered funds to the State of Indiana. The MCE's share of recovery is as follows:

- From the recovery, the State (including the IMFCU) shall retain its costs of pursuing the action, including any costs associated with OMPP PI Unit operations associated with the investigation, and its actual documented loss (if any). The State will pay, to the MCE, the remainder of the recovery, not to exceed the MCE's actual documented loss. Actual documented loss of the parties is determined by paid false or fraudulent claims, canceled checks or other similar documentation which objectively verifies the dollar amount of loss.

- If the State determines it is in its best interest to resolve the matter under a settlement agreement, the State has final authority concerning the offer, or acceptance, and terms of a settlement. The State will exercise its best efforts to consult with the MCE about potential settlement. The State may consider the MCE's preferences or opinions about acceptance, rejection, or the terms of a settlement, but they are not binding on the State.
- If final resolution of a matter does not occur until after the contract has expired, the preceding terms concerning the disposition of any recovery and consultation with the MCE shall survive expiration of the contract and remain in effect until the final resolution of a matter referred to the IMFCU by the MCE under this section.

If the State makes a recovery from a fraud investigation and/or corresponding legal action where the MCE has sustained a documented loss, but the case did not result from a referral made by the MCE, the State is not obligated to repay any monies recovered to MCE but may do so at its discretion. Funds recovered as a result of a multi-state fraud investigation/litigation, however, will be shared with MCE as prescribed for funds recovered as a result of MCE's fraud referral absent extenuating circumstances.

The MCE is prohibited from the repayment of State, federally, or MCE-recovered funds to any provider when the issues, services or claims upon which the repayment is based meets one or more of the following:

- The funds from the issues, services, or claims have been obtained by the State or federal governments, by the State or as part of a resolution of a State or federal audit, investigation, and/or lawsuit, including but not limited to false claims act cases;
- When the issue, services, or claims that are the basis of the repayment have been or are currently being investigated by the OMPP PI Unit, the Federal Unified Program Integrity Contractor (UPIC), Indiana MFCU, or Assistant United State Attorney (AUSA), are the subject of pending federal or State litigation, or have been/are being audited by the State Recovery Audit MCE (RAC)

This prohibition described previously shall be limited to a specific provider, for specific dates, and for specific issues, services, or claims. The MCE must check with the OMPP PI Unit before initiating any repayment of any program integrity-related funds to ensure that the repayment is permissible.

8.f Auditing Program Integrity Operations

The OMPP PI Unit may conduct audits of MCE's SI Unit activities to determine the effectiveness of the MCE's operations. Such audit activities may include:

- conducting interviews of relevant staff,
- reviewing all documentation and systems used for Special Investigation Unit activities, and
- reviewing the SI Unit's performance metrics.

The OMPP PI Unit may issue a corrective action or performance improvement plan and outline timelines for improvement measures. The failure to adhere to operational improvement measures may result in the State's imposing liquidated damages up to the amount of overpayments recovered from MCE's providers by OMPP PI Unit audits for the preceding calendar year or imposing other non-compliance remedies including liquidated damages as outlined in the scope of work.

8.f.1 Provider Audits by MCE

Managed Care Entities (MCEs) participating in the *Indiana Pathways for Aging* program will conduct audits of specific provider types and ensure compliance with section 8.6 of the *Indiana Pathways for Aging* scope of work.

Post-payment audits of providers are a long-standing tool in the continued detection and prevention of fraud, waste, and abuse in Medicaid systems.

Each MCE will document in its Compliance Plan, provisions to coordinate audits of home health, personal care, hospice, nursing facilities, and assisted living providers. MCEs shall ensure providers are only audited by one MCE and will document results from such audits.

1. On or before December 1 of each year each MCE will submit an email to Program Integrity listing out the home health, personal care, hospice, nursing facilities, and assisted living providers they have selected to audit in the upcoming calendar year.
2. PI will review all lists from the MCEs to ensure there are no duplicated providers.
 - If no providers are duplicated, PI will communicate approval of the list to the MCEs.
 - If a duplicated provider is identified, the MCE who submitted their list first will get priority for provider audit. The other MCE(s) must select another provider and submit the proposed provider to PI for another duplication check.
3. Each participating MCE will include the approved list of providers on their compliance plan. They will also include the results of the prior year's LTSS provider audits.
4. If an MCE has not completed a selected audit within the calendar year, that provider will be included on the MCE's list of audits for the subsequent calendar year. Any MCE who has not completed all their identified audits within the calendar year will lose priority for duplicate choices in the following year.

MCEs may refer to the following codes for additional information:

- [42 CFR 447](#) Program Integrity: Medicaid
- [42 CFR 455](#) Program Integrity: Medicaid
- [405 IAC 1 Office of the Secretary of FSSA](#)

8.f.2 Provider Payment Suspensions

As required per [42 CFR 455.12](#), the State's Program Integrity (PI) section has processes to investigate allegations of Medicaid provider fraud, waste, or abuse that have been brought to the State's attention. As a result, the State may exercise the following actions:

- make CAF determinations ([42 CFR 455.2](#))
- refer providers with suspected cases of fraud to MFCU ([42 CFR 455.15](#))
- issue a payment suspension to the provider unless there is a good cause exception (GCE) ([42 CFR 455.23\(e\)](#))

Payment suspensions will be implemented for all Indiana Health Coverage Programs (IHCP) providers that the State warrants as fraud or abuse. The Program Integrity Provider Review Committee (PIPRC) makes determination of Credible Allegation of Fraud (CAF) that are investigated by the Medicaid Fraud and Control Unit (MFCU). Suspensions will remain in place until MFCU communicates that its investigation is complete.

Suspension Procedure

1. When a matter is set for review by the Program Integrity Provider Review Committee (PIPRC) the Managed Care Coordinator will send an email to each of the MCEs requesting the following information:
 - The number of members impacted if the provider stops providing service and
 - Assurances that all members will be contacted to ensure the continuation of services.
2. Each MCE will provide the requested information within 10 business days from the initial email.
3. Upon receipt of the PIPRC's determination that provider allegations are credible, and a CAF is determined, PI refers the provider to MFCU for a full investigation. PI may institute a full or partial

payment suspension on all future Indiana Medicaid payments unless a good cause exception or law enforcement exception.

4. If payment suspension is deemed on the provider, the Managed Care Coordinator will send an email to each of the MCEs alerting them to the forthcoming payment suspension.
5. A signed payment suspension letter is sent via certified U.S. mail. The letter must be sent within the time frames identified in [42 CFR §455.23\(b\)\(1\)\(i\)-\(ii\)](#):
 - Five days after suspending payments unless a law enforcement agency has submitted a written request to delay the notice; or
 - Thirty days after suspending payments when a delay was properly requested by law enforcement, except the delay may be renewed twice in writing not to exceed 90 days.
6. Gainwell and MCE staff will be notified via emails and the signed payment suspension letter sent as an attachment to implement the payment suspension. The Managed Care Coordinator will gather and save the verification responses from the MCE and Gainwell staff.
7. The State's Provider Enrollment unit will be notified of the payment suspension letter to elevate the provider's risk level as appropriate.

MCEs may refer to the following codes for additional information:

- The State shall adhere to all Federal and State regulations and requirements.
- [Federal Regulations \(42 CFR 447\) - 42 CFR 447.90](#)
- [42 CFR 447](#) Program Integrity: Medicaid
- [42 CFR 455](#) Program Integrity: Medicaid
- [405 IAC 1 Office of the Secretary of FSSA](#)

8.g Medical Management Standard Compliance

The MCE must have written policies and procedures for monitoring its providers and for sanctioning providers who are out of compliance with the plan's medical management standards.

The MCE must conduct periodic reviews of claims files and medical audits to determine the following:

- Treatment was consistent with diagnosis,
- The treatment resulted in appropriate outcomes for members with certain high-risk chronic or acute conditions (e.g., asthma, hypertension, diabetes, otitis media, lead poisoning, drug dependency, and diseases preventable by routine immunization),
- The services provided emphasized preventive care and resulted in early detection,
- The PMP appropriately referred members for specialty care, and
- Other compliance and appropriateness of services were provided.
- The State recommends that MCEs implement internal desk review procedures. Utilization review is emphasized particularly for outlier cases. MCEs are also required to provide the State with additional information to assist in investigation of outlier and other unusual cases.

8.h Long-Term Services and Supports

If a home health or personal service agency (as defined by *IC 16-27-1* and *IC16-27-4-5*), Residential Care Facility (also known as an assisted living facility) licensed under *IC 16-28-2*, a health facility (also known as nursing facility) licensed under *IC 16-28-2*, or a hospice agency licensed under *IC 16-25-3* determines it is unable to continue providing services to a member because of an action under Indiana law, per *IC 16-27-4*,

the MCE must cooperate in supporting the member in utilizing a different provider, of the member's choice, within the MCE's network.

In the event of a sanction of a home health or personal service agency or any other HCBS provider, per 455 IAC 2-6-5(c)(2), a suspension of participation, or a termination of participation of a home health, agency personal services agency, or residential care facility (by the State or from the MCE), the MCE must inform the State of the number of members impacted and must contact members to ensure that members continue to receive needed care and have been given choice of provider within the MCE's network.

The MCE must, for personal services as defined by IC 16-27-4-4, home health, personal care agencies, hospice agencies, nursing facilities, assisted living facilities, and any other HCBS provider per 455 IAC 2-6-2(a)(3), obtain either an expanded criminal history check as defined at IC 20-26-2-1.5; or a national criminal history background check as defined at IC 10-13-3-12.)

The MCE must have provisions in its Program Integrity Plan regarding instructions to Home Health, Hospice, Assisted Living, Nursing Facility, and Personal Care Service providers to maintain written policies and procedures of their business model. The policy and procedures shall include at a minimum:

- roles and responsibilities of key personnel,
- organizational chart, succession planning,
- ownership,
- background checks for all personnel,
- fraud, waste, and abuse reporting protocols, and
- a plan for fraud, waste, and abuse employee training (as required by *Deficit Reduction Act of 2005 Section 6032.2.20.3.10*).

8.i Program Integrity Definitions

- *Program Integrity Provider Review Committee (PIPRC)* - the State entity responsible for making credible allegation of fraud determinations.
- *Credible Allegation of Fraud (CAF)* - an allegation from any source which has been verified by the State based on a review of all facts and evidence presented. As indicated in [42 CFR 455.21](#), CAF's are referred to MFCU for full investigation.
- *Good Cause Exception* - the State may find that good cause exists to continue paying a provider, either in full or in part, determined to have a CAF due to recipient access to services being jeopardized, or due to a request from law enforcement officials out of concern that its investigation may be compromised if the provider stops receiving payments, or any other circumstances as identified in [42 CFR 455.23\(e\)-\(f\)](#).
- *Medicaid Fraud and Control Unit (MFCU)* - a unit within the Indiana Attorney General's office which investigates and prosecutes suspected cases of Medicaid fraud, waste, or abuse. Federal law mandates that the IHCP agency be able to identify, and if warranted, refer cases of suspected Medicaid fraud, waste, or abuse to the Indiana Attorney General's MFCU for investigation and prosecution.
- *Payment Suspension* - the temporary suspension of all Indiana Medicaid payments to an Indiana Medicaid provider determined to have a credible allegation of fraud.
- *Completion of an Audit* - a final letter of overpayment has been sent out to the provider who has been audited, this does not mean that monies have been collected; "overpayment," when referring to the letter name, is used to encompass both audits with overpayments and audits without overpayments.

Section 9: Information Technology Systems

The managed care entity (MCE) must have a management information system (MIS) sufficient to support the *Indiana Pathways for Aging* program requirements. The MCE must have a plan for accessing and storing data files and records in a manner that is in keeping with *Health Insurance Portability and Accountability Act* (HIPAA), *Code of Federal Regulations 45 CFR 162* and *164* requirements for confidentiality when transmitting and maintaining medical data, including:

- Administrative procedures and safeguards
- Physical safeguards
- Technical safeguards

The MCE's information system must support HIPAA Transaction and Code Set requirements for electronic health information data exchange, National Provider Identifier (NPI) requirements and *Privacy and Security Rule* standards. The MCE's electronic mail encryption software for HIPAA security purposes shall provide no less protection than the State's electronic mail encryption software. In the event the State's technical requirements require a contract amendment, the State will work with MCEs in establishing the new technical requirements. The MCE must be capable of adapting to any new technical requirements established by the State, and the State may require the MCE to agree in writing to the new requirements. After the MCE has agreed in writing to a new technical requirement, any MCE-initiated change must be approved by the State and the State may require the MCE to pay for additional costs incurred by the State to implement the MCE-initiated change.

The MCE must make all collected information available to the State and, on request, to the Centers for Medicare & Medicaid Services (CMS). In accordance with *42 CFR 438, subpart H*, the MCE must submit all data with the signatures of its financial officer and executive leadership (e.g., president, chief executive officer or executive director), certifying the accuracy, truthfulness, and completeness of the MCE's data.

The MCE must comply with all *Indiana Office of Technology (IOT) standards, policies, and guidelines*. All hardware, software and services provided to or purchased by the State are compatible with the principles and goals contained in the electronic and information accessibility standards adopted under *Section 508 of the Federal Rehabilitation Act of 1973 (29 USC 794d)* and *Indiana Code IC 4-13.1.3*. Any deviation from these architecture requirements must be approved in advance and in writing by IOT.

9.a Disaster Recovery Plans

For purposes of this policy, *disaster* means an occurrence of any kind that adversely affects the error-free and continuous operation of the MCE's or its subcontracting entities' claim processing system, or that affects the performance, functionality, efficiency, accessibility, reliability, or security of the system.

IT system contingency planning must be developed in accordance with *45 CFR 164.308*. Contingency plans must include:

- data backup plans,
- disaster recovery plans,
- emergency mode of operations plans,
- application and data criticality analysis, and
- testing and revisions procedures.

The MCE must maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file backups, and disaster recovery.

The MCE must maintain full and complete backup copies of data and software and must proficiently backup tapes or optical disks and store data in an approved off-site location. The MCE must maintain or otherwise arrange for an alternate site for its system operations in the event of a catastrophe or other serious disaster.

The MCE must take the steps necessary to recover the data or system from the effects of a disaster and to reasonably minimize the recovery period. The State and the MCE jointly determine when unscheduled system downtime is elevated to disaster status. Disasters may include natural disasters, human error, computer virus or malfunctioning hardware or electrical supply. The MCE's responsibilities include, but are not limited to:

- Supporting immediate restoration and recovery of lost or corrupted data or software
- Establishing and maintaining, in an electronic format, a daily and weekly backup that is adequate and secure for all computer software and operating programs; database tables; files; and system, operations, and user documentation
- Demonstrating an ability to meet backup requirements by submitting and maintaining a *Disaster Recovery Plan* that addresses:
 - Checkpoint and restart capabilities
 - Retention and storage of backup files and software
 - Hardware backup for the servers
 - Hardware backup for data entry equipment
 - Network backup for telecommunication.
- Developing coordination methods for disaster recovery activities with the State and its contractors to ensure continuous eligibility, enrollment and delivery of services
- Resuming normal business functions as early as possible, not exceeding 30 calendar days, following a catastrophic or natural disaster;
- If it is deemed appropriate by the State, the MCE must coordinate with the State fiscal agent to restore the processing of claims by Core Medicaid Management Information System (*CoreMMIS*), if the claim processing capacity cannot be restored within the MCE's system
- Resuming normal business functioning as early as possible, not exceeding 10 calendar days, following other disasters caused by such events as criminal acts, human error, malfunctioning equipment, or lack of electrical supply
- Notifying the State **within two hours** of any disruptions in its normal business operations. The MCE may be required to supply a plan for resuming operations to the State
- Coordinating required system operations with other MCEs, including backups of information sent or accepted; and
- Providing the State with, annually, updated business resumption documents, such as:
 - Disaster recovery plans
 - Business continuity and contingency plans
 - Facility plans
 - Other related documents as identified by the State

9.b Member Enrollment, Capitation and Data Exchange

The MCE is responsible for verifying member eligibility data and reconciling with capitation payments for each eligible member. The MCE must reconcile its eligibility and capitation records at least monthly. If the MCE discovers a discrepancy in eligibility or capitation information, the MCE must notify the State and the State fiscal agent within 30 calendar days of discovering the discrepancy and no more than 90 calendar days after the State delivers the eligibility records. The MCE must return any capitation overpayments to the State within 45 calendar days of discovering the discrepancy.

The MCE must accept enrollment data in electronic format, currently via secure file transfer protocol ("FTP"), as directed by the State and as detailed in the [834 Contractor Benefit Enrollment and Maintenance Transaction](#) IHCP Companion Guide. The State reserves the right to amend the 834 Companion Guide during the contract term. The current 834 Companion Guide is provided in the Bidders' Library as an

example only. The MCE is responsible for loading the eligibility information into its claims system within five calendar days of receipt. In addition, the MCE's IT systems must accommodate the State's 12-digit member identification number (MID) for each member as well as the case number.

9.b.1 Capitation Adjustments – Systematic

Capitation payments are subject to change even after they have been paid to the MCE. Most are performed systematically as in the case of retroactive capitation rates. The State may retroactively reset capitation rates for the MCEs. The State sends written notification to the fiscal agent's care programs director. This written notification includes

1. the capitation categories,
2. time period,
3. newly calculated rate, and
4. the affected MCE/region.

Adjustments can apply to *Indiana Pathways for Aging* capitation rates.

The State fiscal agent processes the rate changes in *CoreMMIS*. The systematic capitation reconciliation process then determines affected prior payments and creates recoupment adjustments. The corresponding payment adjustment is also created. All recoupment and payment adjustments are noted by reason codes that distinguish adjustment details from regular per member per month details in the MCE's 820s. See applicable program capitation adjustment reason codes in [Appendix A](#).

Capitation adjustments can also occur for eligibility-based scenarios:

- Member date of death reported retroactively (IEDDS)
- Member date of birth corrections (IEDDS)
- Retroactive member eligibility changes (aid category, level of care, benefit package)
- Retroactive MCE assignment changes

9.b.2 Manual Capitation Adjustments

Manual adjustments to monthly capitation payments are performed by the fiscal agent as required. Manual adjustments are placed on *hold* status in *CoreMMIS* until reviewed and approved by the fiscal agent. Approved manual adjustments are activated prior to the capitation cycle.

9.c Rate Information

MCEs may negotiate their own rates with network providers that do not fall under a directed payment (such as HAF and PFAC). MCEs must pay 98% of the IHCP fee schedule for out of network LTSS providers.

9.c.1 IHCP Fee Schedules

The Indiana Health Coverage Programs (IHCP) publishes two fee schedules on the [Fee Schedule](#) page at in.gov/medicaid/providers. The IHCP Fee Schedules reimbursement information for all Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and American Dental Association (ADA) procedure codes that are currently recognized by the IHCP.

The Professional Fee Schedule reflects the most current allowed rate for all procedure codes pertinent to professional and dental billers. The Professional Fee Schedule contains the following information:

- Procedure code
- Certain modifiers
- Program coverage indicator
- Program prior authorization (PA) indicator

- Pricing indicator
- Pricing effective date
- Pricing end date
- Fee schedule amount
- Anesthesia base units, if applicable
- Attachment Required
- Min-Max Units
- Age Min-Max
- CMS Add Date/Termination Date

The IHCP Outpatient Fee Schedule contains outpatient facility payment information for applicable procedure codes and revenue codes, including ambulatory surgical center (ASC) rates used for paying outpatient surgery claims.

The IHCP Professional Fee Schedule information is updated each Sunday and promoted to the web on the following Tuesday. The IHCP Outpatient Fee Schedule is updated and published monthly.

The MCE must have policies and procedures in place to load new fee schedules and fee schedule updates from the State into their claims processing systems. The MCE shall update fee schedules within 30 days of the fee schedule effective date or date of notice of the fee schedule change, whichever is later. Failure to adhere to this requirement will result in corrective action.

Supplemental IHCP Rate Information

MCEs have access to supplemental IHCP rate information through File Exchange. The supplemental rate files contain rate segments. As rates change, the historical rate segments are maintained for rate files available through File Exchange. Rate updates occur with the monthly IHCP Fee Schedule update.

Supplemental rate information for inpatient pricing includes:

- Diagnosis-related group (DRG) base rates (universal base rates and provider specific base rates), weights and average lengths of stay
- Provider-specific rates apply to certain children's hospitals (not applicable to *Indiana Pathways for Aging*)
- Capital cost per diem for calculating capital cost payment for hospital inpatient claims
- Provider-specific medical education rates to calculate the medical education payment for hospital inpatient claims
- Medical education payments are given for hospitals that are classified as teaching facilities
- Inpatient level-of-care rates including psychiatric, burn and rehabilitation per diem rates
- Provider-specific inpatient level-of-care rates including psychiatric, burn and long-term acute care per diem rates
- Provider-specific cost-to-charge ratios used to calculate cost outlier payments for hospital inpatient claims
- Marginal cost factor percentage used to calculate cost outlier payments for hospital inpatient claims
- Cost outlier threshold used to calculate cost outlier payments for hospital inpatient claims
- Revenue flat-fee rates associated with treatment room revenue codes, add-on revenue codes and stand-alone revenue codes for payment of outpatient claims
- Max fee rates for technical component (modifier TC) of radiology services provided in outpatient hospital settings
- Lab-fee rates that are used in payment of laboratory services performed in outpatient hospital settings
- Max fee rates for chemotherapy administration in outpatient hospital settings
- Nursing facility level-of-care rates used for reimbursement of long-term care claims.

9.d Claim Processing

The MCE must have policies and procedures to audit and monitor providers' encounter claim submissions for accuracy, completeness, and timeliness of claims information. The MCE must have policies and procedures regarding claims submissions and processing that integrate with and support the internal quality management and improvement plan.

MCEs 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, easily understandable and efficient, aiming to simplify and streamline the provider experience. MCEs shall continually assess administrative billing requirements to identify onerous practices in need of change.

MCEs shall meet on a frequent and reoccurring basis with all providers, but especially, HCBS entities, who may be new to managed care, to receive feedback about abrasion concerns with the claims process or MCE's portal. MCEs will work with providers to resolve claims abrasion points and communicate solutions to the State and providers.

MCEs will also meet regularly with nursing facility providers to address claims' abrasion points, resolve process and system issues, and report solutions to Indiana Medicaid and nursing facility providers.

Each MCE shall employ a local Provider Claims Educator to work collaboratively to educate LTSS (with an emphasis on HCBS and nursing facility providers) transitioning from fee-for-service reimbursement to managed care. Each managed care entity shall implement claim requirements and processing rules that are consistent with IHCP manuals, modules, and bulletins and educate providers (with an emphasis on HCBS and nursing facility providers) on interpretation and implementation of those requirements and processes.

The MCE 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 of the *Indiana Pathways for Aging* scope of work. For any additional information on HCBS waiver claims processing, refer to the [IHCP NCCI Module](#) and the [Claims Processing Module](#). The MCE shall offer provider participation in testing and auditing for accurate payment to LTSS providers. If, during testing, the managed care entity learns about provider abrasion areas with the claims process or portal, the MCE will resolve the issues to improve the provider experience and report resolved abrasion points to providers and Indiana Medicaid. Managed care entities shall report to the State on their collaborative efforts at least 90 days prior to initial contract implementation.

In accordance with Section 2.9, of *Indiana Pathways for Aging* scope of work, the State must pre-approve the managed care entity's delegation of any claims processing function to a subcontractor, such as but not limited to a Dental Benefits Manager or Transportation Broker. The managed care entity must submit a request and a plan of implementation to the State at least 60 days prior to planned implementation and secure the State's approval of any change to sub-contracting arrangements for claims processing. Additionally, each MCE must provide to Indiana Medicaid a plan implementation for training and ongoing training and auditing function of any subcontractor processing provider claims. If, at any time, the MCE changes subcontractors, the MCE will communicate the change to providers and render robust training to providers on any changes in processes or requirements associated with the new subcontractor.

Each MCE 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 MCE shall use code sets and standards established and maintained by the State.

Each MCE shall develop policies and procedures to monitor claims adjudication accuracy and shall submit its policies and procedures for monitoring its claims adjudication accuracy to the State for review and approval.

The MCE shall demonstrate to the State as well as 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 of the *Indiana Pathways for Aging* scope of work. It is anticipated that MCEs will experience higher volumes of HCBS LTSS provider claims disputes given that this group is new to managed care. As

many HCBS LTSS providers are small agencies that depend on timely Medicaid reimbursement within five to seven business days, the managed care entities will demonstrate boutique customer service to HCBS LTSS providers and attempt all possibilities to ensure providers are reimbursed.

It is also anticipated HCBS LTSS providers will, from time-to-time, seek advances, loans, and loan guarantees over \$50,000 per Provider Tax Identification Number within a contract year. These requests shall be submitted by the MCE to the State for approval prior to payment. The request shall include a letter from the MCE with an explanation including:

1. The provider's name and ID number,
2. Cause resulting in the need, including any mitigation strategies implemented prior to the request,
3. Process for repayment including timeline,
4. Corrective action that will be implemented to avoid future occurrences, and
5. The total advance or loan amount and range of dates for the impacted claims.

In the event that this type of loan is requested, the MCE will provide robust support to providers to prevent future cashflow issues

For any additional information on HCBS waiver claims processing please refer to the [IHCP NCCI Module](#) and the [Claims Processing Module](#).

9.d.1 Claim-Processing Capability

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

The State must preapprove the MCE's delegation of any claim processing function to a subcontractor and the MCE must notify the State and secure the State's approval of any change to subcontracting arrangements for claim processing.

The MCE must develop policies and procedures to monitor claims adjudication accuracy and must submit its policies and procedures for monitoring its claims adjudication accuracy to the State for review and approval. The MCE must also submit its policies and procedures for monitoring its claims adjudication accuracy against its own internal criteria. The State recommends that the MCE's standards for accuracy of internal claim processing and financial accuracy be no less than 95%.

The out-of-network provider filing limit for submission of claims to the MCE is six 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 MCE's provider agreements pursuant to the guidelines set forth in Section 6.9 of the *Indiana Pathways for Aging* scope of work, which generally require in-network providers to submit claims within 90 calendar days from the date of service. MCEs have up to 15 months from the date of service to submit encounter data to the fiscal agent. Voids and replacements of previously paid encounter claims can be submitted up to 2 years from the "to" date of service on the claim.

9.d.2 Compliance with State and Federal Claim-Processing Regulations

The MCE must comply with state and federal claim processing regulations, such as the following:

- The MCE must have a claim processing system to support electronic claims submission for in- and out-of-network providers.
- The MCE's system must process all claim types, such as professional and institutional.
- The MCE must comply with claim processing standards and confidentiality standards under *IC 12-15-13-1.6* and *IC 12-15-13-1.7*, and any applicable federal regulations.
- The MCE must ensure that communication with providers, particularly out-of-network providers, and submission requirements are efficient and not burdensome for providers.

- The MCE is prohibited from requiring out-of-network providers to establish an MCE-specific provider number to receive payment for claims submitted.
- The MCE shall not require providers to bill using any number other than the State assigned Member ID number.

9.d.3 Claims Payment Timelines

A *clean claim* is one in which all information required for processing the claim is present on the claim form. The MCE must pay or deny all electronically filed clean claims within 21 calendar days of receipt, with the exception of HCBS claims. The MCE must pay HCBS related electronically filed clean claims within seven calendar days of receipt. With regards to paper claims, the MCE must pay both HCBS related and non-HCBS related clean paper claims within 30 calendar days of receipt. If the MCE fails to pay or deny a clean claim within these time frames and subsequently reimburses for any services itemized within the claim, the MCE must also pay the provider interest, as required under *IC 12-15-13-1.6* and *IC 12-15-13-1.7*.

The MCE must pay interest on all clean claims paid late (e.g., in- or out-of-network claims) for which the MCE is responsible, unless the MCE and provider have made alternate written payment arrangements. The State reserves the right to perform a random-sample audit of all claims and expects the audited MCE to fully comply with the requirements of the audit by providing all requested documentation, including provider claims and encounters submissions.

All providers must be offered, on their provider agreement, the option to select Electronic Fund Transfer (EFT) for provider payments. The MCE must develop a plan to issue payments predominantly via EFT and submit to the State for approval.

9.e Encounter Data Submission

The MCE must have policies, procedures, and mechanisms in place to support the encounter data reporting process detailed within this section and in the State fiscal agent's companion guides. MCEs must strictly adhere to the standards set forth in the State fiscal agent's companion guides for professional and institutional claims, such as the file structure and content definitions (including any content definitions as may further be interpreted or defined by the State). Notable information is as follows:

- A diagnosis code and DRG, as applicable, is a required data field and must be included on all encounter claims.
- When an encounter involves products or services with National Drug Codes (NDCs), the MCE's encounter claims must include the NDCs, an indication of claim payment status and an identification of claim type (e.g., original, void or replacement).
- The MCE must submit an encounter claim to the State fiscal agent for every service rendered to a member for which the MCE either paid or denied reimbursement. Encounter data provides reports of individual patient encounters with the MCE's healthcare network.
- These claims contain fee-for-service equivalent detail as to procedures, diagnoses, place of service, units of service, billed amounts and rendering providers' identification numbers, and other detailed claims data required for quality improvement monitoring and utilization analysis.
- Payment of liquidated damages does not relieve the MCE of its responsibility to provide complete and accurate encounter claims as required under the scope of work.

9.e.1 Weekly Batch Submission

The MCE must submit at least one batch of encounter claims (in the format specified by the State), for institutional, professional and pharmacy claims, before 5 p.m. ET on Wednesday of each week. If, during any calendar month, the MCE fails to submit all encounter claims on a weekly basis when due (unless the delay is caused by technical difficulties of the State or its designee), the MCE will be required to submit a formal Corrective Action Plan, as set forth in Section 2 of Exhibit 2 of the *Indiana Pathways for Aging* scope of work.

9.e.2 Pre-cycle Edits

For each weekly encounter claim batch submission, the MCE must achieve no less than 97% compliance rate with pre-cycle edits. The State assesses pre-cycle edit compliance based on the average compliance rate of the weekly encounter claims batch submissions made during the calendar month. If the average compliance rate is less than 97% for any type of encounter claim, the MCE pays liquidated damages, as described in the scope of work.

The MCE Technical Meeting provides a forum for MCE technical support staff to participate in the development of the data exchange process and ask questions related to data exchange issues, including encounter data transmission and reporting issues. The MCE must report any problems it is experiencing with encounter data submissions and reporting at this monthly meeting and to its designated State contract compliance officer.

The State will use the encounter data to make tactical and strategic decisions related to the *Indiana Pathways for Aging* program, including using only encounter data to calculate MCE's future capitation rates. It will also use encounter data to calculate incentive payments to the MCE, monitor quality and assess the MCE's contract compliance.

9.e.3 Encounter Claims Quality

The MCE must have written policies and procedures to address its submission of encounter claims to the State. These policies shall address the submission of encounter data from any sub-capitated providers or subcontractors. At least annually, or on a schedule determined at the discretion of the State, the MCE must submit an encounter claims work plan that addresses the MCE's strategy for monitoring and improving encounter claims submission. Additional requirements for encounter claims include the following:

- **Compliance with Pre-cycle Edits**

- The State fiscal agent will assess each encounter claim for compliance with pre-cycle edits. The MCE must correct and resubmit any encounter claims that do not pass the pre-cycle edits. The State will require MCEs to submit a corrective action plan to address noncompliance issues and will assess liquidated damages if the MCE fails to comply with pre-cycle edits.

- **Timeliness of Encounter Claims Submission**

- The MCE shall submit 98% of adjudicated claims within 14 calendar days of adjudication. MCEs have up to 15 months from the earliest date of service to submit encounter data to the fiscal agent. Voids and replacements of previously paid encounter claims can be submitted up to two years from the "to" date of service on the claim.

- **Accuracy of Encounter Claims Detail**

- MCEs must demonstrate that it implements policies and procedures to ensure that encounter claims represent the services provided and that the claims are accurately adjudicated according to the MCE's internal standards and all state and federal requirements. The State reserves the right to monitor encounter claims for accuracy against the MCE's internal criteria and its level of adjudication accuracy. The State will regularly monitor accuracy by reviewing the MCE's compliance with its internal policies and procedures for ensuring accurate encounter claims submissions and by performing a random sample audit of all claims. The State expects MCEs to fully comply with the requirements of the review and audit and to provide all requested documentation, including provider and encounter claims submissions and medical records.

- **Completeness of Encounter Claims Data**

- MCEs must have in place a system for monitoring and reporting the completeness of claims and encounter data received from providers

For example, for every service provided, providers must submit corresponding claim or encounter data with claim detail identical to that required for fee-for-service claim submissions.

MCEs must also have in place a system for verifying and ensuring that providers are not submitting claims or encounter data for services that were not provided.

The MCE shall adhere to CMS encounter submission requirements under *42 CFR 438.242*. Encounters shall include allowed amounts and paid amounts. Subcontractor administrative costs must be excluded from paid amounts.

9.e.4 Coordination of Benefits Details

MCEs are required to submit coordination of benefits as follows:

- MCEs must follow the 837 COB format and include their encounter data in the coordination of benefits (COB) loops of the transaction.
- MCEs format the 837 with their payment information in the first iteration of the COB loops before submitting encounter data.
- Encounter data is accepted only from MCEs and rejected from all others.
- MCEs send only claims that have been paid or denied at the claim and detail level in their systems.
- MCEs exclude claims that have not been finalized in their systems.

9.e.5 Encounters Voids for Services Payable as FFS

The State fiscal agent redirects providers to the MCEs when providers are having claims deny due to duplicate encounters for FFS-payable services that are less than 2 years old. MCEs must then void the encounter claims so that providers can resubmit the services as FFS and bypass the duplicate claims editing.

For services more than 2 years old, the fiscal agent's Provider Relations team will work with the provider and the MCE to verify common agreement that the claim, indeed, needs to be voided. After all parties agree, the Client Services team will submit a special batch request to the State Care Programs and Claims teams for their approval. The provider is notified after the approval is obtained, the void is completed, and the special batch claim is processed.

9.e.6 Capitated Provider Encounters

The MCEs must submit *CMS-1500* claims that report services rendered under a LTSS provider-capitated arrangement by sending the LOOP 2320 Segment CAS with ARC code 24 and \$0 as the billed amount.

The fully denied encounter claims are processed through the front end (EDI) editing bypassing the MCE ARC logic and applied edit 292. The denied encounter data is stored in a separate table with ICN beginning with 24 and is not viewable in *CoreMMIS*. The denied encounter data will be utilized by the State for reporting purposes. The fiscal agent will not process these claims through *CoreMMIS* and will not be applying the back-end claim edits and audits.

MCEs have up to 15 months from the date of service to submit denied LTSS encounter data to the fiscal agent. Voids and replacements of previously paid encounter claims can be submitted up to 2 years from the "to" date of service on the claim.

9.e.7 Denied Encounters and Rejected Common Definitions

Rejected claims must not be submitted as encounter data. A rejected claim is a claim that the MCE cannot accept into its inventory for future adjudication. Rejected claims include:

- **Misdirected claims:** A claim submitted to the wrong entity for processing (i.e., claim submitted to the wrong MCE)
- Claims for members not currently enrolled
- Claims for which the MCE or Managed Behavioral Healthcare Organization (MBHO) is not financially responsible (for example, a provider submits a claim to the MCE for an MBHO covered service)

- Unclean claims (a claim in which all the information required for processing is not present – per IC 12-15-13.0.6)

Claims that were rejected or claims that were received and denied by the MCE because they did not pass HIPAA compliance edits must not be submitted as encounters. These rejected claims correlate with the fiscal agent's electronic data interchange (EDI) Edit #132 (non-HIPAA-compliant transaction). They will not pass the fiscal agent's pre-cycle edits. The MCE must conduct provider outreach and education to assist the provider with resubmitting a corrected claim to secure payment. Therefore, this subsequent submission would be available for utilization data as either a paid encounter or denied encounter from resubmission.

Denied encounters include all clean claims that do not fall into one of the aforementioned categories and must be submitted as encounter data. This includes all clean paid claims (partially paid and fully paid) and all clean fully denied claims. A clean claim is a claim submitted by a provider for payment that can be adjudicated without obtaining additional information from the provider of the service or a third party.

9.e.8 HIPAA Adjustment Reason Codes

The MCE adjustment reason codes (ARCs) are used for denied details in the paid encounter processing. Each MCE is required to maintain and provide its applicable ARCs to the State fiscal agent. The MCE's ARCs are utilized in the encounter claim processing at the detail level.

The fiscal agent's Care Programs Unit coordinates with the MCEs and the fiscal agent Systems Unit to incorporate the new ARC into the MCE's ARC tables. The Care Programs Unit sends an *ARC Code Update* form to the MCEs 1 week prior to January, April, July and October. Each MCE completes the form, listing new ARC codes to indicate denied details for the encounter claim processing. The MCE can also designate if no updates. Email response is sent to the fiscal agent Care Programs Unit team.

9.e.9 Encounter Data Edits and Audits

LTSS encounter data is subjected to appropriate system edits to ensure that data is valid. These edits fall into the following two broad categories:

1. Electronic claim capture (ECC) pre-cycle edits
2. Claim resolution edits and audits (also referred to as back-end edits)

Pre-cycle editing establishes the presence and validity of critical data elements before the claim's acceptance into CoreMMIS.

For example, to pass the pre-cycle edit, the Member ID field must contain a valid combination of numeric characters recognized by CoreMMIS.

The pre-cycle editing process does not attempt to link the number to a specific member's eligibility or other information. The ECC pre-cycle edits for encounter data are identical to those in FFS electronic claim submission (ECS) claims, except for the addition of two edits created for encounter data:

1. MCE ID MISSING
2. MCE ID INVALID.

The pre-cycle edits are described in the Electronic Data Interchange Reports and Acknowledgements companion guides; the companion guides are available at in.gov/medicaid/providers.

Claim resolution editing and auditing validates information specific to a particular enrollee's IHCP program eligibility, subprogram affiliation and claim history. These edits and audits are designed to support benefit limits and conditions of payment in state and federal requirements and are described fully in *the fiscal agent Claim Edits and Audits data file*.

For example, a claim with a Member ID accepted in CoreMMIS during pre-cycle editing may be denied during claim resolution editing if the member was ineligible for benefits on the date of service or if the member's name or Member ID on the claim did not match the name or Member ID on file in CoreMMIS.

The State fiscal agent provides semiannual claim edit and audit information via File Exchange that includes the historical and current editing documentation as defined by the State and coded in *CoreMMIS*.

In IHCP's FFS claim processing environment, generating system edits and audits causes claims to be suspended for review, pending requests of additional information, or denied. In the encounter data environment, claims are subjected to the same edit and audit criteria for data collection, utilization, and program comparison. Because encounter data has been fully adjudicated by the MCE, it adjudicates in *CoreMMIS* as paid or denied.

The FFS edits and audits related to validity of data, member eligibility, provider enrollment, or duplicate claim submissions are also active for encounter data claims. FFS audits limiting duration or frequency of specific services, restricting place of service, or requiring prior authorization are inactive, or post and pay for encounter data. Claims that are potential (but not exact) duplicates adjudicate as paid because the MCE has determined the validity of the paid claim before its submission as encounter data.

The disposition of each edit and audit applicable to encounter data is recommended by the fiscal agent care programs director or designee and approved by the State managed care director or designee. MCEs can request a review of the disposition of a specific edit or audit by submitting a request to the State's fiscal agent care programs director.

Generation of the FFS edits and audits in an encounter data processing environment causes claims to adjudicate with a paid or denied status in *CoreMMIS*, even though payments are not actually issued. Encounter data is not suspended or pending for review because it reports claims payments adjudicated by MCEs to their contracted and noncontracted providers.

9.e.10 Encounter Data Output Documents

CoreMMIS acknowledges each encounter submitted by the MCE. This acknowledgment includes the *Submission Summary Report*, an electronic Remittance Advice (RA) and the *835 Remittance Advice Transaction*.

9.e.11 Encounter Submission Summary Report

The *Encounter Submission Summary Report (ESSR)* shows claims accepted in *CoreMMIS* for processing in addition to claims rejected in the pre-cycle editing process. Error code descriptions are located in the [835 Health Care Claim Payment/Advice Transaction](#) companion guide. The *ESSR* is generated by the Enterprise Data Warehouse every Tuesday at 5:00pm ET and posted to the State SFTP site. The *ESSR* is the basis for the application of liquidated damages that may be applied, at the discretion of the State, if the acceptance rate falls below 98% for any single batch submission.

9.e.12 Remittance Advice (RA)

The MCE is required to produce a remittance advice related to their payments and/or denials to providers. 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. Each remittance advice must include, at minimum:

- appropriate explanatory remarks related to a payment or reason(s) for denials and adjustments, including but not limited to TPL data.
- a detailed explanation/description of all denials, payments and adjustments.
- the amount billed.
- the amount paid.
- application of COB and copays.
- specific identifying language which details any necessary information and documentation for all claims which are denied, in any capacity (in part or wholly), due to the provider's failure to submit required evidence with the claim.

- provider rights for claim disputes, which includes detailed instructions and timeframes for submission of claim disputes/corrected claims and contact information for the local provider relations team. If a remittance advice is electronically sent to a provider, the detailed instructions and information can be explained and located through a link or supplemental file. Direction to the link and/or how to access the supplemental file must be explained on the remittance advice.
- a declaration which states, “I understand that payment and satisfaction of this claim will be from federal and state fund and that any false claims, statements, documents, or concealment of a material fact may be prosecuted under applicable federal and/or state laws.”

CoreMMIS acknowledges each encounter submitted by the MCE and includes a *Submission Summary Report*, an electronic RA, and the *835 Remittance Advice Transaction*. Because encounter data is adjudicated with either a paid or denied disposition, the RA for these claims indicates the disposition.

The supplemental file provides a detailed description of the back-end edits that were applied to an MCEs' adjudicated, paid, and denied encounters and is supplied to the MCE by the fiscal agent business objects reporting unit.

The 835 is completed on the weekend and posted after the financial cycle, acknowledging the claims processed during the previous week's claim cycle. The 835 is then available on the File Exchange server or the dial-up server (dependent on how the trading partnership is arranged). The cut-off time for claims to be included in the weekly financial cycle is Wednesday at 4 p.m. ET.

Each 835 remains on the File Exchange server for 30 days unless the trading partner deletes them. It is very important that the MCE download these files in a timely manner. The files will remain on the dial-up server until the downloads are complete.

9.e.13 Encounter Data Corrections and Resubmissions

MCEs must have a procedure in place to review the *Submission Summary Reports* and RA files previously described to identify claims denied in either the pre-cycle or adjudication processes. The *Submission Summary Reports* reference error codes contained in the [835 Health Care Claim Payment/Advice Transaction](#) companion guide. The MCE may resubmit the corrected claim in the next batch submission.

CMS-1500 or 837P claims containing paid and denied details may be completely resubmitted or denied details only resubmitted. Resubmitted details on claims that adjudicated with a paid status deny as duplicates on the resubmission. UB-04 or 837I claims are not adjudicated at the detail level, so denied elements must be corrected and the entire claim resubmitted.

ADA 2012 claim form and 837D transaction are used for dental claims same as above.

MCEs may bring questions about any aspects of encounter data submission and adjudication to the monthly MCE technical meeting.

9.e.14 Encounter Data Adjustments

The void and replacement process through *837 Professional and Encounter Claim Transaction* allows MCEs the ability to adjust or reverse an adjudicated LTSS claim with a paid status. Additional claim filing elements, unique to LTSS encounter data adjustments, are described as follows:

- The MCE ID, Provider ID and State region must appear on the replacement exactly as they appear on the claim being replaced. If the NPI is used on the claim, the taxonomy and service location ZIP Code + 4 on the replacement must be identical to those on the claim being replaced.
- The MCE ID, Provider ID, State region and member information on a void must be identical to the same information on the claim being voided. If the NPI is used on the claim, the taxonomy and service location ZIP Code + 4 on the void and on the claim being voided must be identical.
- The type of claim on the void or replacement must be the same type on the claim being voided or replaced.
- The void or replacement cannot be older than 2 years from the dates of service on the claim being voided or replaced.

- The void or replacement request must be completed against the most recent occurrence of the bill.
- The void or replacement request must be for an IHCP claim that is found in the database.
- A void cannot be processed against a claim that denied in CoreMMIS.
- A replacement request cannot be performed against a claim that denied because of a previous void request.

Additional instructions for void and replacement, as well as information about file formats, are in the [837P Health Care Claim: Professional Transaction](#) and [837I Health Care Claim: Institutional Transaction](#) companion guides. The companion guides are available on the [IHCP Companion Guides](#) page at in.gov/medicaid/providers.

9.f Third-Party Liability (TPL)

If a member is also covered by another insurer, the MCE is fully responsible for coordinating benefits so as to maximize the utilization of third-party coverage. The MCE must share information regarding its members, especially those with special healthcare needs, with other payers as specified by the State and in accordance with *42 CFR 438.208(b)*. In the process of coordinating care, the MCE must protect each member's privacy in accordance with the confidentiality requirements stated in *45 CFR 160* and *164*. The MCE is responsible for payment of the member's coinsurance, deductibles, copayments, and other cost-sharing expenses, but the MCE's total liability must not exceed what the MCE would have paid in the absence of third-party liability (TPL), after subtracting the amount paid by the primary payer.

The MCE must coordinate benefits and payments with the other insurer for services authorized by the MCE but provided outside the MCE's plan. Such authorization may occur prior to provision of service, but any authorization requirements imposed on the member or provider of service by the MCE must not prevent or unduly delay a member from receiving medically necessary services. The MCE remains responsible for the costs incurred by the member with respect to care and services, which are included in the MCE's capitation rate, but which are not covered or payable under the other insurer's plan.

MCEs may exercise any independent subrogation rights it may have under Indiana law in pursuit or collection of payments it has made when a legal cause of action for damages is instituted by the member or on behalf of the member.

[Appendix F](#) contains a list of the hierarchy of third party payment options and rules for which benefit should be considered the primary payor for billing.

9.f.1 Coordination of Benefits

Coordination of benefits is covered for many of the MCE's members. Each aid category must be treated appropriately in accordance with the State policy. Each MCE must have policies and procedures in place to ensure the appropriate application when coordinating benefits for its members.

If the *Indiana Pathways for Aging* member primary insurer is a commercial health maintenance organization (HMO) and the MCE cannot efficiently coordinate benefits because of conflicts between the primary HMO's rules and the MCE's rules, the MCE may submit to the enrollment broker a written request for disenrollment. The request must provide the specific description of the conflicts and explain why benefits cannot be coordinated. The enrollment broker will consult with the State and the request for disenrollment will be considered and acted upon accordingly.

Coordination of Benefits– Dually Eligible Members - Medicare Primary Considerations

For Medicare B claims, the IHCP pays only when the Medicaid allowed amount exceeds the amount paid by Medicare, such as the following:

- If the Medicaid allowed amount exceeds the Medicare paid amount, the IHCP pays the lesser of the coinsurance or copayment plus deductible, or the difference between the Medicaid allowed amount and the Medicare paid amount.
- If the Medicare paid amount exceeds the Medicaid allowed amount, the IHCP processes the claim with a paid claim status with a zero-reimbursed amount.

- For QMB-Also and SLMB-Also members, if the Medicare payment amount for a claim exceeds or equals the Medicaid allowable amount for that claim, Medicaid reimbursement will be zero. If the Medicaid allowable amount for a claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement is the lesser of:
 - The Medicaid allowable amount minus the Medicare payment amount or
 - The Medicare coinsurance or copayment and deductible, if any, for the claim.

Crossover Claims

IHCP reimburses covered services for Medicare and Medicare Advantage Plan crossover claims only when the Medicaid-allowed amount exceeds the amount paid by Medicare. When the Medicare-paid amount exceeds the Medicaid-allowed amount, claims are processed with a paid claim status with a zero reimbursed amount.

If the Medicaid-allowed amount exceeds the Medicare-paid amount, the IHCP reimburses using the lesser of the Medicare coinsurance or copayment plus deductibles, or the difference between the Medicaid-allowed amount and the Medicare-paid amount. The reimbursement also reflects any other third-party liability (TPL) payments and Medicaid waiver and patient liability amounts. The following formulas represent how payment for crossover claims is calculated:

- **Institutional crossover claims:** $(\text{Medicare Deductible} + \text{Coinsurance or Copayment} + \text{Blood Deductible}) - (\text{TPL Payments} + \text{Medicaid Waiver Liability [if applicable]} + \text{Patient Liability [Nursing Homes Only]}) = \text{Reimbursement Amount}$
- **Professional crossover claims:** $(\text{Medicare Deductible} + \text{Coinsurance or Copayment}) - (\text{Medicaid Waiver Liability [if applicable]} + \text{TPL Payments}) = \text{Reimbursement Amount}$

The MCE must have a signed Coordination of Benefits Agreement (COBA) with CMS and participate in the automated crossover claim process administered by Medicare.

In accordance with *IC 12-15-8* and *405 IAC 1-1-15*, the State has a lien upon any money payable by any third party who is or may be liable for the medical expenses of a Medicaid recipient when Medicaid provides medical assistance. The MCE may exercise any independent subrogation rights it may have under Indiana law in pursuit or collection of payments it has made when a legal cause of action for damages is instituted by the member or on behalf of the member.

Waiver Liability Considerations Related to Medicare

For members with waiver liability who have not met their liability for the month, Medicare crossover claims credit the waiver liability with the combined sum of the amounts shown as the coinsurance or copayment, blood deductible, and deductible.

- The billed amount of a crossover claim cannot be used to credit waiver liability.
- The coinsurance or copayment and deductible amounts for Medicare Part A claims are prorated, based on the number of days billed.
- Medicare Part B claims spanning more than one month are credited to the month of the first date of service.
- Coinsurance or copayment and deductible amounts on crossover claims for members who have only Qualified Medicare Beneficiary coverage (QMB-Only) do not credit waiver liability.

In some instances, such as billing for inpatient care, claims must include span dates. The claim types and the methodology used to credit waiver liability for each claim type are as follows:

- **Institutional/837I/UB-04**
 - Inpatient: Inpatient claims with dates of services spanning more than one month are prorated on a daily basis, not counting the discharge date. Waiver liability is credited in each month based on the number of days of service reported on the claim for each month minus the day of discharge. The reimbursement is based on the total claim allowed minus the sum of the waiver liability credits.

- Outpatient: Outpatient hospital claims spanning more than one month are credited to waiver liability based on individual dates of services, as reported on the detail lines of the claim.
- Professional/837P/CMS-1500 – Medical claims with dates of services spanning multiple months are credited to waiver liability on the month of the first date of service.

9.f.2 Third-Party Liability Data Sources

The State fiscal agent provides each MCE with a monthly list of known TPL resources for its enrolled members. The jobs that create the MCE TPL files run on the evening of the 20th of every month. The files are available for download from the File Exchange during the early morning hours of the 21st of each month. Medicare information is also provided to the MCEs for members who have overlapping Medicare. The TPL file layout and Medicare extract file layout are available from [MCE Secure Landing](#) page at in.gov/medicaid/partners.

Username is **MCEhealthplans**

This site is password protected. MCEs can obtain the password by contacting their State contract compliance officer.

The extract runs monthly and is posted to File Exchange monthly.

The data on the monthly TPL file and TPL information accessed via the automated eligibility systems (AVR, 270/271 transaction and the Portal) are limited to the most current information on file with the fiscal agent.

The fiscal agent obtains TPL information for members from several sources, including the following:

- Member's caseworker
- HMS, the fiscal agent's subcontractor
- Other MCEs Portal
- Providers

The fiscal agent verifies for accuracy all TPL information received from providers and members (except when the information comes from the caseworker). Health Management Systems (HMS) verifies its data before sending it to the fiscal agent and the TPL data from IEDSS is not independently verified by the fiscal agent. Any TPL information found for members can be submitted to the fiscal agent using either the [Medicaid Third Party Liability Questionnaire](#) or the [Provider TPL Referral Form](#). Additional TPL forms may be found <https://www.in.gov/medicaid/providers/provider-references/forms/>. The completed form is mailed to the following address:

Gainwell TPL/Casualty Unit
P.O. Box 7262
Indianapolis, IN 46207-7262

The completed form may also be faxed to **866-667-6579**. TPL information can also be submitted via the **Provider Healthcare Portal > Eligibility** inquiry by selecting **TPL Form**.

9.f.3 Managed Care Entity Third-Party Liability Responsibilities – Cost Avoidance and Coordination of Benefits

When the MCE is aware of health or casualty insurance coverage before paying for a healthcare service for a member, the MCE can reject a provider's claim and direct that the claim be submitted first to the appropriate third party.

When the MCE becomes aware that an enrollee has instituted a legal cause of action for damages against a third party (i.e., accident or injury lawsuit), the MCE sends written notification to the fiscal agent that includes the following:

- Enrollee's name
- IHCP Member ID

- Date of accident or incident
- Nature of injury
- Name and address of enrollee's legal representative

The MCE also provides the fiscal agent with copies of pleadings and any other documents in its possession related to the action.

If insurance coverage is not available, or if one of the exceptions to the cost-avoidance rule applies, then payment must be made and a claim made against the third party, if it is determined that the third party is or may be liable.

The MCE must ensure that its cost-avoidance efforts do not prevent an enrollee from receiving medically necessary services in a timely manner.

For dually eligible members, according to TPL regulations, Medicare is treated the same as any other available resource. Thus, when an IHCP member is also enrolled in Medicare, providers must bill Medicare prior to submitting a claim to the IHCP for reimbursement.

Certain services are excluded and never covered by Medicare; therefore, the IHCP can be billed first for these services, bypassing the requirement to bill Medicare (or a Medicare supplemental plan) first. For all other services provided to dually eligible members, IHCP benefits can be paid only after Medicare payment or denial.

Cost Avoidance Exceptions

Cost avoidance exceptions in accordance with 42 CFR 433.139(c) include the following situation in which MCEs must first pay the provider and then coordinate with the liable third party:

- The claim is for services provided that were covered by a third party at the time services were rendered or reimbursed (for example, the MCE was not aware of the third-party coverage); the MCE must pursue reimbursement from potentially liable third parties.
- **Retroactive Recoveries Involving Commercial Insurance Payor Source**
 - For a period of two years from the date of service, the MCE shall engage in retroactive third party recovery efforts for claims paid to determine if there are commercial insurance payor sources that were not known at the time of payment. In the event a commercial insurance payor source is identified, the MCE shall seek recovery from the commercial insurance. The MCE is prohibited from recouping related payments from providers, requiring providers to take action, or requiring the involvement of providers in any way, unless the provider was paid in full from both the MCE and the commercial insurance. Encounters shall be adjusted as a result of retroactive recoveries.
- **Retroactive Medicare Coverage**
 - Program members may become retroactively Medicare eligible. When this occurs, the MCE shall recover medical expenses payable by Medicare for the months of retroactive Medicare eligibility. The State will recoup the capitation rate paid for months with retroactive Medicare eligibility and pay a reduced dual-eligible capitation rate, as applicable.

9.f.4 Third-Party Liability Collection and Reporting

As an incentive to identify TPL and coordinate benefits, the MCE may retain a portion of TPL collections for their members. TPL collections must be reported in accordance with reporting requirements outlined in the *MCE Reporting Manual*. In accordance with IC 12-15-8 and 405 IAC 1-1-15, the State has a lien upon any money payable by any third party who is or may be liable for the medical expenses of a Medicaid recipient when Medicaid provides medical assistance. MCEs may exercise any independent subrogation rights it may have under Indiana law in pursuit or collection of payments it has made when a legal cause of action for damages is instituted by the member or on behalf of the member.

The MCE may retain all TPL collections received on behalf of its members. No coordination of benefits occurs except with casualty insurers. The MCE may retain all TPL collections from any insurer or responsible party other than health insurers (such as automobile insurers and workers compensation).

TPL Timely Filing Exceptions

The MCE shall not deny a claim for timeliness if the untimely claim submission results from a provider's efforts to determine the extent of a third party liability. The claim must be submitted with documentation that clearly identifies multiple filing attempts in a timely manner along with all responses from the payer or third party.

If third-party payer notification is delayed, the timely filing limit is extended to 180 days from the date on the explanation of benefits (EOB) from a primary payer. A copy of the primary payer's EOB must be included as an attachment to the claim.

The MCE shall waive timely filing in cases where a retroactive coverage change or error has resulted in another MCE, Insurer, or Fee for Service recouping or recovering a claim. The MCE shall permit the provider to submit a claim for payment within 90 days of claim's recovery or recoupment notice from the previous payer.

There is no filing limit for paid Medicare or Medicare Advantage Plan crossover claims.

Medicare regulations 42 C.F.R. §424.44(b) allows for exceptions to the one calendar year time limit for filing Medicare claims. Retroactive Medicare entitlement involving State Medicaid Agencies, where a State Medicaid Agency recoups payment from a provider or supplier six months or more after the date the service was furnished to a dually eligible beneficiary, is an allowed exemption. Refer to Chapter 1, subsection 70.7 of the [Medicare Claims Processing Manual](#) for qualifying exceptions and associated billing instructions.

The State will be responsible for estate recovery activities.

9.g Electronic Visit Verification

Federal law requires personal care service and home health service providers to use an electronic visit verification (EVV) system to document services rendered and directs Medicaid programs to implement this requirement. The requirement that personal care service providers use an EVV system has been in place since January 1, 2021 and will be in place for home health service providers as of January 1, 2024.

The MCE will be required to configure their claims processing systems to integrate with the State's EVV solution. The State, through its fiscal agent Gainwell Technologies, currently has a relationship with Sandata Technologies. The MCE is required to utilize Sandata for its EVV solution. The MCE must follow the following standards around EVV implementation:

- The MCE must configure its claim processing system to edit for EVV noncompliance. System edits should include:
 - identification if a claim lacks any corresponding EVV activity
 - Identification if the number of units submitted on a claim is greater than the number of units identified in a corresponding verified EVV record
- The MCE's EVV-specific claim edits must remain in post-and-pay until given explicit direction from the State.
- If the MCE wishes to initiate any claim recoupment based upon EVV noncompliance, this activity must be approved by the State before initiating.
- The MCE must configure these claim edits to appear for the following providers who submit claims for EVV-impacted services:
 - Provider Type 32 (Waiver)
 - Provider Type 05 (Home Health)
- The MCE must configure its EVV-specific claim edits to be utilized for services requiring verified EVV records. The IHCP maintains an up-to-date list of service codes requiring EVV on the IHCP Code Set [here](https://provider.indianamedicaid.com/ihcp/Publications/providerCodes/Service_Codes_That_Require_Electronic_Visit_Verification.pdf):
https://provider.indianamedicaid.com/ihcp/Publications/providerCodes/Service_Codes_That_Require_Electronic_Visit_Verification.pdf

- The MCE will receive instructions from Sandata on how to make the MCE's claim processing system integrate correctly with the Sandata Aggregator. The Sandata Aggregator is the central repository for all State of Indiana EVV activity (managed care and fee-for-service).
- The MCE must provide a dedicated resource/point of contact to assist providers with EVV-related inquiries, including claim denials/recoupment
 - The MCE may direct providers to contact Gainwell Technologies for questions on basic utilization of the Sandata State-Sponsored EVV solution, such as adding members, adding services, or modifying employee information.

9.h Health Information Technology and Data Sharing

The MCE must develop, implement, and participate in healthcare information technology (HIT) and data-sharing initiatives to improve the quality, efficiency, and safety of healthcare in Indiana. The State's requirements for HIT and data sharing vary by resources available in each region.

MCEs are required to enter into data-sharing agreements with any health information technology entity that the State enters into data-sharing agreements with.

The State reserves the right to require MCEs to establish *personal health records (PHRs)* for its members in the future. A PHR is an electronic health record of the member that is maintained by the MCE. PHRs typically include a summary of member health and medical history such as diagnoses, allergies, family history, lab results, vaccinations, and surgeries and may also include claims information. In the event the State adopts a standard PHR format, the MCE is required to implement the State's standard format.

MCEs are required to implement and maintain systems that meet the CMS Interoperability and Patient Access requirements in *42 CFR 438.242*, *42 CFR 457.1233*; *42 CFR 457.760*, *42 CFR 438.62*, and *42 CFR 438.10* introduced in the *Interoperability and Patient Access Final Rule*. This includes but is not limited to patient access and provider directory APIs and payer to payer data exchanges.

All health information technology, as applicable to its nature and recipient, must be compliant with Section 508 of the *US Rehabilitation Act*, the *Americans with Disabilities Act*, the *HIPAA Privacy Rule*, the *HIPAA Security Rule*, and all other applicable state and federal laws. Additionally, all member/potential member, provider, and member-provider communications created by the MCE (to include electronic) must be developed and pre-approved in accordance with the requirements in their respective sections of the *Indiana Pathways for Aging* scope of work and this MCE Policies and Procedures manual, identified below.

Communications Audience	Scope of Work	This Manual
Member and Potential Member Communications	Section 5.8	Section 5.f.1
Provider Communications	Section 6.11.1	Section 6.o.1
Member-Provider Communications	Section 5.10	Section 5.q

The following are examples of HIT initiatives the MCE should actively be involved in, or otherwise have a plan to participate in:

- **Electronic Health Record (EHR) or Electronic Medical Record (EMR)**
 - An electronic health/medical record is a digital version of a patient's paper chart that contains their medical and treatment histories. EHR/EMRs are real-time member-centered records that make information available instantly and securely to authorized users. They are built to share information with other health care providers and organizations in order to coordinate information for and from all clinicians involved in a member's care such as: medical history, diagnoses, medications, treatment plans, immunization dates, allergies, radiology images, and laboratory and test results.
 - Appropriate technical, administrative, and physical safeguards should also be in place to protect patient health information contained in the EHR/EMR. To ensure interoperability among providers including laboratory, pharmacy, radiology, inpatient hospital/surgery center, outpatient clinical care, home health, public health and others, organizations at the national level (including the Health IT Standards Panel and the Certification Commission for Health IT) are working to develop standards

related to IT architecture, messaging, coding, and privacy/security and a certification process for technologies. The MCE is strongly encouraged to use these standards in developing their electronic data sharing initiatives.

- **Electronic prescribing (e-prescribing)**

- In a basic e-prescribing system, providers use computers to enter permissible prescriptions. E-prescribing may also include electronic access to clinical decision support information, including clinical guidelines and formulary information; electronic connectivity between clinicians, pharmacies, and health plans to transmit prescriptions, verify eligibility and benefits, and process renewal requests; integration with an electronic medical record for access to information such as medical conditions, current and prior medications, allergies, and laboratory results.
- In 2017 Indiana implemented a statewide, comprehensive platform for healthcare professionals to review patients' controlled-substance prescription history more quickly and efficiently. This platform supports Indiana's Prescription Drug Monitoring Program (INSPECT) and transfers data into electronic health records and pharmacy management systems. Statewide integration of the INSPECT platform is a key component of Indiana's ongoing efforts to attack the opioid crisis.

- **Inpatient Computerized Provider Order Entry (CPOE)**

- CPOE refers to a computer-based system of ordering diagnostic and treatment services, including laboratory, radiology and medications. A basic CPOE system promotes legible and complete order entry and can provide basic clinical decision support such as suggestions for drug doses and frequencies. More advanced CPOE systems can integrate with an EHR/EMR for access to a patient's medical history.

- **Health information exchanges (including regional health information organizations (RHIOs))**

- These exchanges, such as the *Indiana Health Information Exchange*, allow participating providers to exchange clinical data electronically. The capacity of health information exchanges varies. Some initiatives provide electronic access only to lab or radiology results, while others offer access to shared, fully integrated medical records.

- **Benchmarking**

- MCEs can pool data from multiple providers and *benchmark*, or compare metrics related to outcomes, utilization of services, and populations. Practice pattern analysis, with appropriate risk adjustment, can help to identify differences in treatment of patients and best practices. Information can be shared with MCEs and providers to help them identify opportunities for improvement or can be linked to pay for performance initiatives.

- **Telehealth**

- Telehealth allows provider-to-provider and provider-to-member live interactions and is especially useful in situations where members do not have easy access to a provider, such as for members in rural areas. Providers also use telehealth to consult with each other and share their expertise for the benefit of treating complex patients in *Indiana Pathways for Aging*. MCEs shall develop reimbursement mechanisms to encourage appropriate use of telehealth.

- **Secure Mobile and Self-Service Technology**

- The MCE must utilize secure mobile and self-service technology in delivering services to members. This includes, but is not limited to, secure remote monitoring devices which enable members to record health measures for delivery to the MCE and/or physician practices, as well as appointment reminders through voice or secure text messages. Per 45 CFR § 164.308(a)(1)(ii)(A-B), the MCE shall complete a risk assessment prior to the implementation of any secure mobile and self-service technology.

- **Admission, Discharge, and Transfer (ADT) alerts**

- ADT alerts are automatic electronic notifications of admissions, discharges, and transfers that are sent to a patient's primary care physician or other healthcare provider. Implementing ADT alerts

help to reduce avoidable hospital readmissions and improves care transitions and coordination. The MCE will promote provider utilization of ADT alerts and integrate their monitoring into health plan operations and delivery of care.

To ensure interoperability among providers (including laboratory, pharmacy, radiology, inpatient hospital/surgery center, outpatient clinical care, home health, public health and other providers), organizations at the national level, including the Health IT Standards Panel and the Certification Commission for Health IT, are working to develop standards. The MCE is encouraged to use these standards in developing its electronic data sharing initiatives, if any. These standards relate to:

- IT architecture
- Messaging
- Coding
- Privacy/security
- A certification process for technologies

Currently, resources and infrastructure for HIT vary widely throughout Indiana. There are multiple strategies and tactics that MCEs can adopt to participate directly and to incentivize providers to participate in HIT. Some examples include:

- Contract or affiliate with existing health information exchanges and information networks.
- Develop coalitions with other healthcare providers to develop health information exchanges and information networks.
- Develop proposals for health information exchanges and information networks and apply for grants to support those proposals.
- Require providers to participate in one of Indiana's established health data exchanges or information networks, in regions where those networks are currently established.
- Require high-volume prescribers to use some level of e-prescribing, in regions where an infrastructure to support e-prescribing exists.
- Require high-volume providers to use EHR/EMRs, e-prescribing, CPOE or other HIT to focus incentives.
- Offer incentives to providers for adopting HIT, such as providing free or subsidized handheld devices to physicians for electronic prescribing, and/or providing financial or nonfinancial incentives to providers that adopt EMRs or electronic prescribing.

Section 10: Performance Reporting

All MCEs must submit required performance data in the form and manner specified by the State. MCEs are responsible for establishing policies, procedures, and validation mechanisms to ensure that the financial and nonfinancial performance data submitted to the State and/or the State's subcontractors is accurate. In accordance with 42 CFR 438.604 and 42 CFR 438.606, all data must be certified by the MCE's Chief Executive Officer, Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to one of named officers. The certification must attest, based on best knowledge, information and belief to the accuracy, completeness and truthfulness of the data and documents submitted to the State. This certification must be submitted concurrently with the certified data.

The State reserves the right to require the MCE to work with and submit data to third-party data warehouses or analytic vendors.

The required reports, format and reporting calendar is produced by the State on an annual basis and compiled in the *MCE Reporting Manual*. However, the State may modify the frequency of reports and may require additional recurring reports with reasonable advance notice to the MCE. For purposes of this policy, reasonable advance notice is defined as at least 30 calendar days' notice. The State may request ad hoc reports at any time.

Performance reports must be submitted in the format specified by the State, using the most current version of supplied Report Templates, if applicable. Reports may be required for subcontracted entities. It is the MCE's responsibility to accurately, completely, and timely report all delegated performance data.

Reports may be due on an annual, semiannual, quarterly, monthly, or ad-hoc basis. MCEs must submit performance reports by the dates due as indicated in current version of the *MCE Reporting Manual* (or as otherwise directed by the State). The MCE must submit all performance reporting data electronically to the State's reporting SharePoint site in the appropriate folders by the due date in the format and naming conventions described in the *MCE Reporting Manual*. Early submission of performance data is allowable given the data is complete. The State will consider the performance data late if the State does not receive the performance data electronically in the designated location on the due date by 4 p.m. Eastern Standard Time (EST). If the deadline falls on the weekend, it is due the first business day following the deadline.

The MCE may occasionally encounter internal operational issues that prevent timely submission of performance data. The State may consider a request for a submission extension under the following conditions:

- The MCE must submit its request for an extension at least one full business day before the data is due to the State.
- The MCE must submit the request in writing via email directly to its assigned state contract compliance manager with a carbon copy to the contract compliance officer.
- The MCE's written request must be sent from the MCE compliance officer or the officer's alternate.
- The MCE's written request must explain why an extension is necessary and must suggest an alternative submission due date for the State to consider.

The State responds with a decision to the MCE's request via email. The State may consider the MCE's reporting submission as untimely if the request does not follow the prescribed protocol. Further, extensions are granted solely at the State's discretion. If the extension request is denied, the State will consider the submission untimely if received passed the due date.

MCEs must submit complete and accurate data. However, if the plan discovers that it has omitted some performance data during a reporting cycle or discovers errors in data submitted to the State, the plan must notify its designated State contract compliance manager upon discovery.

If the MCE fails to provide performance data as required, the State may consider the plan noncompliant in its performance reporting and may assess liquidated damages or take corrective action, as outlined in the *Contract Compliance and Pay for Outcomes* section of the *Indiana Pathways for Aging* scope of work.

10.a State Response

The State may schedule meetings or conference calls with the MCE upon receiving the performance data. When the State identifies potential performance issues, the MCE must formally respond in writing to these issues within five business days of the receipt of State feedback. If the MCE fails to provide a formal, written response to the feedback or fails to respond within five business days, the State may deem noncompliance in performance reporting that are subject to corrective actions.

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

If the MCE discovers an error or omission after a reporting submission to the State, the MCE must notify its designated State contract compliance officer upon discovery and provide an action plan with timeline of correction. It is the State's discretion to determine if non-compliance is applicable to discoveries.

If the MCE fails to provide performance data as required, the State may consider the MCE noncompliant in its performance reporting and may assess non-compliance remedies, correction actions, liquidated damages, and/or other remedies determined by the State.

If the MCE's non-compliance with the reporting requirements impacts the State's ability to monitor the MCE's solvency, and the MCE's financial position requires the State to transfer members to another MCE, the State will require the MCE to pay any difference between the capitation rates that would have been paid to the MCE and the actual rates being paid to the replacement MCE as a result of member transfer. In addition, the MCE must pay any costs the State incurs to accomplish the transfer of members. Further, the State will withhold all capitation payments or require corrective action until the MCE provides satisfactory financial data. See Exhibit 2 for additional plan solvency expectations.

If MCE fails to submit any report required in the contract or *MCE Reporting Manual* in a timely, complete, and accurate manner, MCE shall pay liquidated damages of \$500 per day per report. On the third business day that a report is late, the MCE shall pay liquidated damages of \$5,200 per report per month until a complete and accurate report is submitted to the State. Payment of liquidated damages does not relieve the MCE of its responsibility to provide any report required under the contract.

Refer to contract Exhibit 2 for State corrective actions and non-compliance remedies.

10.b Ad-hoc Reports and Presentations

To meet the deliverables in the *Indiana Pathways for Aging* scope of work or as requested by the State, the MCE may be asked to submit ad hoc reports not listed in MCE Reporting Manual. If the State makes such a request, the MCE must submit such material within 30 calendar days or at an alternative date specified by the State (whichever comes sooner). The MCE must provide such reports to the State in the following format, unless directed otherwise by the State:

- Cover Page
 - MCE ID/Name
 - Program Name
 - Report Title

- Report Description – The Report Description must outline its purpose, as well as what each of the rows and columns of the report represent
 - For example, a key as to how the report is to be read and interpreted.
- Data Period
- Data Source
- Date Run
- Table of Contents (if appropriate for content)
- Executive Summary – The Executive Summary must include, but is not limited to, a clear statement of the question at hand, the MCE’s high-level analysis of the data, its key findings, a clear statement of its recommendations and/or any action items, and the MCE staff responsible for each action item. It must not exceed two pages in length.
- Component reports as directed by the State
- Definition of terms/terminology used in the report
- The report is to be paginated in a sequential fashion, beginning to end, first page to last, and the Table of Contents (if applicable) is to match exactly to the pagination. The overall appearance of the report (for example, orientation of information [landscape vs. portrait] as it appears on the pages, how the report is bound) is not to vary substantially from iteration to iteration unless approved by the State. Each individual component report must have identifying information located in the margin that is unique to each report.
- The report is to be provided in electronic and hard copy format to the State.
- The electronic version of the report must be in a printer-friendly format requiring no manual manipulation to format print readiness.
- For presentations to stakeholders, the report must be the primary document to support the material presented and all attending MCE staff must be thoroughly conversant with the content of the entire report.
- The report must be submitted in the same font, preferably 12-point throughout the document.

The header and footer of the document must be defined across all pages of the report. The footer must include the MCE name, page number X of XX total pages, and date of the information. The title of the report must be included in the header or footer as appropriate for formatting of the document as well as the reference to *Indiana Pathways for Aging* program.

10.c Report Listing

Reference the *MCE Reporting Manual for Indiana Pathways for Aging* for additional information on reporting listing and requirements.

10.c.1 Financial Reports

Financial Reports assist the State in monitoring the MCE’s financial status and trends to assess its stability and continued ability to offer health care services to its members. If the MCE does not meet the financial reporting requirements, the State will notify the MCE of the noncompliance and designate a period of time, not less than 10 calendar days, during which the MCE must provide a written response to the notification. MCEs must meet IDOI licensure and financial requirements. Examples of Financial Reports to be submitted by the MCE, in accordance with the terms of the *MCE Reporting Manual*, include but are not limited to:

- IDOI Filing
- Physician Incentive the Contractor Disclosure
- Encounter Data Quality Validation template

- Insurance Premium Notice
- Capitation Reconciliation Report
- Vendor Contact Sheet
- Key Staff and Other Staffing

On an annual basis, the MCE must submit audited financial reports based solely and distinctly on *Indiana Pathways for Aging* program. **The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.** Audits are to be performed for calendar years using data on a service-incurred basis with six 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 listed in *45 CFR 158.150b*. The audit shall review if quality improvement spending passes the requirements under referenced federal code.

10.c.2 Member Service Reports

Member Service Reports identify the methods the MCE uses to communicate to members about preventive health care and program services and monitor member satisfaction.

The State reserves the right to require more frequent Member Service reporting at the beginning of the contract and as necessary to ensure satisfactory levels of service for members and caregivers.

10.c.3 Network Development Reports

Network Development Reports assist the State in monitoring the MCE's network composition by specialty and geo-access ratios to assess member access and network capacity. The MCE shall identify current enrollment, gaps in network services, and the corrective action strategies that the MCE is undertaking to resolve any potential problems relating to network access and capacity.

The State will require frequent Network Geographic Access Assessment reporting to ensure satisfactory network access during *Indiana Pathways for Aging* readiness review process and on-going monitoring of network changes, as necessary.

10.c.4 Provider Service Reports

Provider Service Reports assist the State in monitoring the methods the MCE uses to communicate to providers about clinical, technical, and quality management and improvement issues relating to the program. The State reserves the right to require more frequent provider service reporting at the beginning of the contract to ensure satisfactory levels of provider service.

10.c.5 Quality Management Reports

Quality Management Reports document the methods and processes the MCE uses to identify program and clinical improvements that enhance the appropriate access, level of care, quality, and utilization of program services by its members and providers. These reports assist the State in monitoring the MCE's quality management and improvement activities.

10.c.6 Utilization and Authorization Reports

Utilization Reports assist the State in monitoring the MCE's utilization trends, performance, and progress towards performance targets. The MCE will monitor utilization by subpopulation when appropriate and as directed by the State.

The State reserves the right to require the MCE to submit regular prior authorization detail information on every prior authorization request received and processed in an electronic State specified format.

10.c.7 Claims Reports

Claim reports assist the State in monitoring the MCE's claims processing activities to ensure appropriate member access to services and payments to providers. The MCE shall submit claims processing and adjudication data. The MCE shall also identify specific cases and trends to prevent and respond to any potential problems relating to timely and appropriate claims processing.

10.c.8 Care Coordination and Service Coordination Reporting

Care Coordination and Service Coordination Reports are necessary to monitor the critical collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet members' individual health needs through communication and available resources to promote quality and cost-effective outcomes. Care Coordination and Service Coordination reports will include metrics and performance data on Service Plan Timeline Requirements referenced in Section 4.10.5 of the *Indiana Pathways for Aging* scope of work.

10.c.9 Health Outcomes and Clinical Reporting

Health Outcomes and Clinical Reports assist the State in monitoring the health status of *Indiana Pathways for Aging* members and to identify the effectiveness of MCE interventions.

10.c.10 CMS Reporting

The MCE shall cooperate the State in meeting all federal reporting obligations. The MCE shall be required to submit data requested by the Centers for Medicare and Medicaid Services (CMS), including but not limited to all required MCE reporting obligations described in the CMS Special Terms and Conditions (STCs) for the State's waiver. For example, in addition to the specific reports described in the STCs, CMS often requests additional data and reports from the State. Upon notification of CMS reporting needs, the State will require the MCE to submit the data in a timeframe specified by the State. The MCE agrees to submit data for quarterly and annual reports to the State in a timeframe and format as set forth in the *Indiana Pathways for Aging* MCE Reporting Manual. For any reports not specifically set forth in the MCE Reporting Manual, the State will request any such reporting and data directly to the MCE Compliance Officer.

10.c.11 Other Reporting

The State shall have the right to require ad-hoc reports to address program-related issues that may be necessary for program monitoring and oversight. Additional information on ad hoc reporting requirements is listed in Section 10.b.

Appendix A: Indiana Pathways for Aging Capitation Payment Transaction Codes

Indiana Pathways for Aging MCE Capitation Rate Cells

Description	Capitation Categories
Indiana Pathways for Aging member who is: • receiving Medicare, and/or • receiving MSP Aid Category (SLMB or QMB), • without Advance Determination of Medicare Coverage (ADMC) Benefit Plan, and • without mLTSS Nursing Facility Level of Care (NFLOC)	Acute Dual (AD)
Indiana Pathways for Aging member who is: • Not receiving Medicare, • without Advance Determination of Medicare Coverage (ADMC) Benefit Plan, and • without mLTSS Nursing Facility Level of Care (NFLOC)	Acute Non-Dual (AN)
Indiana Pathways for Aging member who is: • receiving Medicare, and/or • receiving MSP Aid Category (SLMB or QMB), • with Advance Determination of Medicare Coverage (ADMC) Benefit Plan, and/or • with mLTSS Nursing Facility Level of Care (NFLOC)	LTSS Dual (LD)
Indiana Pathways for Aging member who is: • Not receiving Medicare, • with Advance Determination of Medicare Coverage (ADMC) Benefit Plan, and/or • with mLTSS Nursing Facility Level of Care (NFLOC)	LTSS Non-Dual (LN)

Indiana Pathways for Aging MCE Payment Reason Codes

Description	Capitation Reason Codes
As of March 2023, this information is not available.	

Appendix B: Extracts and Reports

The following table depicts extracts, files and reports that are shared with or submitted by the MCEs on a regular basis. These extracts and reports are generated by the State Fiscal Agent, the FSSA Enterprise Data Warehouse (EDW) or OptumRx.

Report/Extract Title	Topic	Frequency	Definition of Report/Extract	Source	File Location
As of March 2023, this information is not available.					

Appendix C: Member FAQ & Who to Contact

Division of Family Resources 800-403-0864

- Report changes to personal or eligibility information (see [2.a.1](#))
- Apply for Medicaid
- Obtain Medicaid case number
- Questions about Medicaid eligibility redetermination
- Incorrect liability calculation
- Incorrect transfer of property calculation
- Appeal of Medicaid eligibility decision
- Report Medicaid Fraud
- Update Medicaid Authorized Representative

Enrollment Services Vendor IndianaLeads@Maximus.com

- Select or Change MCE (see [5.c](#))

MCE

- Appeal claim denial
- File grievances
- Understanding available services and benefits
- Order a new Member ID card
- Appeal of Medicaid eligibility decision
- Prior authorization questions and issues
- Unable to access waiver services
- Change PMP
- Member received a medical bill

Adult Protective Services 800-992-6978

- Report abuse or neglect

LTC Ombudsman 800-622-4484

- Complain about care received in a facility

Member Services and Supports

- Assistance with appeals
- Assistance with grievances

Appendix D: MCE Remittance to the State

MCE must establish a vendor account in the State's accounting system. Required forms are a W-9 and the *Automated Direct Deposit Authorization Agreement* (47551). MCE shall submit to ClaimsInfo.FSSA@fssa.IN.gov.

- ♦ The W-9 can be found at <https://www.irs.gov/forms-instructions>
- ♦ The Automated Direct Deposit Authorization Agreement can be found at <https://www.in.gov/auditor/forms/>
- ♦ Checks shall be made payable to the State of Indiana
- ♦ The MCE must notify the State of date and amount of remittance to allow for tracking purposes

Two remittance options are available with **ACH preferred**:

ACH/WIRE

Huntington Bank
ACH or EFT Transfer Routing Number: 074-000-078
Wire Routing Number: 044000024
Account: 01401153681

MAIL CHECK

Lockbox: FSSA Claim Repayment
P.O. Box 621007 Indianapolis, IN 46262-1007

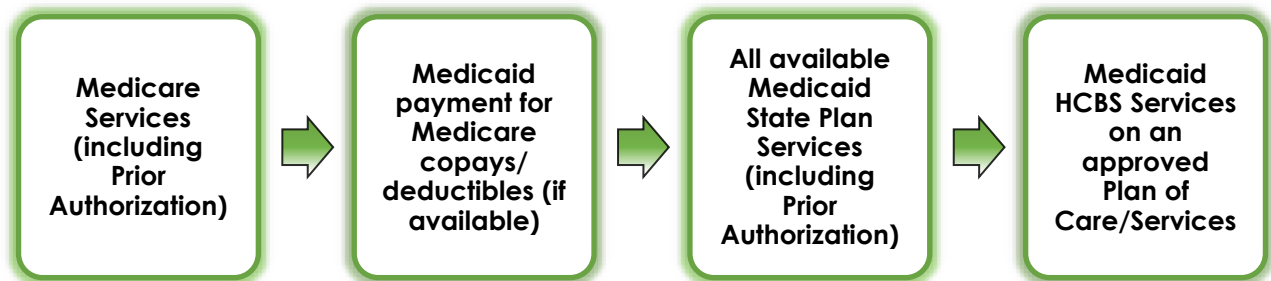
Appendix E: State Systems and Vendors

Vendor	Function	Scope Related to <i>Indiana Pathways for Aging</i>
Deloitte	Indiana Eligibility Determination Services System (IEDSS)	• Indiana's Medicaid Eligibility System overseen by DFR. This is the eligibility system of record.
Gainwell	CoreMMIS	• Receives eligibility information from IEDSS • Receives level of care information from ESV • Receives MCE selection information from Enrollment Broker • Facilitates the IHCP provider enrollment • Sends all member eligibility data to MCEs and other standard data transaction files (834, 820, and 835) • Sends IHCP provider enrollment data to the MCEs • Receives and processes the MCE PMP Assignments. This is the plan assignment system of record. • Receives and processes the MCE Encounter Data files (837) • Administers FFS benefits and processes FFS claims • Pays MCE capitation • Operates the Provider Healthcare Portal
EDW/SSDW	Secure FTP	• Contains MMIS data extracts and provides reporting to the MCEs. Also contains Medicaid eligibility, SNAP and TANF data from IEDSS • Receives the FFS prior authorization and claims data and provides it to the MCEs • Receives and processes the MCE pharmacy encounter data • Produces the Encounter Submission Summary Report for the MCEs • Receives the Health Needs Screening data from the MCEs
Maximus	Enrollment Broker	• Supports member MCE selection counseling for new applicants and existing members
To Be Determined	Member Support Services Vendor	• Post enrollment beneficiary support

Appendix F: TPL Hierarchy

There are many rules and requirements for billing TPL when it concerns Medicare and Medicaid, as well as State-funded services (those services funded with 100% State dollars). In general, all available Medicare services should be exhausted prior to billing Medicaid. For Medicaid, all State Plan services should be exhausted (including those requiring Prior Authorization) prior to utilizing services on a Waiver plan of care/services. A State-funded service should be billed after exhausting all other sources.

Medicare and Medicaid



How does other insurance work with Medicare?

Third Party Liability considerations is challenging if a beneficiary has other insurance, such as employer-sponsored health plans, size of employer or former employer, etc. Below is a list of the hierarchy of Third Party Payment options.

Type of Insurance	Primary Payor
Member has Retiree Health Coverage from self or spouse's former employment	Medicare
For member 65 years of age or older who: - has insurance through a current (active) employer which has 20 or more employees, or - their employer has Federal Employee Health Plan Benefits (FEHB)	Employer Group Health Plan
For member 65 years of age or older who: has insurance through a current (active) employer which has fewer than 20 employees	Medicare
For disabled members under 65 years of age - Member or their family member has insurance through current (active) employer which has 100 or more employees, or - their employer has Federal Employee Health Plan Benefits (FEHB)	Employer Group Health Plan
For disabled members under 65 years of age Member or their family member has insurance through current (active) employer which has fewer than 100 employees	Medicare
Member has TRICARE	Medicare unless the member is on Active Duty or receiving services obtained from military hospital, clinic, or other federal health care provider
Member receives Veterans Administration (VA) Benefits	VA benefits can only be received at VA facilities and private facilities accepting VA benefits.
Member receives Indian Health Services	Medicare