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EXHIBIT 1
ACKNOWLEDGEMENT OF AWARENESS, SERVICES TO BE PROVIDED

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EXHIBIT 1
ACKNOWLEDGEMENT OF AWARENESS, SERVICES TO BE PROVIDED

1. ACKNOWLEDGMENT OF AWARENESS

By executing this agreement, the Medicare Advantage Organization (MAO) Contractor acknowledges it is aware of, understands, and agrees to the following:

CY2027 Intentions

A. The State implemented the Indiana PathWays for Aging program (PathWays) to replace its Fee-For-Service (FFS) Long-Term Services and Supports (LTSS) service delivery system for individuals aged 60 and older. The Indiana PathWays for Aging program population is comprised of a significant proportion of dual eligible members. The State views Medicare Advantage Dual-eligible Special Needs Plan(s) (D-SNP(s)) as a critical component of the Indiana PathWays for Aging program, as the State desires to better align and integrate care for dually eligible members.

B. The State values the opportunities for increased integration of care and improved health outcomes that the alignment of Medicaid and Medicare systems provides. A significant investment of State and health plan resources has been made to evolve Indiana dual eligible programs to the current, FIDE SNP status. Not only does the FIDE SNP Indiana PathWays for Aging Dual Care (PathWays Dual Care) set the stage for the strongest population health strategy a state can have for duals, it also increases alignment and increases opportunities for success achieving our Medicaid Managed Long-Term Services and Supports (mLTSS) program goals. The State is committed to supporting the success of our integrated models of care and continuing to advance our model.

C. The State expects the Contractor to refine internal and external communication practices in an appropriate manner as a PathWays Dual Care Plan. This includes, but is not limited to:

- The Contractor having internal information sharing procedures updates so that staff in need of information shared at any D-SNP or Managed Care Entity (MCE) meeting, that is relevant for successful D-SNP operations, receive needed updates in a comprehensive and timely manner.
- The Contractor will proactively communicate to the State information about changes that stand to impact dual eligibles and/or Medicare processes that impact the Indiana dual eligible population. For example, anything that may impact or delay dual eligible enrollment into your D-SNPs or the addition or sunsetting of other Medicare products the Contractor may offer that also enroll individuals with dual eligibility.

D. The Indiana PathWays for Aging MCEs are required to maintain a fully developed companion D-SNP that operates both CO D-SNP and FIDE SNP Plan Benefit Packages (PBPs) statewide. The State shall only contract with D-SNPs that have an aligned parent company holding a contract under Indiana PathWays for Aging Medicaid and mLTSS program.

E. The State has the right to establish an enrollment freeze for any D-SNP offered under this contract based on regulatory actions taken by the State that are in the best interest of the State.

F. The State will require the continued use of integrated materials as outlined in Section 3.CC and will require the use of an integrated Annual Notice of Change (ANOC) and Member Handbook (Evidence Of Coverage) effective for CY2027.

G. The State is continuing to explore greater consistency with Indiana PathWays for Aging Dual Care plans PBP structure and will require Contractors to offer four (4) D-SNP PBPs going forward, including two (2) distinct Indiana PathWays for Aging Dual Care PBPs, as specified in Section 3.N.

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Future Intentions

H. The State will take appropriate action to implement any policy changes necessary to effectuate the most recent CMS regulatory requirements around D-SNPs.

I. The State intends to be a more active partner with the Contractor in determining its supplemental benefit offerings and better capturing the value of supplemental benefits offerings for CY2027 to Indiana members. The State intends to collaborate with the Contractor as they develop D-SNP supplemental benefit offerings to ensure alignment with the State's supplemental benefit design principles. This includes moving into a review and approval relationship between the State and Contractor prior to CMS supplemental benefit offering submission. The State acknowledges that the details it receives about a D-SNP's proposed supplemental benefits offerings are subject to this Contract's confidentiality and non-disclosure provisions, specifically including, without limitation, the supplemental benefits confidentiality and non-disclosure provisions in Exhibit 1, Section 3 (Administrative Duties of Contractor).

J. The State may pursue passive enrollment in accordance with CFR 422.60 (g), if transitioning in any new MCEs and D-SNPs. In this case, the Contractor must work with the State to support passive enrollment.

K. The State is actively working to more comprehensively integrate the State's quality measurement and improvement strategy across Medicaid MCE and dual eligible programming to align efforts and resources to deliver greater impact.

2. BACKGROUND

FSSA administers the Medicaid program in the State of Indiana under Title XIX of the Social Security Act.

The State partners with the Centers for Medicare and Medicaid Services (CMS) to sponsor MAOs under Title XVIII of the Social Security Act, including D-SNP(s) that arrange for the provision of Medicare services for individuals who are dually eligible for both Medicare and Medicaid benefits pursuant to Titles XVIII and XIX of the Social Security Act.

The Medicare Improvements for Patients and Providers Act of 2008 and its implementing regulations issued by CMS require that the Contractor enters into a contract with the State Medicaid Agency to coordinate benefits and/or services for members of the Contractor's D-SNP(s) within the State. The Balanced Budget Act of 2018 and its implementing regulations issued by CMS require the Contractor's D-SNP(s) to maintain a level of integration between Medicaid and Medicare.

The Contractor and the State desire to enter into an arrangement regarding the provision of Medicare benefits by the Contractor's D-SNPs within the State in an effort to improve the integration and coordination of such benefits as well as to improve the quality of care and reduce the costs and administrative burdens associated with delivering such care.

3. ADMINISTRATIVE DUTIES OF CONTRACTOR

Administrative Requirements

A. To support ongoing engagement and commitment to improving integration of Medicare and Medicaid services for dual eligible individuals in Indiana and to foster increased efficiencies and alignment between Medicare and Medicaid operations, processes, and administration, the State shall require the Contractor to dedicate resources and time to attend and engage in regular, ongoing meetings to build meaningful communication and collaboration between the State and all Indiana D-SNPs.

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The Contractor shall designate sufficient resources, time, and personnel to attend, at a minimum the following recurring meetings:

1. Monthly D-SNP/Area Agency on Aging (AAA) Care Coordination Workgroups;
2. Routine D-SNP/State Compliance Updates;
3. Monthly D-SNP/MCE Integration Meeting;
4. D-SNP Member Materials Workgroup; and
5. D-SNP Integrated Performance Improvement Workgroup

The Contractor will also be expected to participate and commit sufficient time and staff for initiatives and projects that support the implementation of State Agency Medicaid Contract (SMAC) requirements. The Contractor shall also attend ad-hoc meetings as requested by the State. The State reserves the right to request and require specific Contractor D-SNP staff members to attend any D-SNP related meetings. The Contractor shall accommodate staff schedules to permit staff attendance and participation in scheduled ad hoc meetings.

It is the expectation of the State that the Contractor has internal processes in place to consistently and comprehensively share information conveyed in meetings with the appropriate staff that have responsibility for D-SNP operations and policy. This includes Contractor's MCE staff, subcontractors and/or vendors as applicable.

The Contractor is required to have a D-SNP/Dual Care Director. This position is responsible for compliance with Indiana's state-specific SMAC which requires the coordination of Medicare and Medicaid benefits. Key requirements include maintaining the State contracts, implementing the Model of Care (MOC) for care coordination, and ensuring compliance with State-specific regulations. The position serves as a liaison with the State and must participate in State dual care meetings and all-MCE collaboration discussions.

The Contractor shall coordinate with the Medicare and Medicaid Coordination Manager in the Indiana Office of Medicaid Policy and Planning (OMPP) to determine all required meeting participants as well as agenda content, meeting duration, scheduling logistics, and meeting frequency.

B. The Contractor must maintain compliance with all Indiana PathWays for Aging contract requirements in addition to SMAC requirements for the Contractor's FIDE SNPs to be considered compliant Indiana PathWays for Aging Dual Care plans.

In the event the requirements outlined in this contract differ from those in the Indiana PathWays for Aging contract, the Contractor must follow the contract with the more stringent requirements.

C. The State requires the Contractor to operate and maintain a D-SNP Only H Contract with CMS exclusive to the Indiana D-SNP market that is compliant with 42 CFR 422.107.

D. The State requires that PathWays Dual Care maintain an integrated provider network that has at minimum 80% of the PathWays Medicaid plan network providers in the D-SNP network except for those that are Medicaid only. Should the Contractor fall below the 80% threshold, the Contractor is required to submit monthly network overlap reporting on the template provided by the State until the Contractor has had three (3) consecutive months of 80% or higher. The Contractor must be compliant with PathWays network notification requirements; the State may pursue noncompliance remedies if the Contractor does not maintain compliance.

- The Network Overlap Reporting is due in September, utilizing the template provided by the State.

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- The Contractor must comply with all requirements in Indiana Health Coverage Programs (IHCP) Bulletin BT202595 regarding required Medicare enrollment for home health agencies.

E. The Contractor is required to outreach at least two (2) times to any full benefit dual eligible member enrolled in its non-D-SNP Medicare Advantage product(s). The purpose of this communication is to provide education about the D-SNP product, benefits of enrolling in the D-SNP, and support on changing plan selection. These communications need to occur prior to the Medicare annual enrollment period with at least one (1) of the communications required to be in writing.

The Contractor is required to report to the State details of outreach efforts made (date, communication mode, messaging and impact analysis that stratify dual populations) by the end of October annually in a format as required by the State, as specified in Section 5. D-SNPs are additionally required to submit their overarching dual-eligible member outreach marketing plans to the State quarterly, as specified in Section 5.A.

F. The Contractor must submit to the State a copy of its required D-SNP training for insurance agents. The training material must be submitted on an annual basis prior to annual agent recertification.

To align with the State's alignment and integration goals, the State may provide the Contractor with Indiana PathWays for Aging educational material that must be shared with the Contractor's insurance agent community.

G. The Contractor shall provide "Deemed Continued Eligibility" for six (6) months to maintain the maximum continuity of care for individuals that no longer meet D-SNP eligibility criteria due to a temporary loss of Medicaid eligibility (in accordance with the guidance provided by CMS in its annual Medicare Advantage enrollment and disenrollment guidance documents available at https://www.cms.gov/medicare/enrollment-renewal/managed-care-eligibility-enrollment).

H. To mitigate Medicaid eligibility churn and ensure continuity of care, the Contractor shall actively assist D-SNP members in establishing appropriate and timely Medicaid eligibility or reestablishing Medicaid eligibility for members who temporarily lose it. This shall include but is not limited to:

1. Supporting Contractor staff with direct member interaction—including care management and call center staff—in maintaining the knowledge and capacity to help members connect with Medicaid navigators and; understanding where they can access the Medicaid eligibility application; what members need to know about the State redetermination processes; and the State's expectations for maintaining Medicaid eligibility;

2. Maintaining knowledge of the State agencies, organizations, requirements, and processes for assessing and determining Medicaid eligibility; how these State entities function and serve Medicaid members in Indiana; and how to connect members to them;

3. Assisting D-SNP members in locating and compiling the necessary information and documentation to establish or reestablish Medicaid eligibility;

4. Assisting D-SNP members identified by the Contractor as potentially eligible for but not yet enrolled in a Medicare Savings Program (MSP) and contacting the Indiana Division of Family Resources (DFR) in order to have MSP eligibility determined.

The State shall provide the Contractor with education opportunities and training on

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Medicaid eligibility processes and requirements. The State reserves the right to establish additional review of Contractor systems, processes, and staff education to assess effectiveness and sufficiency.

I. The Contractor shall include the health plan member ID number on CO D-SNP member ID cards. The Contractor shall not include the Medicaid or Medicare Beneficiary ID number on CO D-SNP member ID cards.

J. The Contractor will verify, prior to enrollment of a potential qualified recipient, the individual's Medicaid eligibility and other eligibility criteria necessary to accurately assign new enrollees to the correct D-SNP PBP. In particular, the Contractor must verify the individual's specific category of Medicaid eligibility, age; PathWays eligibility; and Nursing Facility Level of Care (NFLOC) need. The Contractor will provide the State with an electronic submission, in a mutually agreed upon format, of those qualified recipients that have voluntarily enrolled and disenrolled in the Plan. The State shall verify the eligibility of those persons on the submission and return the enrollment information to the Contractor as soon as reasonably possible. For those enrollees who are not determined eligible by the State and for which CMS records indicate that the recipient should be eligible, it will be the responsibility of the Contractor to resubmit the enrollment to the State on the next submission, specifying the retroactive effective date of the enrollment in the Plan. Enrollments are otherwise effective only on a monthly basis, with the eligibility period beginning as of the first day of the month after the enrollment is received.

For the purpose of determining a PBP for which an individual is eligible, individuals meeting NFLOC can be identified via 270/271 file exchange with the State. The Contractor must use the State's Health Care Eligibility Benefit Inquiry and Response (270/271) Companion Guide as a supplemental resource. The Contractor is required to monitor member NFLOC status changes to effectively move enrolled members into the appropriate FIDE SNP NFLOC/non NFLOC PBP. The State expects plans to move members as quickly as possible into the correct PBP, ideally within two (2) calendar months from the date an NFLOC status change was reflected on the 270/271 file.

In accordance with 42 CFR 422.2, 422.66, 422.107, and applicable CMS Medicare Advantage Enrollment and Disenrollment Guidance, the Contractor acknowledges that individuals enrolled in a CO D-SNP may subsequently become newly eligible for enrollment in a FIDE SNP due to a change in eligibility status.

When an individual becomes newly eligible for the FIDE SNP, the Contractor shall implement procedures to actively facilitate aligned enrollment, including timely identification of eligibility changes, provision of clear and compliant member notices, and education regarding the FIDE SNP as an integrated coverage option. Such outreach shall be conducted in compliance with all applicable Medicare marketing, communication, and beneficiary protection requirements and shall not be coercive or misleading.

Nothing in this section shall be construed to require mandatory enrollment or to limit an individual's right to decline enrollment in the FIDE SNP; however, the Contractor shall demonstrate good faith operational efforts to promote integrated enrollment consistent with federal policy objectives and State goals for Medicare Medicaid integration.

K. The State has the right to establish an enrollment freeze for any D-SNP offered under this contract based on regulatory actions taken by the State that are in the best interest of the State.

L. The Contractor and the State shall mutually agree on the type and format of any information or materials requested by the State that the Contractor agrees to provide. Before submitting to the State any information or materials that the Contractor regards as proprietary or

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confidential, the Contractor shall label all such information and materials as proprietary and confidential.

1. MCEs and D-SNPs must add "CONFIDENTIAL" to the end of the file name.
2. Example of HPMS file name: H9999_HUM_UnableReach_v1_CONFIDENTIAL
3. Example of Salesforce file name: 999999IN012726_ANT_UnableReach_v1_CONFIDENTIAL

The State shall make good faith, reasonable efforts to establish, implement and enforce policies and procedures governing the receipt, maintenance and storage of, and access to any information and materials labeled by the Contractor as proprietary and confidential pursuant to this contract and to limit access to such information and materials to only those staff members with a direct need for that access. The parties acknowledge and agree that, to the extent that information and materials the Contractor provides to the State contain or constitute trade secrets and/or confidential financial information, such information and materials are excepted from disclosure, inspection and copying pursuant to Indiana Code § 5-14-3-4(a).

M. The following is a list of deliverables the Contractor is required to produce in addition to the formal reports listed in Section 5 (Reporting Requirements). This list is meant to support State and Contractor organization and is not exhaustive. The Contractor must follow all requirements of the contract, and the State may adjust the below list at any time.

- Required D-SNP agent training materials (Section 3.F)
- Submission of pre-enrollment Medicaid eligibility information for potentially qualified recipients (Section 3.J)
- Unified grievance and appeal information, as requested by the State (Section 3.BB.2)
- Integrated member materials for State review within the timeframes established by the State (Section 3.CC.1)
- Written care coordination policies for each PBP (Section 4.E)
- Dementia Care Program Plan, including Dementia Caregiver Support Program (Section 4.O)
- Falls Prevention Plan (Section 4.P)
- All required training content and strategies for D-SNP care managers (Section 4.Q)
- Submission of required notifications and information related to High-Risk members (Section 4.S and Section 4.X)
- SDOH assessment tool (Section 4.DD)
- SDOH Interventions Plan (Section 4.FF)
- D-SNP Model of Care (Section 4.GG)
- If applicable, I-SNP and/or C-SNP MOCs (Section 4.MM)

<u>D-SNP Plan Benefit Packages (PBPs)</u>

N. The State requires D-SNPs to offer four (4) D-SNP PBP's that meet the following requirements:

1. CO D-SNP PBP available to full-benefit dual eligible individuals that are not eligible for the Indiana PathWays for Aging program (QMB-Plus, SLMB-Plus, Other Full-Benefit Dually Eligible (FBDE));
2. CO D-SNP PBP available to partial-benefit dual eligible individuals (QMB-only, SLMB-only, QI, QDWI).
3. FIDE SNP PBP available to Indiana PathWays for Aging Dual Care members that are not eligible for Nursing Facility Level of Care (non NFLOC), which include QMB-Plus, SLMB-Plus, and other FBDE members. The State will continue to require FIDE SNP

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PBP(s) that must be branded as Indiana PathWays for Aging Dual Care (PathWays Dual Care). Each FIDE SNP PBP shall use Indiana PathWays for Aging Dual Care or PathWays Dual Care as part of the PBP name.

4. FIDE SNP PBP available to Indiana PathWays for Aging Dual Care members that are NFLOC (PathWays Waiver enrollees, Money Follows the Person (MFP) participants, and long-term Nursing Facility residents), which include QMB-Plus, SLMB-Plus, and other FBDE members. The State will continue to require FIDE SNP PBP(s) that must be branded as Indiana PathWays for Aging Dual Care (PathWays Dual Care). Each FIDE SNP PBP shall use Indiana PathWays for Aging Dual Care or PathWays Dual Care as part of the PBP name.

O. In the event that a member who is ineligible for an Indiana PathWays for Aging Dual Care PBP becomes eligible for one of the FIDE SNP PBPs during the contract year, the State expects the Contractor to actively work with the member to support enrollment into the most appropriate PBP that aligns with eligibility status, ideally within two (2) months from the date the individual qualified for enrollment into a FIDE SNP PBP. For any member that cannot be moved within two (2) months of eligibility effective dates, the D-SNP must work with CMS to crosswalk the member into the appropriate PBP for the following calendar year.

P. In the event that a member in a PathWays Dual Care PBP becomes ineligible due to eligibility change, the State expects the Contractor to actively work with the member to support enrollment into the CO D-SNP PBP that aligns with eligibility status, ideally within two (2) months from the date the individual lost FIDE SNP PBP eligibility. For any member that cannot be moved within two (2) months of eligibility effective dates, the Contractor must work with CMS to crosswalk the member into the appropriate PBP for the following calendar year.

Cost-Sharing and Payment Requirements

The below section outlines cost-sharing coverage in Indiana. The State of Indiana pays for all dual eligible's premiums according to the table below, regardless of Medicaid delivery system. The State of Indiana also covers Medicare Parts A & B cost-sharing (according to the table below) for members in FFS Medicaid. Medicare Parts A & B cost-sharing for members enrolled in Indiana PathWays for Aging are the responsibility of those Medicaid MCEs.

Category	Medicare Part A Premiums	Medicare Part B Premiums	Medicare Cost-Sharing	Other Medicaid Benefits
QMB-Only	X	X	X	
QMB-Plus	X	X	X	X
Other FBDE		X	X*	X
SLMB-Only		X		
SLMB-Plus		X	X*	X
QI		X		
QDWI	X			

*Cost-sharing coverage for SLMB-Plus and Other FBDE members is limited to services covered by IHCP, Medicare covered services not covered by IHCP are not included. QMBs receive cost-sharing coverage on all Medicare covered services, regardless of IHCP coverage of the service.

NOTE: Indiana's Medicaid State Plan Section 3.2 outlines the cost-sharing coverage for members with Medicare. As required by Federal Law, QMB members (with or without full Medicaid) cannot be billed for any cost-sharing for Medicare Part A or Part B services. The above table is only for Medicare Parts A and B; Part D is not included.

Q. Indiana does not allow any nominal Medicaid copayments to be charged to the population(s)

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eligible for enrollment in the Contractor's D-SNP under its state plan for medical assistance. Therefore, per sections 1902(n)(3)(B) and 1852(a)(7) of the Social Security Act and 42 CFR 422.504(g)(1)(iii), the Contractor may not charge any QMB, QMB+, SLMB+ or Other FBDE enrollee of the Contractor's D-SNP any cost sharing for any Medicare A or B service rendered by one of the Contractor's network providers, except in the rare case of Medicare A or B services that are not covered under Indiana's Medicaid state plan or an Indiana Medicaid waiver, wherein SLMB+ and Other FBDE enrollees in the Contractor's D-SNP may be charged the full Medicare cost-sharing amount specified within the D-SNP's PBP. SLMB, QI, and QDWI enrollees are responsible for covering their own cost-sharing amounts for Medicare A and B services.

The Contractor's materials shall:

- Clearly describe the cost-sharing amounts corresponding to each Part A and B service covered under the Contractor's D-SNP and the enrollee populations to whom those cost-sharing amounts apply (specifically, the D-SNP's SLMB, QI, and QDWI enrollees).
- Make clear that QMB and QMB+ enrollees will not owe any Medicare cost-sharing amounts for any Medicare A or B services rendered by a provider in the Contractor's network or an out-of-network provider enrolled in Medicare.
- Make clear that SLMB+ and Other FBDE enrollees will not be held liable for cost-sharing amounts associated with Medicare A and B services rendered by the Contractor's network providers if the services are also covered under Indiana's Medicaid state plan.
- [For PPOs and HMO-POS plans only] Indicate that SLMB+ and Other FBDE individuals may be charged cost-sharing amounts if they see a provider who is not part of the Contractor's D-SNP network or a registered Medicaid provider in Indiana, and/or obtain services that are not covered under Indiana's Medicaid state plan or an Indiana Medicaid waiver.

The Contractor's provider agreements shall specify that:

- For services rendered to QMB and QMB+ enrollees, contracted providers will: (1) accept the Contractor's Medicare reimbursement as payment in full or bill the MCE or State, as applicable, for any additional Medicare cost-sharing payments that may be reimbursable by Medicaid, and (2) refrain from collecting any cost sharing from the QMB or QMB+ enrollees.
- For services rendered to the Contractor's SLMB+ and Other FBDE enrollees, contracted providers will accept the Contractor's Medicare reimbursement as payment in full or bill the MCE or State, as applicable, for services that are covered under Indiana's Medicaid state plan or an Indiana Medicaid waiver, and refrain from collecting cost sharing from SLMB+ and Other FBDE enrollees for those services.
- For services rendered to SLMB, QI and QDWI enrollees, contracted providers will charge the enrollees no more than the cost-sharing amounts established within the Contractor's D-SNP PBP.

R. The Contractor shall recognize limits on the out-of-pocket costs for the dual-eligible persons enrolled in its Plans. The Contractor shall not impose cost-sharing requirements on dual-eligible Plan members that would exceed the amounts permitted under Medicaid regulations.

S. Medicaid is required by federal regulations to access all third-party payment sources and to seek reimbursement for services that have also been paid by Medicaid. "Third Party" means an individual, institution, association, corporation or public or private agency, including Medicare, private health insurance and workers compensation insurance that is liable for payment of all or part of the medical cost of injury, disease or disability of a Medicaid beneficiary. The Contractor shall cooperate with the State's efforts to enforce third party liability, including procedures for appropriate coordination of benefits between Medicare and Medicaid. Medicare benefits, including those offered by the Contractor through its Plans, will

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sometimes pay after third party resources other than Medicaid and nothing in this Contract shall prevent the Contractor from enforcing its rights regarding payments of and by any non-Medicaid third party.

To ensure the State does not duplicate payments on any provided services, the D-SNP will provide a copy of its CMS submitted SNP bid to the State within thirty (30) days of submission to CMS. The D-SNP will provide a copy of the D-SNP's approved CMS bid to the State if the approved bid differs significantly from the submitted bid. The D-SNP must identify information as trade secret prior to or at the time of its submission for the State to consider classifying such trade secret data as non-public.

Supplemental Benefits

T. The Contractor shall collaborate with the State on its supplemental benefit offerings and the development process for its supplemental benefit offerings in order to achieve the goals outlined in Section 1.I of the "Acknowledgement of Awareness" in this contract and to align with member benefits offered through Indiana Medicaid [supplemental benefits are defined under 42 CFR 422.102 and in Chapter 4, Section 30 and Chapter 16b, Sections 20.2.6.1 – 3 of the Medicare Managed Care Manual found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf and https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf respectively].

The State has outlined four (4) key principles that the Contractor should use when designing supplemental benefit offerings:

1. Ensure D-SNPs are offering additional benefits that are both population specific and provide extra value to the Indiana PathWays for Aging Dual Care program,
2. Prioritize benefit designs that fill gaps in current benefit structures and support FSSA-identified clinical goals,
3. Simplify supplemental benefit offerings (remove/reduce duplication of coverage for services already covered by Medicaid & Medicare), and
4. Design D-SNP supplemental benefits to support FSSA dual eligible population health priorities while innovating to meet member needs.

U. The Contractor must submit the following reports specific to supplemental benefits:

1. Proposed Supplemental Benefit Offering Report (due March 15th). The State will provide feedback to the D-SNPs by the end of the first week of April,
2. Finalized Supplemental Benefit Offering Report (due by the end of the first week of September), and
3. Supplemental Benefit Summary Document (due by the end of the first week of September).

The State will provide timely review and approval of supplemental benefit offerings prior to when the Contractor is to file benefits with CMS, in a timeline that aligns with Contractor Medicare bid development work. The State will continue to gather Contractor feedback regarding the updated process and timelines to minimize administrative burden.

Default Enrollment

V. All Indiana PathWays for Aging Dual Care D-SNPs must obtain approval from the CMS to be able to default enroll members enrolled in its aligned Indiana PathWays for Aging Medicaid MCE. In conformance with 42 CFR 422.66(c), 422.68(a) and other CMS-published sub-regulatory guidance, as applicable, PathWays Dual Care D-SNPs shall perform the default enrollment process for individuals already enrolled in its parent company's Indiana PathWays for Aging Medicaid plan who are newly eligible for Medicare Parts A and B for the first time due to age or disability. The State reserves the right to activate or deactivate default

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enrollment based on plan performance at any time but will coordinate with the affected D-SNP for transition.

W. In the event that the Contractor receives returned mail from a default enrollment eligible member then the Contractor must make a minimum of three (3) call attempts to the member regarding their default enrollment eligibility.

X. The Contractor must maintain a minimum STAR rating of three (3) and may not have any prohibition on new enrollment imposed by CMS as outlined under 42 CFR 422.66(c) in order to participate in default enrollment. The State shall provide the Contractor with the information necessary to identify those Indiana Medicaid categorically eligible members who are or will be in their Medicare initial coverage election period during the term of the Contract. At least monthly, the State will use the CMS TBQ and MMA files to identify Affiliated Medicaid MCE members with prospective Medicare Parts A and B eligibility due to age or disability. For the affiliated Medicaid MCE members identified by the State, the State will provide the following information to the Contractor monthly in a proprietary file format via a secure file transfer protocol (SFTP) site no less than seventy (70) days before an affiliated Medicaid MCE member becomes eligible for Medicare Parts A and B due to age or disability:

1. First and last name
2. Medicare Parts A and B entitlement date
3. Date of birth
4. MBI
5. Gender

Y. The Contractor must establish an internal process to validate information shared on the Default Enrollment Extract sent from the State. The Contractor shall supplement information provided by the State where appropriate in order to enroll, to the greatest extent possible, all members included in the Default Enrollment Extract.

Z. The Contractor must also take the necessary steps to renew any existing default enrollment process approval(s) with CMS, as per the requirement of 42 CFR 422.66(c)(2)(ii). To minimize the risk of disruption in default enrollment processing, the Contractor shall submit renewal applications to CMS well in advance of the current approved end dates. CMS notifies the MAO six (6) months before the expiration of default enrollment approval. The Contractor shall submit their renewal application within sixty (60) days of receiving CMS expiration notification. The Contractor is required to notify the State within five (5) business days of receiving CMS expiration notice. The Contractor shall provide the following information in their notification to the State:

1. Date by which the Contractor intends to submit a default enrollment application to CMS. Application must be within sixty (60) days from receiving CMS expiration notice.
2. Date by which the Contractor intends to submit application documents to the State for review and request data sharing process. The Contractor is expected to give the State at least thirty (30) days to complete review of the application documents. Documents must be submitted to the State within thirty (30) days after receiving CMS expiration notice.
3. The expected date by which the Contractor will begin to mail the 60-day advance Notice to Confirm Default Enrollment to impacted members after application is approved.

The State expects the default enrollment application to be approved at least sixty (60) days prior to the currently approved application. The Contractor is required to notify the State of any deviations to this timeline within two (2) business days of identifying potential delay.

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FIDE SNP (PathWays Dual Care D-SNP) Requirements

AA. Exclusively Aligned Enrollment

a. Exclusively aligned enrollment (EAE) limits the PathWays Dual Care D-SNP's membership to individuals whose Medicare and Medicaid benefits are provided under a single entity. Federal and Indiana policy requires all PathWays Dual Care FIDE SNPs to operate with EAE. PathWays Dual Care FIDE SNPs with EAE qualify as an applicable integrated plan (AIP), as defined and governed by 42 CFR 422.561.

b. Under the terms of this Agreement, enrollment into the Contractor's PathWays Dual Care D-SNP will be limited to only those full benefit dual eligible members who are enrolled with the Contractor's companion Indiana PathWays for Aging MCE, and who maintain such plan enrollment throughout the course of their PathWays Dual Care D-SNP enrollment. The PathWays Dual Care D-SNP shall keep a member in its PathWays Dual Care D-SNP for the required 6-month deeming period in accordance with this Agreement if such member loses Medicaid eligibility and can reasonably be expected to regain such eligibility within six (6) months.

c. The PathWays Dual Care D-SNP agrees to conduct enrollment of eligible members in accordance with this Agreement and must maintain EAE for the duration of the contract period. The Contractor is required to incorporate language provided by the State into the Enrollment form.

d. The PathWays Dual Care D-SNP shall provide to the State enrollment reports every year in accordance with the timing and format established by the State to ensure that the EAE process is being implemented appropriately.

BB. Unified Grievances and Appeals

1. The PathWays Dual Care D-SNP must comply with the unified grievance and appeal procedures described under the terms of 42 CFR 422.629 – 42 CFR 422.634, 42 CFR 438.210, 42 CFR 438.400, and 42 CFR 438.402. This includes:
    i. Grievance and appeal systems that meet the standards described in 42 CFR 422.629;
    ii. An integrated grievance process that complies with 42 CFR 422.630;
    iii. A process for making integrated organization determinations consistent with 42 CFR 422.631;
    iv. Continuation of benefits while an integrated reconsideration is pending consistent with 42 CFR 422.632;
    v. A process for making integrated reconsiderations consistent with 42 CFR 422.633; and
    vi. A process for effectuation of decisions consistent with 42 CFR 422.634.
2. The State may request unified grievance and appeal data or information from final CMS audit reports. For any corrective actions issued by CMS for unified grievances and appeals, the PathWays Dual Care D-SNP shall notify the State within fifteen (15) days of receipt from CMS.
    i. The State reserves the right to request ad hoc data and records from the PathWays Dual Care D-SNP separate from any requests from or submissions to CMS.
    ii. In addition to Medicare requirements enumerated at 422.629(h)(2), the PathWays Dual Care D-SNPs shall adhere to any additional requirements for recordkeeping outlined in the PathWays MCE contract and are subject to comply with any changes that occur in the stated section of the PathWays MCE contract, particularly any requirements not captured in CMS reporting.

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3. To operationalize and maintain the unified grievance and appeal process, the PathWays Dual Care D-SNP must ensure alignment between the PathWays and PathWays Dual Care D-SNP grievance and appeal processes, including alignment in timeframes for notices, responses, and resolutions. The PathWays Dual Care D-SNP will operationalize the processes and corresponding timeframes specified below to ensure compliance with both 42 CFR 422 and 423 Subpart M for Medicare and Section 5.14 of the PathWays Scope of Work and 2024 Indiana Code Title 27. Insurance Article 1. Department of Insurance Chapter 37.5. Health Care Service Prior Authorization 27-1-37.5-11:

Requirement	**FIDE SNP Timeline**
Routine Grievances- acknowledgement letter	Three (3) business days
Expedited Grievance and Medicare Fast Complaints	Resolved and responded to within twenty-four (24) hours. No acknowledgement letter required
Appeal acknowledgement	The Contractor must acknowledge receipt of each standard appeal within three (3) business days
Expedited Appeal	Resolved within forty-eight (48) hours
Coverage Decision Letter	Letter notification must be sent within seven (7) calendar days after the date the service request was received
Integrated Organization Determinations/ Coverage Determinations- timing of plan decisions	Letter notification must be sent within seven (7) calendar days after the date the service request was received

4. The PathWays Dual Care D-SNP, as an applicable integrated plan as defined in 42 CFR 422.561, is required to use the CMS-provided model for the Coverage Decision Letter to be issued to members as a result of an integrated organization determination for a service or item (including a Part B drug) that is not resolved fully in favor of the member, as described under 42 CFR 422.631. The State reserves the right to require PathWays Dual Care D-SNPs to use other CMS-provided model materials to support the integrated grievance and appeal process.

5. When populating the Coverage Decision Letter with plan-specific information, the PathWays Dual Care D-SNP must refer to its single member services/customer service phone number as described in Section 3.DD.

6. The Contractor shall have processes in place where the assigned care coordinator, service coordinator, and/or case manager are notified of integrated appeal processes outcomes to support effective care coordination activities.

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CC. Member Materials

Integrated Member Materials

1. The Contractor is required to submit integrated member materials to the State for review within the timeframes established by the State. The State intends to leverage the joint review process in HPMS for integrated materials as well as for other specified materials and reserves the right to review Medicaid information in D-SNP member materials outside of the HMPS joint review process when necessary. The Contractor may be required to make State-requested changes to integrated member materials upon the State's review. Required integrated materials will include the following, and as specified in the CMS/Indiana-provided templates, the Contractor must also post an online version of the integrated Provider and Pharmacy Directory and integrated Formulary on its website:
    i. A single ID card for accessing all PathWays Dual Care D-SNP and PathWays Plan services and benefits provided under the PathWays Dual Care D-SNP PBP and as outlined in the PathWays Contract.
        1. The State may require the Contractor to include the State issued Medicaid State ID number or an approved integrated ID number for the PathWays Dual Care Member ID Card.
        2. The ID card must include a single member services/customer service phone number as described in Section 3.DD.
        3. The ID card must be co-branded displaying the State issued PathWays Dual Care logo.
    ii. A combined Provider and Pharmacy Directory that includes all Providers of PathWays Dual Care D-SNP and PathWays MCE services and benefits, and as stated in the Directory, requires the member to choose a Medicare Primary Care Provider (PCP) which will be primary over any Medicaid provider.
    iii. A Formulary (List of Covered Drugs) that includes Outpatient Prescription Drugs (including both Generic and Name Brand) that are covered under Medicare, Medicaid, or as PathWays Dual Care D-SNP-covered supplemental benefits, and what Tier each medication is on.
    iv. A Summary of Benefits that include Medicare and Medicaid covered benefits.
    v. An integrated Annual Notice of Change (ANOC) document.
    vi. A Member Handbook (EOC).
2. Regarding required integrated member materials, including all written member notices required for the unified grievance and appeal process, the PathWays Dual Care D-SNP shall adhere to the requirements of both 42 CFR 422 Subpart V for Medicare and requirements outlined in the PathWays MCE contract.

    i. The Contractor is required to reference the Indiana Long-Term Care (LTC) Ombudsman resource, as defined in Section 6 Definitions, on relevant member notices, as applicable.

Other Member Materials

3. The Contractor is required to submit other member materials to the State for review per the State's established approval process. Other member materials include, but are not limited to, quarterly member newsletters, materials promoting health, materials regarding preventative care information, and member reminders to complete health screenings. The Contractor may be required to make State-requested changes.

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DD. Integrated Customer Service

1. The Contractor shall be responsible for establishing a single member services/customer service phone number for current dual eligible enrollees to contact the Contractor regarding their PathWays Dual Care D-SNP, PathWays MCE, and benefits. Members must be able to access one line that is directly answered by a single, trained, live representative who is either:
    i. Knowledgeable about the PathWays program, Medicare, and the terms of this Agreement, including covered services and available care coordination, or
    ii. Able to conduct at most, one warm transfer for the member to another live representative or live resource that is knowledgeable about the PathWays program, Medicare, and the terms of this Agreement, including covered services and available care coordination.
2. If a plan must answer first with an automated answering tree, such process shall provide amongst its initial choices the option of speaking with a live representative that, when selected, takes the caller directly to the live representative described in Section 3.DD.1.
    i. Live representatives must be provided access to the PathWays Dual Care D-SNP enrollee database and an electronic provider directory. In addition to Medicare customer service call center requirements and standards as outlined in 42 CFR 422.111(h), and as described in the Medicare Communications and Marketing Guidelines (MCMG), the single member services/customer service phone number shall adhere to member toll-free call center requirements as outlined in the PathWays contract, with the Contractor subject to comply with any changes that occur in the stated section of the PathWays contract. The PathWays Dual Care D-SNP shall adhere to the more member-protective requirements in instances where Medicare requirements at 42 CFR 422.111(h) conflict with sections referenced in the PathWays contract.

4. CLINICAL DUTIES OF CONTRACTOR

Coordination of Care and Services

A. The Contractor will have a process in place which assists providers, family members or others who are calling the D-SNP requesting identification of a member's current case coordinator and/or care manager and contact information, with proper member consent. This process must be efficient and not require the callers to make multiple phone calls to find the requested information.

B. The Contractor will make available to Medicaid qualified recipients ("Qualified Recipients") who have Medicare Part A and Part B coverage and reside in the counties listed in Exhibit 2 of this contract, a health insurance policy (the "Plan") providing benefits as outlined in the Contractor's Medicare Advantage health benefit plan. For those who enroll in the Contractor's D-SNP, the Contractor shall be responsible for coordinating the Plan benefits with the Medicaid covered services applicable to their PBP. For PathWays Dual Care members, this includes coordination and full management of the services set forth in **ATTACHMENT B** to this Exhibit 1, **INDIANA PATHWAYS FOR AGING BENEFITS**.

C. The Contractor shall assist members in coordinating all needed Medicaid services, facilitating access to those services, and arranging for the provision of such services through identification and referral to participating Medicaid providers—including long-term services and supports (LTSS) and home and community-based service (HCBS) providers—in its provider network and within its approved service area as listed in Exhibit 2 of this Contract. This includes proactively identifying members before they become 60 years of age and assisting them in transitioning to PathWays Dual Care and the PathWays Waiver when applicable.

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D. The Contractor shall be responsible for providing care coordination for all Medicare and Medicaid services for all members including those the State has designated as High-Risk. For the purposes of this contract, FSSA defines a High-Risk member as any member of the CO D-SNP PBP available to full-benefit dual eligible individuals that are not eligible for the Indiana PathWays for Aging program (QMB-Plus, SLMB-Plus, Other FBDE) who is currently enrolled in the Health and Wellness (H&W), Community Integration and Habilitation (CIH), or Family Supports (FS) HCBS Waiver or Money Follows the Person HCBS programs.

E. The Contractor shall develop separate written care coordination policies for each PBP: Indiana PathWays for Aging Dual Care (NFLOC PBP and non-NFLOC PBP) non-PathWays Full Duals PBP, and Partial Duals PBP within the MOC submission. Written care coordination policies and amendments for any contract year shall be submitted to FSSA for review at least one hundred and twenty (120) days prior to January 1 of the contract year.

The Contractor shall incorporate the care coordination policies developed under this Section in its D-SNP MOC which shall be reviewed and approved as part of the State's MOC review process. The State shall work in good faith with the Contractor on the most efficient and effective incorporation of this information in its MOC and other relevant plan documents as indicated in Section 4.GG of this contract.

The Contractor shall ensure that its MOC appropriately reflects updated care coordination standards/requirements corresponding to the changes in coordinating care with the Indiana PathWays for Aging MCEs. The D-SNP will submit the MOC to the State with associated care coordination policies and procedures as evidence of implementation of Indiana PathWays for Aging requirements.

F. The Contractor shall assume primary responsibility for care coordination of aligned PathWays members including a designated D-SNP care coordinator (distinguished from D-SNP care manager terminology to be used for non-PathWays D-SNP members) and fully integrated Health Risk Assessment (HRA), Individualized Care Plan (ICP), Interdisciplinary Care Team (ICT), and Care Transition protocols. The Indiana PathWays for Aging Dual Care PBP(s) will provide all covered Medicare benefits to meet or exceed care coordination standards as detailed in the PathWays Scope of Work and include:

a. PathWays stratification to complex care management including but not limited to PathWays Dual Care members with cancer; uncontrolled heart failure, COPD, or diabetes; severe mental illness; or palliative care service needs;
b. PathWays members will have a dedicated longitudinal PathWays Dual Care care coordinator (who serves as the PathWays care coordinator), responsible for developing and ensuring implementation of the ICP;
c. PathWays specifications on components to be included in the ICP of PathWays Dual Care members;
d. PathWays specifications on frequency of care management contacts and in-person vs telephonic contacts;
e. PathWays specifications on PathWays Dual Care care coordinator responsibilities with aligned PathWays Waiver and NF service coordinators;
f. PathWays Dual Care ICT serves as the PathWays ICT;
g. PathWays Dual Care care coordinator responsible for care transition processes of PathWays

G. The Contractor shall collaborate with the State to increase the level of integration and alignment of Medicare and Medicaid services to High-Risk members. This shall include all functional and social supports provided through the waivers. To this end, the Contractor—to the greatest extent possible—shall:

1. For all High-Risk members (H&W Waiver, MFP, CIH Waiver, and FS Waiver), assign a designated D-SNP care manager who provides longitudinal care coordination that includes coordination with the member's waiver service coordinator and serves as the

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member's transitions point of contact. The Contractor must make good faith efforts to enroll these members into case management;

2. Make good faith efforts to incorporate High-Risk members' waiver service plans into their D-SNP care plan. The State shall assist the Contractor with accessing the waiver service plans through a State-designated system into its existing systems and processes;
3. Identify, assess, and incorporate existing advance directives—including the designation of a health care representative—into each High-Risk member's D-SNP care plan when applicable;
4. Assess and document "What Matters" most to Indiana High-Risk D-SNP members pertaining to critical issues in their lives and goals and preferences for care; and include this information and use it to inform the member's individualized D-SNP care plan when applicable. The Contractor shall use the Resources to Practice Age Friendly Care of the Institute for Healthcare Improvement as the source for best practices (http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/Resources.aspx).
5. As part of the Part D Medication Therapy Management (MTM) Program and/or D-SNP care management program, include Comprehensive Medication Review (CMR) annually by a pharmacist working in collaboration with the D-SNP member's care manager and prescriber(s) for PathWays Waiver and H&W Waiver participants with a diagnosis of dementia which includes:
   - Medication Action Plan
   - Personal medication list
   - Summary of recommendations
   - Medication refill reminders

H. To facilitate D-SNP member awareness of local community resources and access to non-institutional long term services and supports, the Contractor shall also offer referrals within seven (7) calendar days to the appropriate Indiana Area Agency on Aging (AAA), any non-waiver/nursing facility D-SNP member identified as having strong predictors of needing LTSS but who may not already be enrolled in the PathWays, H&W, FS or CIH Waiver or may not be receiving any LTSS currently. For Indiana PathWays for Aging members that are identified as having strong predictors of needing LTSS by the Contractor, the Contractor must coordinate with their PathWays MCE to address member needs as first line solution and to avoid duplication of referrals to the AAAs. If there is a need for level of care (LOC) determination and/or waiver eligibility, the Contractor will make the referral directly to the Level of Care Assessment Representative (LCAR) and not to the AAA.

   Strong predictors of needing LTSS shall be identified through the Contractor's health risk assessment or a change in health status that may include but is not limited to members:

   1. Admitted to a Skilled-Nursing facility (SNF);
   2. Needing help in Activities of Daily Living (ADLs);
   3. Having a diagnosis of dementia.

I. The State shall establish procedures, the levels of communication, and data submission systems to support the referrals made under Section 4.H. These shall be continuously developed as part of regular care coordination meetings with the Contractor, the State, and Indiana AAAs. The State shall consider all Contractor feedback and shall have final approval authority. The Contractor shall implement the State-approved procedures established from these meetings. The State will work in good faith with the Contractor to ensure that any new procedures, data systems, and communications do not conflict with CMS regulations and requirements and does not disrupt member care.

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The Contractor shall regularly communicate and collaborate with the State and Indiana AAAs to maintain up-to-date contact information and working knowledge of AAA operations and practices in order to carry out the referral processes developed as part of this section.

The Contractor shall incorporate in its existing care coordination policies the practices and systems developed to support the referrals outlined in Section 4.H. These descriptions must be reviewed and approved as part of the State MOC review process.

J. For non-waiver/nursing facility D-SNP members identified as having strong predictors of needing LTSS under Section 4.H, in addition to offering a referral to the appropriate AAA, the Contractor shall:

1) Work in good faith with the State to develop processes for assessing and documenting informal caregiver supports and to implement a project plan that takes into account the Contractor's system capabilities and capacity. The Contractor is required to update and revise this plan annually to align with State goals and initiatives that involve informal caregivers.

2) The Contractor shall use data and information sharing to enhance the coordination of Medicare and Medicaid services for members identified under Section 4.H. The State reserves the right to designate and make good faith requests to change the system and format of data/information sharing as necessary to support the current state and level of success of referrals for these members. Upon such a request from the State, the Contractor shall make reasonable efforts to change the system and format of data/information sharing to comply. Notwithstanding the foregoing, any change to the system and format of data/information sharing shall be implemented in such a way that will not disrupt member care.

The Contractor shall incorporate all processes developed under Sections 4.G-J of this clause into the D-SNP MOC which will be reviewed and approved as part of the State's MOC review. The State shall work in good faith with the Contractor on the most efficient and effective incorporation of this information in its MOC and other relevant plan documents as indicated in Section 4.GG of this Contract.

K. For all members having a Serious Mental Illness (SMI) diagnosis, the Contractor shall,

a. Assign a designated D-SNP care manager who provides longitudinal care coordination and serves as the member's transition point of contact, and
b. Make good faith efforts to enroll these members into case management. SMI diagnosis is defined as the SMI groupings and diagnoses common to CMS and Indiana: F20 Schizophrenia, F25 Schizoaffective disorder, F31 Bipolar disorder, and F33 Major depressive disorder, recurrent.

L. The Contractor shall identify all members receiving behavioral health services and coordinate care with the appropriate behavioral healthcare provider. These services include:

a. Medicaid Rehabilitation Option (MRO)

b. Behavioral and Primary Healthcare Coordination (BPHC)

M. The Contractor must establish clear procedures for supporting members who are being discharged from State Psychiatric Hospitals (SPH). D-SNP care managers will build in processes for care transition planning for those being discharged from an SPH back to a community setting, such as collaborating with SPH staff and Community Mental Health Center (CMHC) gatekeepers in advance of discharge.

N. For all members having a diagnosis of dementia, the Contractor shall,

a. Assign a designated D-SNP care manager who provides longitudinal care coordination and serves as the member's transitions point of contact, and

b. Make good faith efforts to enroll these members into case management.

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O. The Contractor shall work in good faith with the State to develop dementia care, education and supports programming for all D-SNP members with a diagnosis of dementia as well as for the informal caregivers who support them—which can incorporate aspects of current D-SNP dementia programming. As an important component of the Dementia Care Program, the D-SNP will administer a Dementia Caregiver Support Program to caregivers of non-waiver members with a diagnosis of dementia using State modified GUIDE requirements for ongoing caregiver education and support. The Contractor shall submit a draft Dementia Care Program Plan annually for approval one hundred and twenty (120) days prior to January 1 of the contract year. The draft plan shall include program details for all D-SNP members with a diagnosis of dementia. The State reserves the right to require more than one revision cycle with the draft plan. The approval of the draft plan shall take into account the Contractor's timelines of training, system capabilities, and staffing capacity to support successful implementation. The Contractor shall make good faith efforts to operationalize the plan for dementia care, education and supports by January 1 of the contract year. The Contractor is required to update and revise as needed its dementia plan to align with State goals and initiatives around dementia care and the State Dementia Strategic Plan defined in Indiana code at IC 12-9.1-5.

P. The Contractor shall work in good faith with the State to develop programming for all D-SNP members for risk assessment and prevention of falls. The Contractor shall submit a draft Falls Prevention Plan annually for risk assessment and prevention of falls for D-SNP members. The plan will be submitted to the State for approval one hundred and twenty (120) days prior to January 1 of the contract year. The draft plan shall include program details for D-SNP members with falls and/or at high risk for falls. The State reserves the right to require more than one revision cycle with the draft plan. The approval of the draft plan shall take into account the Contractor's timelines of training, system capabilities, and staffing capacity to support successful implementation. The Contractor shall make good faith efforts to operationalize the Falls Prevention Plan by January 1 of the contract year.

Q. The Contractor must provide the following training content and strategies for D-SNP care managers:

1. "What Matters" and advanced directives;
2. Indiana PathWays for Aging program and PathWays Waiver;
3. Aging network (AAAs/ADRCs) and HCBS services;
4. Health and Wellness Waiver program including service coordination;
5. Community Integration and Habilitation (CIH) and Family Supports (FS) Waiver programs including service coordination;
6. Dementia care and provision of caregiver education;
7. Behavioral health services covered by Medicare (including Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP)) and Medicaid (including MRO, BPHC, and Certified Community Behavioral Health Clinic (CCBHC);
8. Informal caregiver engagement and support;
9. The 4Ms (What Matters, Mentation, Medications, Mobility); and
10. Risk assessment and prevention of falls.

R. The Contractor shall establish and maintain access to the Indiana Health Information Exchange (IHIE) to enhance its capacity to coordinate care for its members and improve service provision transparency. The Contractor's IHIE access shall include at a minimum:

1. Contractor submission of eligibility files and reception of Near Real Time Admission, Discharge, and Transfer (ADT) alerts via the HL7 process; and

2. D-SNP care manager/care coordinator access to CareWeb or Clinical Data Search (CDS).

The Contractor shall use the IHIE data it receives through the Admissions, Discharges, and Transfers alerts to populate fields in the information sharing file submitted to the State

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pursuant to Sections 4.S–Y of this Contract. To the greatest extent possible, the Contractor shall use IHIE data that is as close to real-time as possible. The Contractor shall develop written policies and procedures for how it will use CareWeb/CDS information to supplement member care plans and to exchange the data required for High-Risk Member data feeds outlined in Sections 4.S–Y of this contract.

The Contractor shall exclude from the information sharing files submitted to the State any ADT alerts received from IHIE with admit dates beyond one hundred and twenty (120) days in the past.

Information Sharing

S. Upon the Contractor learning a member, who is identified as High-Risk under Section 4.D of this clause and in Section 6 (Definitions), is subject to one of the following scenarios, the Contractor shall notify FSSA within two (2) business days, in a manner and format prescribed by the State:

1. When a High-Risk member is admitted, discharged, or transferred to/from an acute care hospital or Skilled-Nursing facility;
2. When a High-Risk member receives observation or emergency care within an acute care hospital.

The Contractor shall at minimum use IHIE as a source for this information. See Section 4.R for more details on minimum contracting requirements with IHIE.

In the event the Contractor delegates its responsibility for notifying the State under this clause to a subcontractor, the Contractor shall retain responsibility for compliance with the notification requirements in this clause as well as any data submission requirements, which may include state specified data fields and file format requirements.

T. The State shall provide the Contractor with the file format, data fields, and Secure File Transfer Protocol (SFTP) access to submit the notifications required under Section 4.S of this contract.

U. The Contractor shall have processes in place where the assigned care coordinator, service coordinator and/or case manager are notified of appeal processes outcomes to support effective care coordination activities.

V. Upon receiving notification of admission, discharge, or transfer to/from an acute care hospital or Skilled-Nursing facility, the Contractor shall coordinate care management activities with the High-Risk member's designated HCBS service coordinator (henceforth referred to as "service coordinator") for H&W, CIH, FS, or MFP programs. The Contractor shall coordinate with the service coordinator regarding discharge/transition planning including the arrangement of any medically necessary home health services, the provision of durable medical equipment (DME), the provision of personal care services, as well as any additional HCBS services as appropriate.

W. Upon receiving notification of an observation stay or emergency care, the Contractor shall coordinate care management activities with the service coordinator to address the High-Risk member's needs and services.

X. The State will use an extract process, or other system of data sharing, to support the D-SNP's ability to identify Medicaid participant enrollment and High-Risk status. The Contractor must demonstrate the ability to identify and incorporate the relevant data fields from its eligibility and enrollment file exchange with the State to identify all High-Risk members out of its total Indiana membership. The Contractor shall maintain the capability to refresh its eligibility and enrollment data on a weekly basis, at minimum, to ensure an accurate count of its current High-Risk membership.

Y. The State will provide ongoing and updated guidance and assistance to the Contractor to identify accurately all relevant data fields and information received through the eligibility and

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enrollment file exchange process to enhance its existing data collection and analytical systems to identify High-Risk members.

The Contractor is expected to successfully identify the relevant LOC indicators designated by the State as well as be able to process and incorporate this indicator data into its systems and processes on an ongoing basis.

Social Determinants of Health (SDOH)

Z. The Contractor shall use a Social Determinants of Health (SDOH) assessment for all Indiana D-SNP members. This assessment shall consider members' social risk factors as well as their social needs. The Contractor shall use SDOH assessment to advance person-centered care for its membership.

AA. The Contractor shall use verbatim the SDOH questions required by the State in their SDOH assessment tool which is to be incorporated in the HRA. The Contractor is required to share all information and data collected through SDOH assessments. The State reserves the right to require the designated tool, domains, questions, process of collection, as well as the file and data sharing procedures required for SDOH assessments.

BB. The Contractor shall account for State goals and initiatives in the SDOH assessment. The State shall provide information and guidance to the Contractor on its broader goals and specific initiatives.

CC. The Contractor shall partner with the State and other community stakeholders to improve SDOH assessment process, data collection, and information sharing to improve ability to identify specific SDOH drivers for D-SNP members in their communities.

DD. The Contractor shall submit its final SDOH assessment tool for State approval one hundred and twenty (120) days prior to January 1 of the contract year. The State will review and either ask for additional revisions or approve. If the State has not requested changes or provided its written approval within thirty (30) days of initial Contractor submission, it will be deemed approved.

EE. The Contractor shall submit member responses to the SDOH questions required by the State, in a format and timeline prescribed by the State.

FF. The Contractor shall work in good faith with the State to develop SDOH interventions for all D-SNP members. The Contractor shall submit a draft SDOH Interventions Plan annually for addressing health related social needs identified in D-SNP members through State required SDOH questions. The plan will be submitted to the State for approval one hundred and twenty (120) days prior to January 1 of the contract year. The draft plan shall include program details for D-SNP members with needs pertaining to their living situation, food, and/or transportation (medical and non-medical). The State reserves the right to require more than one revision cycle with the draft plan. The approval of the draft plan shall take into account The Contractor's timelines of training, system capabilities, and staffing capacity to support successful implementation. The Contractor shall make good faith efforts to operationalize the SDOH Interventions Plan by January 1 of the contract year.

Model of Care (MOC)

GG. The Contractor must submit its MOC for State review and approval prior to submission to CMS. The State review will be in addition to the required NCQA review of the D-SNP MOCs. The State review process will ensure that the MOC meets State-designated requirements and criteria that are not subject to NCQA scoring. The State will, at a minimum, require review of the MOC for sufficient detail and description of:

1. The Contractor's Indiana dually eligible population overall and by PBP: Indiana PathWays for Aging Dual Care PBP(s), non-PathWays eligible Full benefit Duals PBP, and Partial

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Duals PBP. The population description must specifically account for key characteristics and the realities of the care experience for the Contractor's D-SNP membership in Indiana. Characteristics shall include but are not limited to:

a. Demographic information (i.e. age, gender, race, income);
b. Geographic location and concentration;
c. Distinct subpopulations the State designates as Most Vulnerable Beneficiaries:
   - PathWays Waiver
   - Health and Wellness Waiver
   - Money Follows the Person
   - Family Supports Waiver
   - Community Integration and Habilitation Waiver
   - Diagnosis of Dementia
   - SMI Diagnosis
d. Prevalent diagnoses including behavioral health and co-occurring chronic conditions;
e. Medicaid service provision and eligibility status;
f. Level of Care (LOC) status;
g. Prevalence of Activities of Daily Living (ADLs) deficiencies in their Indiana population;
h. The identification of members living with dementia, their informal caregivers, and other supports; and a detailed description of what defines their experiences of care;
i. Prevalent trends in utilization including hospital, SNF, home health, physician, and emergency department (ED) visits; and
j. Qualitative data that provides member perspectives, relevant stakeholder feedback, and provider insights.

The Contractor should draw from existing State-specific data sources to form an accurate composite of its Indiana population. This shall include using identifiers included in the State eligibility file data accessed through the 270/271 file exchange process. For all population detail and descriptions, the Contractor shall identify how it determines and defines all data fields—including but not limited to aspects such as diagnoses, LOC, morbidity, etc. The State reserves the right to define any data fields used in the above population analysis and shall work with the Contractor to obtain those data fields. The Contractor should seek to avoid broad generalizations and should ultimately reflect in its MOC a thorough and meaningful understanding of the Contractor's Indiana D-SNP membership. The Contractor shall provide easy to read tables that outline all Indiana subpopulations and subcategories to accompany written descriptions.

2. All written care coordination policies for:

   a. Members identified as High-Risk under Section 4.D of this clause;
   b. Members identified as having strong predictors of needing LTSS under Section 4.H of this clause;
   c. Members identified as having a diagnosis of dementia;
   d. Members identified as having a SMI diagnosis; and
   e. Summary care coordination policies and procedures.

3. A detailed description of how the Contractor will align its HRA model with existing State LTSS assessments and information to better identify member risks and needs.

HH. The State shall make good faith efforts to ensure its MOC review process does not interfere with the Contractor's submission of its MOC for CMS review. The State's MOC review process shall be prior to the Contractor's submission to CMS.

II. The State shall make good faith efforts to assist the Contractor in meeting the requirements under Sections 4.GG–HH of this contract and will take into account the Contractor's specific circumstances pertaining to its MOC in order to evaluate compliance. This includes but is not limited to consideration of the date of its MOC submission; CMS approval status and the

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length of its MOC approval period; the availability of MOC off-cycle review process; as well as the availability of other avenues of achieving the State goals outlined in Sections 4.GG–HH.

JJ. The Contractor shall notify the State within fifteen (15) business days of receipt of MOC approval, approval score, and acceptance by CMS. The Contractor shall also notify the State within fifteen (15) business days of receipt of failing a CMS MOC submission and plans to remedy.

KK. The Contractor is required to outline in its D-SNP MOC all appropriate structures, processes, and assessments outlined in Sections 4.Q, 4.G-N, 4.S-FF, and 5.A.3 of this contract. All details and descriptions must be reviewed and approved as part of the State review of the D-SNP MOC. The State shall work in good faith with the Contractor on the most efficient and effective incorporation of this information in its MOC and other relevant plan documents as indicated in Section 4.GG of this contract.

LL. D-SNPs must also ensure its MOC aligns with the Care Coordination Program Plan of its companion Indiana PathWays for Aging Medicaid plan and must coordinate with the plan to achieve necessary alignment.

MM. If an entity that operates a D-SNP in Indiana also operates an Institutional Special Needs Plan (I-SNP) or Chronic Conditions Special Needs Plan (C-SNP) in the State, the entity shall provide a copy of the Model of Care for all I-SNPs or C-SNPs operated within Indiana to the State once it has been approved for informational purposes, per 42 CFR 422.107(c)(1)(i).

NN. Any new requirements outlined in this contract, not previously included in the MOC, must be reflected in the next CMS required MOC update.

5. REPORTING REQUIREMENTS

A. The Contractor shall submit the following to the State within the timeframes indicated below, and in the manner and format specified and/or subsequently agreed upon by the State. The Contractor has responsibility to submit all reports required by the SMAC, even if not listed below:

1. All reports included within the State's Reporting Manual. The State reserves the right to add, modify, or remove reports from the Reporting Manual at its discretion. The State shall collaborate with the Contractor on the development of reporting requirements.
2. Weekly Medicare encounter claims data provided in a format and timeline prescribed by the State. The Medicare encounter claims submitted to the State shall include:

   - Professional and Institutional claims submitted to CMS;
   - Part D Pharmacy claims submitted to CMS; and
   - Supplemental benefit claims.

   With regard to these submissions, the Contractor must also:

   - Shall not submit a Chart Review Record (CRR) without a previously accepted Encounter Data Record (EDR) or CRR.
   - Shall only submit encounter claim records for valid IN D-SNP members.
   - Shall not submit encounter claim records with Medicare IDs for members that are not valid Indiana D-SNP dual eligible members.
   - Shall submit header and detail adjudication status on all encounter claim submissions.
   - Shall include the CMS Claim Number on all encounter claim submissions.
   - Shall submit an accepted original claim prior to submission of any Void or Replacement encounter record.

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- Shall submit encounter records to the State within seven (7) days after being accepted by CMS.
- Shall submit corrections to rejected encounters within thirty (30) days.

3. Currently reported quality assessment data and deliverables consistent with those described in Chapter 5 of the Medicare Managed Care Manual, Section 30 (found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c05.pdf) to be received within thirty (30) business days of submission or receipt—which includes but is not limited to:

    - Audited summary-level and patient-level Healthcare Effectiveness Data and Information Set (HEDIS) data the Contractor is required to submit to National Committee for Quality Assurance (NCQA) and CMS respectively;
    - The final NCQA HEDIS Compliance Audit Report provided to the Contractor by the NCQA-licensed audit firm;
    - NCQA HEDIS Measures stratified from aggregated Star Ratings for the Indiana population, and reported monthly, quarterly, and/or annually by PBP, H&W Waiver subpopulation and PathWays Waiver subpopulation:
        a. Measure C08: Care for Older Adults – Medication Review
        b. Emergency Department Utilization (EDU)
        c. Acute Hospital Utilization (AHU)
        d. Measure C18: Plan All-Cause Readmissions (PCR)
        e. Measure C20: Transitions of Care (TRC)
            - Notification of inpatient admission and discharge;
            - Receipt of discharge information;
            - Patient engagement after inpatient discharge; and
            - Medication reconciliation post-discharge.
        f. Use of High-Risk Medications in the Elderly (DAE)
        g. Follow-up after Hospitalization for Mental Illness (FUH)
        h. Measure C21: Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions
    - All Medicare Health Outcomes Survey (HOS) data feedback reports provided to the Contractor by CMS; and
    - Any reports or materials pertaining to annual Contractor participation in the Medicare Advantage and Prescription Drug Plan (MA & PDP) Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

4. Three (3) supplemental benefit reports (also described in Section 3, Supplemental Benefits section above):

    i. Proposed Supplemental Benefit Offering Report (due March 15th)

    ii. Finalized Supplemental Benefit Offering Report (due by the end of the first week of September)

        - The Contractor shall document where its supplemental benefits overlap with Medicare covered benefits, Medicaid benefits covered under Indiana's Medicaid State Plan, MCE enhanced benefits, or Medicaid Waiver and the potential impact on coordination of benefits, third-party liability, and HCBS access.

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- In areas where service overlap occurs, the Contractor shall ensure it adjudicates those claims first for in-network services under its D-SNP supplemental benefits before denying such claims as State responsibility under the Indiana Medicaid State Plan, MCE enhanced benefits, or Medicaid Waiver.
- The Contractor is also required to document if the supplemental benefit will be reflected in encounter data.

iii. Supplemental Benefit Summary Document (due by the end of the first week of September)

- The State will use this information annually to update the Benefit Compare Document that is posted on the FSSA D-SNP website.

5. D-SNPs outreach efforts made (date, communication mode, messaging and impact analysis) to duals enrolled in the Contractor's non D-SNP products by the end of October annually.
6. Submission of the D-SNPs overarching dual-eligible member outreach marketing plans quarterly
7. Annual medical loss ratio (MLR) data in the format submitted to CMS within thirty (30) days after submission to CMS.
8. Significant changes to the terms of the Contractor's Medicare contract with CMS, including D-SNP non-renewals, terminations, and service area reductions within fifteen (15) business days of approval by CMS.
9. Any non-compliance, including but not limited to audit notices, findings, and corrective action plans, within fifteen (15) business days of either being notified by CMS or submitting them to CMS.
10. Any changes made to the use of projected Medicare savings and rebates within fifteen (15) business days of CMS approval of the changes.
11. Notices of non-compliance from CMS within fifteen (15) business days of the notification.
12. Sanctions of any kind, including civil monetary penalties, imposed by CMS within fifteen (15) business days of receipt of notification.
13. Performance information, including CMS warning letters, deficiency notices, Ad Hoc CAPs, and notices of Medicare star ratings less than 3.0, within fifteen (15) business days of the notification.
14. Member newsletters must be submitted to the State—for informational purposes—within fifteen (15) business days after the date newsletters are provided to members.
15. Copies of all marketing strategies, oral and written solicitations, application and enrollment forms, member policies and any other materials specifically related to the enrollment of dually eligible D-SNP plan members—for informational purposes within thirty (30) days of CMS approval.
16. The State may request any communication or marketing materials from the Contractor to review for informational purposes and the Contractor must submit to the State within thirty (30) calendar days of request.
17. Annual Network Overlap Reporting.
18. Enrollment reports every year to ensure that the EAE process is being implemented appropriately.
19. All information and data collected through SDOH assessments including member responses to the SDOH questions required by the State.

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B. Materials that contain reference to Indiana Medicaid program benefits, any Indiana Medicaid program or any reference to Indiana Medicaid must be submitted to FSSA for review and written approval prior to submission to CMS. The Contractor shall submit at least thirty (30) calendar days to allow State review and to request modifications. In its submission, the Contractor must clearly identify and locate all specific references to Medicaid program benefits and/or Indiana Medicaid programs as well as provide a clear description of the particular marketing methods/media being used for promotion. These materials also must be provided in a manner and format that is easily understood. This means written materials shall not exceed a fifth-grade reading level and shall be in plain language. During the State review process, the Contractor shall respond to all State requests for additional information and fully address any State-identified issues and/or requested modifications.

   The State and the Contractor shall make good faith efforts to establish mutually agreeable processes to identify the types of materials subject to FSSA review as well as how to meet any CMS-required deadlines. If the Contractor does not receive written approval from the State within the previously mentioned thirty (30) calendar day requirement—and the Contractor is at risk of not meeting a CMS submission deadline—the Contractor shall adhere to the CMS submission deadline in the absence of the State's written approval. The Contractor shall provide concurrent notice to the State in such a scenario.

C. The Contractor shall not use the Medicaid provider listing as a resource for marketing purposes. Any attempt to use the Medicaid provider information without obtaining explicit written approval from FSSA may result in termination of this contract.

D. FSSA may request ad hoc reports and/or information from the Contractor. The Contractor must fulfill these requests within thirty (30) calendar days of the date of the agreed upon business requirements unless otherwise required by FSSA.

6. DEFINITIONS

Alignment: The coordination and streamlining of Medicare and Medicaid regulations, policies, and operations to increase overall program effectiveness; to identify and eliminate conflicting program requirements and competing program incentives; as well as to bridge identified program gaps.

Aligned Enrollment: The enrollment in a dual eligible special needs plan of full-benefit dual eligible individuals whose Medicaid benefits are covered under a Medicaid managed care organization contract under section 1903(m) of the Act between the applicable State and the dual eligible special needs plan's (D-SNP's) MA organization, the D-SNP's parent organization, or another entity that is owned and controlled by the D-SNP's parent organization. When State policy limits a D-SNP's membership to individuals with aligned enrollment, this condition is referred to as exclusively aligned enrollment.

Community Integration and Habilitation (CIH) Waiver: The CIH Waiver program provides Medicaid home and community-based services 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. The CIH Waiver serves individuals with an intellectual/developmental disability, autism spectrum disorder or related conditions, who have substantial functional limitations, as defined in 42 CFR 435.1010.

Default Enrollment: Subject to both State and CMS approval, Medicare Advantage Organizations (MAOs) may automatically enroll members of an affiliated Medicaid Managed Care Entity (MCE) into its Medicare Dual Eligible Special Needs Plan (D-SNP) when that member becomes newly eligible for Medicare Parts A and B by virtue of age or disability for the first time and will remain in the Medicaid managed care plan upon conversion to Medicare.

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EXHIBIT 1
ACKNOWLEDGEMENT OF AWARENESS, SERVICES TO BE PROVIDED

Exclusive Alignment: When a state policy limits a D-SNP's membership to individuals with aligned enrollment (see 42 CFR 422.2)

Family Supports (FS) Waiver: The FS Waiver program provides Medicaid home and community-based services 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. The FS Waiver serves individuals with intellectual/developmental disabilities or autism, who have substantial functional limitations, as defined in Code of Federal Regulations 42 CFR 435.1010.

Health and Wellness Waiver: An Indiana Medicaid waiver program authorized under §1915(c) of Title XIX of the Social Security Act that provides an alternative to nursing facility admission for individuals under age 60. The waiver is designed to provide services to supplement informal supports for people who would require care in a nursing facility if waiver or other supports were not available. Waiver services can be used to help people remain in their own homes, as well as assist people living in nursing facilities to return to community settings such as their own homes, apartments, assisted living, or Adult Family Care.

High-Risk Member: For the purposes of this agreement, this term refers to any member of the CO D-SNP PBP available to full-benefit dual eligible individuals that are not eligible for the Indiana PathWays for Aging program (QMB-Plus, SLMB-Plus, Other FBDE) who is enrolled with Health and Wellness (H&W), Community Integration and Habilitation (CIH), or Family Supports (FS) HCBS Waiver services or Money Follows the Person (MFP) and not any specific clinical condition. *(The Indiana PathWays for Aging definition differs from this D-SNP specific definition).*

Home and Community-Based Services (HCBS): Services that are provided, pursuant to the Indiana Section 1915(c) waiver, as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or to delay or prevent placement in a nursing facility. For the purposes of this contract, HCBS Waiver refers to the Waiver population within the Indiana PathWays for Aging program.

Indiana PathWays for Aging: Indiana's health care program for Medicaid enrollees who are 60 years of age and older and are eligible for Medicaid on the basis of age, blindness, or disability. Enrollees include members who have a full Medicare benefit, those in a nursing facility, and those who are receiving long-term care services and supports in a home or community-based setting.

Indiana PathWays for Aging Dual Care: A D-SNP PBP that provides exclusively aligned enrollment and integrated Medicare coverage for PathWays eligible Medicaid members under the same corporate entity as an Indiana PathWays for Aging MCE.

Integration: Providing a full array of Medicaid and Medicare benefits through a single delivery system to provide quality care for dual eligible enrollees, improve care coordination, and reduce administrative burdens.

Long-Term Care (LTC) Ombudsman Program: A statewide program that advocates for residents of long-term care facilities, which includes nursing facilities and licensed assisted living facilities, to promote and protect the resident rights guaranteed to residents under federal and state law.

Other Full-Benefit Dual Eligible (Other FBDE): The member is eligible for full Medicaid benefits but is not enrolled as QMB or SLMB. The member's benefits include payment of the member's Medicare Part B premium as well as coverage for Medicare Parts A and B deductibles and coinsurance.

Qualified Disabled Working Individual (QDWI): The member's benefit is payment of the member's Medicare Part A premium. Members in this category are ineligible for full coverage

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under the Medicaid State Plan. The EVS identifies this coverage as Qualified Disabled Working Individual.

Qualified Medicare Beneficiary (QMB) Only: The member's benefits are limited to payment of the member's Medicare Part A and Part B premiums as well as Medicare deductibles, coinsurance, and copayments on services covered under Medicare Parts A and B.

Qualified Medicare Beneficiary Plus (QMB+): The member's benefits include payment of the member's Medicare Part A and Part B premiums as well as Medicare deductibles, coinsurance, and copayments on services covered under Medicare Parts A and B. This is in addition to Traditional Medicaid benefits.

Qualifying Individual (QI): The member's benefit is payment of the member's Medicare Part B premium. Members in this category are ineligible for full coverage under the Medicaid State Plan. The Eligibility Verification System (EVS) identifies this coverage as Qualified Individual.

Specified Low-Income Medicare Beneficiary (SLMB) Only: The member's benefits are limited to payment of the member's Medicare Part B premium only.

Specified Low-Income Medicare Beneficiary Plus (SLMB+): The member's benefits include payment of the member's Medicare Part B premium in addition to Traditional Medicaid benefits. Traditional Medicaid benefits provide coverage for Medicare Parts A and B deductibles and coinsurance for services also covered by IHCP.

Supplemental Benefits: An item or service not covered by original Medicare, that is primarily health related and for which the Medicare Advantage plan must incur a non-zero direct medical cost.

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Exhibit 1 Attachment A
KEY RESOURCES

Indiana PathWays for Aging: Find information about the Indiana PathWays for Aging program.

https://www.in.gov/pathways/home/

Indiana FSSA D-SNP: Find information about the Indiana D-SNP market, including State Medicaid Agency Contracts (SMAC), IHCP Companion guides, and other program details,

https://www.in.gov/medicaid/partners/medicaid-partners/dual-eligible-special-needs-plans/

About IHCP Programs: Find information about the healthcare programs included under the Indiana Health Coverage Programs (IHCP) umbrella – the primary programs serving most children and adults as well as those designed to serve special member populations.

https://www.in.gov/medicaid/providers/about-ihcp-programs/

FSSA Benefits Portal: Allows individuals to manage benefits provided by the Indiana Family and Social Services Administration (FSSA) including continuing an incomplete online application; print summaries of recently completed online applications; review benefits; print proof of eligibility; print an authorized representative form; report changes in status; and view notices/correspondence.

https://fssabenefits.in.gov/bp/#/

IHCP Provider Business Transactions: Find information here about conducting business transactions with the Indiana Health Coverage Programs (IHCP), including member eligibility, billing, reimbursement, and recordkeeping.

https://www.in.gov/medicaid/providers/business-transactions/

Indiana Medicaid for Members: https://www.in.gov/medicaid/members/

Indiana Medicaid for Providers: The Indiana Health Coverage Programs (IHCP) offers providers easy access to the resources and tools needed to conduct business with Indiana Medicaid. Provider updates and announcements, important reference materials, and general program information are all available through links and webpages located on this website.

https://www.in.gov/medicaid/providers/

IHCP Provider Reference Materials: For information about Indiana Health Coverage Programs (IHCP) policies and procedures, including billing guidance, refer to the IHCP provider reference module appropriate to the topic of interest. This page includes links to the IHCP Provider Reference Modules; IHCP Provider Code Tables; IHCP Companion Guides; and the Indiana Medicaid State Plan.

https://www.in.gov/medicaid/providers/provider-references/provider-reference-materials/

Indiana Medicaid State Plan and Waiver Authorities: Medicaid is a state-administered program, and each state sets its own guidelines regarding eligibility and services. The Indiana State Plan provides specifics on how Medicaid is implemented and governed in Indiana.

http://provider.indianamedicaid.com/ihcp/StatePlan/state_plan.asp

Medicaid Eligibility Policy Manual: The Indiana Health Coverage Program Policy Manual is an integrated eligibility manual that contains information about health coverage under Medicaid, Hoosier Healthwise, Hoosier Care Connect, and the Healthy Indiana Plan. The requirements for

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State Burial Assistance under the Medicaid program are also included. The manual contains eligibility and administrative policies based on state and federal laws and regulations that govern the programs, as well as system procedures using the Indiana Client Eligibility System.

https://www.in.gov/fssa/ompp/forms-documents-and-tools/medicaid-eligibility-policy-manual/

What is Covered by Indiana Medicaid: This is a general description of the benefits available through Indiana Medicaid (other than the Healthy Indiana Plan) based upon a member's eligibility.

https://www.in.gov/medicaid/members/member-programs/what-is-covered-by-indiana-medicaid/

Area Agencies on Aging (AAA): Find information about Indiana's Area Agencies on Aging.

https://www.in.gov/fssa/da/area-agencies-on-aging/

Indiana Long-Term Care (LTC) Ombudsman Program: Advocates for residents of long-term care facilities, which are nursing facilities and licensed assisted living facilities. The LTC ombudsman does not assist members receiving Home and Community-Based Services (HCBS) or other services.

Office of the Long-Term Care Ombudsman
402 West Washington Street, Room W451
Post Office Box 7083, MS 27
Indianapolis, Indiana 46207-7083

Information/complaint line: 800-622-4484 or 317-232-7134

Fax number: 317-972-3285

Email: LongTermCareOmbudsman@ombudsman.IN.gov

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EXHIBIT 1 ATTACHMENT B
INDIANA PATHWAYS FOR AGING BENEFITS

Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Adult Mental Health and Habilitation (AMHH) – 1915(i) (405 IAC 5-21.6)	NO	Coverage is available for individuals determined by the Division of Mental Health and Addiction (DMHA) State Evaluation Team to meet the clinical criteria of the program. Services include: • Adult day services; • HCB habilitation; • Respite • Therapy and behavioral support services; • Addiction counseling; • Peer support services; • Supported community engagement services; • Care coordination; and • Medication training and support.
Behavioral and Primary Healthcare Coordination (BPHC) – 1915(i) (405 IAC 5-21.8)	NO	Coverage is available for individuals determined by the Division of Mental Health and Addiction (DMHA) State Evaluation Team to meet the clinical criteria of the program. Includes coordination of healthcare services to manage the healthcare needs of the recipient including direct assistance in gaining access to health services, coordination of care within and across systems, oversight of the entire case and linkage to appropriate services. Limited to forty-eight (48) units per six (6) months.
Care Conferences	YES	Providers participating in member Care Conferences may be eligible for reimbursement. Refer to the Evaluation and Management Services provider reference module for more information.

[1] In Traditional FFS Medicaid benefits and services: *Prior Approval Required Under Certain Circumstances and **Prior Approval Always Required

[2] Services not reimbursed through the PathWays program are covered (available) and reimbursed for members under traditional Medicaid benefits reimbursement.

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INDIANA PATHWAYS FOR AGING BENEFITS

Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Chiropractors* (405 IAC 5-12)	YES (Self-referral)	Coverage is available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic treatment. Limited to five (5) visits and fifty (50) therapeutic physical medicine treatments per member per year.
Dental Services (405 IAC 5-14)	YES	Coverage for medically necessary, covered dental services with no annual dollar limit applied. Reimbursement is available for diagnostic services, including initial and periodic evaluations, prophylaxis, radiographs and emergency treatment. Full mouth series or panorex are limited to one (1) set per recipient every three (3) years, one (1) set per recipient every twelve (12) months for bitewing radiographs. Comprehensive detailed oral evaluation is limited to one (1) per lifetime, per recipient, per provider, with an annual limit of two (2) per recipient when rendered by different providers. A periodic or limited oral evaluation is limited to one (1) every six (6) months, per recipient. Topical fluoride is not covered for recipients twenty-one (21) years of age or older. Prophylaxis is limited to one unit every twelve (12) months for non-institutionalized recipients over age (21). Periodontal surgery is a covered service only for cases of drug-induced periodontal hyperplasia. Payment for office visits is not covered; reimbursement is only available for covered services actually performed.
Diabetes Self-Management Training Services* (405 IAC 5-36)	YES	Limited to sixteen (16) units per member per year. Additional units may be prior authorized. Refer to the Diabetes Self-Management Training Services module
Drugs, Legend (405 IAC 5-24)	YES	Medicaid covers legend drugs if the drug is: approved by the United States Food and Drug Administration; included in the Medicaid Drug Rebate Program; not designated by CMS as less than effective or identical, related, or similar to less than effective drug; and not specifically excluded from coverage by Indiana Medicaid. The Indiana Medicaid fee for service pharmacy benefit website identifies drugs that are carved out of the PathWays program
Drugs, Non-legend (405 IAC 5-24)	YES	Medicaid covers non-legend (over-the-counter) drugs on its formulary. This is available via a link from the IHCP website at https://inm.pharmacy.optum.com/inm/prelogin

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EXHIBIT 1 ATTACHMENT B
INDIANA PATHWAYS FOR AGING BENEFITS

Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Emergency Services (IC 12-15-12-15 & 12-15-12-17)	YES (Self-referral)	Emergency services are covered subject to the prudent layperson standard of an emergency medical condition. All medically necessary screening services provided to an individual who presents to an emergency department with an emergency medical condition are covered.
Eye Care, Eyeglasses and Vision Services (405 IAC 5-23)	YES (Self-referral)	Coverage for the initial vision care examination will be limited to one (1) examination every two (2) years for a recipient twenty-one (21) years of age or older unless more frequent care is medically necessary. Coverage for eyeglasses, including frames and lenses, will be limited to a maximum of one (1) pair every five (5) years for members twenty-one (21) years and older.
Family Planning Services and Supplies **(405 IAC 10-2-1)**	YES (Self-referral)	Family planning services include: limited history and physical examination; pregnancy testing and counseling; provision of contraceptive pills, devices, and supplies; education and counseling on contraceptive methods; laboratory tests, if medically indicated as part of the decision-making process for choice of contraception; initial diagnosis and treatment (no ongoing treatment) of sexually transmitted diseases (STDs); screening, and counseling of members at risk for HIV and referral and treatment; tubal ligation; vasectomies. Pap smears are included as a family planning service if performed according to the United States Preventative Services Task Force Guidelines.
Federally Qualified Health Centers (FQHCs) (405 IAC 5-16-5)	YES	Coverage is available for medically necessary services provided by licensed health care practitioners.
Food Supplements, Nutritional Supplements, and Infant Formulas** (405 IAC 5-24-9)	YES	Coverage is available only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.
Hospital Services Inpatient* (405 IAC 5-17)	YES	Inpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.

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INDIANA PATHWAYS FOR AGING BENEFITS

Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Hospital Services Outpatient* (405 IAC 5-17)	YES	Outpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.
Home Health Services** (405 IAC 5-16)	YES	Coverage is available to home health agencies for medically necessary skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech language services; and renal dialysis for home-bound individuals.
Hospice Care** (405 IAC 5-34)	YES (including hospice in an institutional setting)	Hospice is available under Medicaid if the recipient is expected to die from illness within six (6) months. Coverage is available for two (2) consecutive periods of ninety (90) calendar days followed by an unlimited number of periods of sixty (60) calendar days.
Immunizations	YES (Self-referral)	Immunizations are self-referral to any IHCP-enrolled provider. Immunizations are covered regardless of where they are received.
Laboratory and Radiology Services (405 IAC 5-18. 405 IAC 5-27)	YES	Services must be ordered by a physician or other practitioner authorized to do so under state law.
	YES	Medicaid covers legend drugs if the drug is: approved by the United States Food and Drug Administration; not designated by CMS as less than effective or identical, related, or similar to less than effective drug; and not specifically excluded from coverage by Indiana Medicaid. • The Indiana Medicaid fee for service pharmacy benefit website identifies drugs that are carved out of the PathWays program

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EXHIBIT 1 ATTACHMENT B
INDIANA PATHWAYS FOR AGING BENEFITS

Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Long Term Acute Care **Hospitalization**	YES	Long term acute care services are covered. Prior authorization is required. An all-inclusive per diem rate is paid based on level of care.
Medical supplies and equipment (includes prosthetic devices, implants, hearing aids, dentures, etc.)** (405 IAC 5-19)	YES	Coverage is available for medical supplies, equipment, and appliances suitable for use in the home when medically necessary.
Mental health/Behavioral health services- **Inpatient**** **(State Psychiatric Hospital)** (405 IAC 5-20-1)	NO	PathWays members are disenrolled from the Contractor when admitted to a State psychiatric hospital.
Mental health/Behavioral health services- **Inpatient**** (405 IAC 5-20)	YES	Covered.
Mental health/ Behavioral health services- **Outpatient** (405 IAC 5-20-8)	YES, except MRO services	Coverage includes partial hospitalization services, Clinic Option services, mental health services provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities and psychologists endorsed as Health Services Providers in Psychology. Prior authorization is required for services that exceed twenty (20) units, per recipient, per provider, per rolling twelve (12) months.

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INDIANA PATHWAYS FOR AGING BENEFITS

Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Medicaid Rehabilitation Option (MRO) -Community Mental Health Centers (405 IAC 5-21)	NO	Services provided by community mental health centers (CMHCs). Service packages are assigned based on level of need, as determined by an individualized assessment conducted by CMHCs, and qualifying behavioral health diagnosis. Additional units can be prior authorized when determined medically necessary. Services include: • Adult intensive rehabilitation services (AIRS) addition counseling; • Addiction counseling; • Behavioral health counseling and therapy; • Behavioral health level of need redetermination; • MRO case management; • CAIRS; • Medication training and support; • Psychiatric assessment and intervention; and • Skills training and development.
Nurse-midwife services (405 IAC 5-22-3)	YES	Coverage is available for services rendered by a certified nurse-midwife. Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.
Nurse Practitioners (405 IAC 5-22-4)	YES	Coverage is available for medically necessary services or preventive health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.

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Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Nursing Facility Services** **(Long-term)** (405 IAC 5-31-1)	YES	Requires PASRR and level of care determination by LCAR vendor. Coverage includes room and board; nursing care; medical and nonmedical supplies and equipment; durable medical equipment; medically necessary and reasonable therapy services; transportation to community settings.
Nursing Facility Services (Short-term) (405 IAC 5-31-1)	YES	Requires PASRR and level of care determination by LCAR vendor. Coverage is for a short-term basis and includes room and board; nursing care; medical and nonmedical supplies and equipment; durable medical equipment; medically necessary and reasonable therapy services; transportation to community settings. Admission to a nursing facility on a short-term basis is contingent on a medical necessity review and concurrent stay review. Short-term level of care approval should not exceed a length of stay more than ninety (90) days.
Occupational Therapy** (405 IAC 5-22)	YES	Services must be ordered by an M.D. or D.O. and provided by a qualified therapist or assistant. Must be performed by a registered occupational therapist or by a certified occupational therapy assistant under the direct on-site supervision of a registered occupational therapist. Therapy services provided away from the facility must meet the criteria outlined in 405 IAC 5-22. Prior authorization is not required for initial evaluations, services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate or for services provided within thirty (30) calendar days (up to thirty (30) units) following discharge from a hospital when ordered by a physician prior to discharge. Prior authorization is required for therapy in excess of thirty (30) units in thirty (30) calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) units in thirty (30) calendar days without prior authorization. Evaluations and reevaluations are limited to three (3) hours of service per evaluation. General strengthening exercise programs for recuperative purposes are not covered by Medicaid. Passive range of motion services as the only or primary modality of therapy and occupational therapy psychiatric services are not covered by Medicaid. Therapy for rehabilitative services will be covered for a recipient no longer than two (2) years from the initiation of the therapy unless there is a significant change in medical condition requiring longer therapy.

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Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Organ Transplants (405 IAC 5-3-13)	YES	Coverage is in accordance with prevailing standards of medical care. The Contractor shall not pay for organ transplants unless the Contractor follows the written standards included in the State Plan that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high-quality care to members. For additional information, please see the following: • https://provider.indianamedicaid.com/ihcp/StatePlan/Attachments_and_Supplements/Section_3/3.1e.pdf • https://provider.indianamedicaid.com/ihcp/StatePlan/Section_3/3.1.f.g.h.pdf Prior authorization is required.
Orthodontics**	YES	No orthodontic procedures are approved except in cases of craniofacial deformity or cleft palate.
Out-of-state Medical Services** (405 IAC 5-5)	YES	Medicaid reimbursement is available for the following services provided outside Indiana: acute general hospital care; physician services; dental services; pharmacy services; transportation services; therapy services; podiatry services; chiropractic services; durable medical equipment and supplies; hospice services, subject to the conditions in 405 IAC 5-34-3; and diagnostic services, including genetic testing. All out-of-state services are subject to the same limitations as in state services. Prior authorization is required except for Emergency services (however, continuing inpatient treatment and hospitalization does require prior authorization). Services may be obtained in the following designated out-of-state cities subject to the prior authorization requirements for in-state services: Louisville, Kentucky; Cincinnati, Ohio; Harrison, Ohio; Hamilton, Ohio; Oxford, Ohio; Sturgis, Michigan; Watseka, Illinois; Danville, Illinois; and Owensboro, Kentucky. Recipients may obtain services in Chicago, Illinois if the recipient's physician determines the service is medically necessary, transportation to an appropriate Indiana facility would cause undue hardship to the patient or the patient's family, the service is not available in the immediate area, the recipient's physician complies with all of the criteria set forth in accordance with the state plan and 42 CFR 456.3. Prior authorization will not be approved for the following out of state services: nursing facilities, ICFs/IID, or home health agency services; or any other type of long-term care facility, including facilities directly associated with or part of an acute general hospital.

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Physician Assistant (IC 25-27.5)	YES	Coverage is available for medically necessary services or preventive health care services provided by a licensed, certified Physician Assistant within the scope of the applicable license and certification.
Physicians' Surgical and Medical Services* (405 IAC 5-25)	YES	Covers reasonable services provided by a M.D. or D.O. for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within scope of practice. PMP office visits limited to a maximum of thirty (30) per calendar year per member per provider without prior authorization. New patient office visits are limited to one (1) per recipient, per provider within the last three (3) years.
Physical Therapy** (405 IAC 5-22)	YES	Services must be ordered by an M.D. or D.O. and provided by a qualified therapist or assistant. Prior authorization is not required for initial evaluations, or for services provided within thirty (30) calendar days (up to thirty (30) units) following discharge from a hospital when ordered by a physician prior to discharge, and services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate. Prior authorization is required for therapy in excess of thirty (30) units in thirty (30) calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) units in thirty (30) calendar days without prior authorization. Evaluations and reevaluations are limited to three (3) hours of service per evaluation.
Podiatrists (405 IAC 5-26)	YES (Self-referral)	Reimbursement provided for podiatric services performed within the scope of the practice of the podiatric profession. Services covered shall include diagnosis of foot disorders and mechanical, medical, or surgical treatment of these disorders. Surgical procedures involving the foot, laboratory or x-ray services, and hospital stays are covered when medically necessary. No more than six (6) routine foot care visits per year are covered for patients with a systemic disease of sufficient severity that unskilled performance of such procedure would be hazardous; and has resulted in severe circulatory embarrassment or areas of desensitization in the legs or feet. Proof must be submitted of patient visit to a medical doctor or doctor of osteopathy for treatment or evaluation of the systemic disease during the six (6) month period prior to the rendering of routine foot care services. Prior Authorization is required for inpatient hospital stays and fitting or supplying of orthopedic shoes for patients with severe diabetic foot disease.
Rehabilitative Unit Services - Inpatient** (405 IAC 5-32)	YES	The following criteria shall demonstrate the inability to function independently with demonstrated impairment: cognitive function, communication, continence, mobility, pain management, perceptual motor function or self-care activities.

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Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Residential Substance Use Disorder (SUD) Services	YES	Prior authorization (PA) is required for all residential SUD stays. Admission criteria for residential stays for OUD or other SUD treatment is based on the following American Society of Addiction Medicine (ASAM) Patient Placement Criteria: • ASAM Level 3.1 – Clinically Managed Low-Intensity Residential Services • ASAM Level 3.5 – Clinically Managed High-Intensity Residential Services
Respiratory Therapy* (405 IAC 5-22)	YES	Services must be ordered by an M.D. or D.O. and provided by a qualified therapist or assistant. Prior authorization is not required for inpatient or outpatient hospital, Emergency, and oxygen equipment and supplies necessary for the delivery of oxygen, therapy within thirty (30) calendar days (up to thirty (30) units) following discharge from hospital when ordered by physician prior to discharge and services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate. Prior authorization is required for therapy in excess of thirty (30) units in thirty (30) calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) units in thirty (30) calendar days without prior authorization. Evaluations and reevaluations are limited to three (3) hours of service per evaluation.
Rural Health Clinics (405 IAC 5-16-5)	YES	Coverage is available for services provided by a physician, physician assistant, nurse practitioner, a clinical psychologist, or a clinical social worker. Reimbursement is also available for services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services. Services to a homebound individual are only available in the case of those clinics that are located in an area that has a shortage of home health agencies as determined by Medicaid.

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Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Smoking Cessation and Tobacco Dependence Treatment **Services** (405 IAC 5-37)	YES	Treatment may include prescription of any combination of smoking cessation and tobacco dependence treatment products and counseling. Providers can prescribe one or more modalities of treatment. Providers must include counseling in any combination of treatment. Providers must order tobacco dependence treatment services for the IHCP to reimburse for the services. Ordering and rendering practitioners must maintain sufficient documentation of respective functions to substantiate the medical necessity of the service rendered and to substantiate the provision of the service itself. The IHCP does not require prior authorization for reimbursement for smoking cessation and tobacco dependence treatment products or counseling. The IHCP reimburses pharmacy providers for smoking cessation and tobacco dependence treatment products, including over-the counter products, only when a licensed practitioner prescribes them for a member, including utilization of the statewide standing order for tobacco cessation products. Only patients who agree to participate in tobacco dependence counseling may receive prescriptions for tobacco dependence treatment products. The prescribing practitioner may want to have the patient sign a commitment to establish a “quit date” and to participate in counseling as the first step in tobacco dependence treatment. A prescription for such products serves as documentation that the prescribing practitioner has obtained assurance from the patient that counseling will occur concurrently with the receipt of tobacco dependence drug treatment. Providers must perform tobacco dependence counseling for a minimum of 30 minutes (two units) and a maximum of 150 minutes (10 units) within the course of treatment. IHCP coverage of tobacco dependence counseling services is limited to a maximum of 10 units of counseling per member per calendar year.

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Service[1]	Reimbursed by MCE[2]	Limitations/Coverage
Speech, Hearing and Language Disorders* (405 IAC 5-22)	YES	Services must be ordered by an M.D. or D.O. and provided by a qualified therapist or assistant. Prior authorization is not required for initial evaluations, for services provided within thirty (30) calendar days (up to thirty (30) units) following discharge from a hospital when ordered by physician prior to discharge or following discharge from hospital when ordered by physician prior to discharge and services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate. Prior authorization is required for therapy in excess of thirty (30) units in thirty (30) calendar days. Services ordered in writing to treat an acute medical condition provided in an outpatient setting may continue for a period not to exceed twelve (12) units in thirty (30) calendar days without prior authorization. Evaluations and reevaluations are limited to three (3) hours of service per evaluation.
Transportation - Emergency* (405 IAC 5-30)	YES	Coverage has no limit or prior authorization requirement for Emergency ambulance or trips to/from hospital for inpatient admission/discharge, transportation for patients on renal dialysis or those residing in nursing homes, accompanying parent or recipient attendant (or both) or for a return trip from the emergency room in an ambulance, if use of ambulance is medically necessary for the transport.
Transportation – Non-emergency medical (405 IAC 5-30)	YES	Non-emergency medical travel is available when another alternative is not available.
Urgent Care Services	YES (Self-referral)	Urgent Care Services are covered provided that they are medically necessary. Urgent Care is needed for non-life threatening emergencies that cannot wait for a normal scheduled office visit.
HCBS Services For those with HCBS LOC determination		

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Included HCBS 1915(c) LTSS Waiver Services	*YES, BUT ONLY FOR THOSE ELIGIBLE	Please reference the most current version of the Indiana Health Care Provider manual for the most up to date covered services and their respective service definitions for those eligible for HCBS LTSS in the 1915(c) Managed Care Medicaid Waiver. Current list below: Adult Day Service Attendant Care Caregiver Coaching Home and Community Assistance Respite Community Home Share Assisted Living Community Transition Home Delivered Meals Home Modification Assessment Home Modifications Integrated Health Care coordination Nutritional Supplements Participant Directed Attendant Care Personal Emergency Response System Pest Control Specialized Medical Equipment and Supplies Structured Family Caregiving Transportation Vehicle Modifications