AMENDMENT #1

CONTRACT #00000000000000000000XXXXX

This is an Amendment to the Contract (the "Contract), entered into by and between the Indiana Family & Social Services Administration, Office of Medicaid Policy and Planning (“FSSA”, “OMPP”, and/or the “State”) and (the "Contractor") approved by the last State signatory on July 20th 2021.

In consideration of the mutual undertakings and covenants hereinafter set forth, the parties agree as follows:

The Contract is hereby extended for an additional period of one (1) year. It shall terminate on December 31, 2023.

Exhibit 1 – Acknowledgement of Awareness, Services to be Provided is superseded by **Exhibit 1A – Acknowledgement of Awareness, Services to be Provided** and is attached hereto and incorporated herein. The effective date of Exhibit 1A is January 1, 2023.

Exhibit 2 – Dual Eligibility Categories and Service Area is superseded by **Exhibit 2A – Dual Eligibility Categories and Service Area** which is attached hereto and incorporated herein. The effective date of Exhibit 2A is also January 1, 2023.

All matters set forth in the original Contract and not affected by this Amendment shall remain in full force and effect.

Non-Collusion and Acceptance

The undersigned attests, subject to the penalties for perjury, that the undersigned is the Contractor, or that the undersigned is the properly authorized representative, agent, member or officer of the Contractor. Further, to the undersigned's knowledge, neither the undersigned nor any other member, employee, representative, agent or officer of the Contractor, directly or indirectly, has entered into or been offered any sum of money or other consideration for the execution of this Contract other than that which appears upon the face hereof**. Furthermore, if the undersigned has knowledge that a state officer, employee, or special state appointee, as those terms are defined in IC § 4-2-6-1, has a financial interest in the Contract, the Contractor attests to compliance with the disclosure requirements in IC § 4-2-6-10.5.**

Agreement to Use Electronic Signatures

I agree, and it is my intent, to sign this Contract by accessing State of Indiana Supplier Portal using the secure password assigned to me and by electronically submitting this Contract to the State of Indiana. I understand that my signing and submitting this Contract in this fashion is the legal equivalent of having placed my handwritten signature on the submitted Contract and this affirmation. I understand and agree that by electronically signing and submitting this Contract in this fashion I am affirming to the truth of the information contained therein. I understand that this Contract will not become binding on the State until it has been approved by the Department of Administration, the State Budget Agency, and the Office of the Attorney General, which approvals will be posted on the Active Contracts Database: https://secure.in.gov/apps/idoa/contractsearch/

In Witness Whereof, the Contractor and the State have, through their duly authorized representatives, entered into this Contract. The parties, having read and understood the foregoing terms of this Contract, do by their respective signatures dated below agree to the terms thereof.

Indiana Family and Social Services Administration,
Office of Medicaid Policy and Planning

By:

Title:

Date:

By:

Title:

Date:

Electronically Approved by: Indiana Office of Technology By: (for) Tracy Barnes, Chief Information Officer	Electronically Approved by: Department of Administration By: (for) Rebecca Holwerda, Commissioner
Electronically Approved by: State Budget Agency By: (for) Zachary Q. Jackson, Director	Electronically Approved as to Form and Legality: Office of the Attorney General By: (for) Theodore E. Rokita, Attorney General

Exhibit 1A

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 and understands the following:

A. The State values the opportunities for increased integration of care and improved health outcomes that the alignment of Medicaid and Medicare systems provides, and views increased alignment as a primary tool to achieve its LTSS program goals. To support these values, the State is currently developing a Managed Medicaid Long-Term Services and Supports program (mLTSS) to replace the existing Fee-For-Service Long-Term Services and Supports (LTSS) programs for individuals aged 60 and older. This program would serve a significant proportion of dually eligible members;

B. The State views Medicare Advantage Dual-eligible Special Needs Plan(s) (D-SNP(s)) as a critical component of any new mLTSS program, as the State desires to better align and integrate care for its dually eligible members;

C. The State intends for its mLTSS program to be fully operational in the first quarter of calendar year 2024;

D. The State will require all mLTSS Managed Care Entities (MCEs) to develop and operate companion D-SNPs statewide. The State intends to require exclusively aligned enrollment for full-benefit dually eligible mLTSS members choosing to enroll in an aligned D-SNP as defined under 42 CFR §422.2;

E. The State plans to limit fully Indiana's D-SNP marketplace in in CY2025 to only those D-SNPs aligned with a companion Medicaid Managed Care Entity (MCE) to which the State has awarded an mLTSS contract. The State views limiting its D-SNP market in this manner is the best way to ensure the sufficient and sustainable alignment and integration between Medicaid and Medicare in its mLTSS system;

F. For all other D-SNPs whose parent companies are not awarded an mLTSS bid, the state will allow for an optional one-year grace period for CY2024 to afford those plans a smooth transition out of the Indiana market. During the one-year grace period, D-SNPs transitioning from the Indiana market during CY2024 shall not be allowed to enroll additional members who are not already enrolled with the plan on December 31, 2023;

G. In addition to an exclusively aligned plan benefit package (PBP) for Indiana's mLTSS members, the State will require all companion D-SNPs to offer two (2) additional and separate PBPs for any (1) full-benefit dual eligible enrollees under sixty (60) years of age and (2) partial-benefit dual eligible enrollees (QMB-only, SLMB-only, QI, QDWI) in the State. These PBPs will be in addition to its PBP for full-benefit dually eligible mLTSS members enrolled in a D-SNP that is exclusively aligned with its mLTSS MCE;

H. At mLTSS go-live, the State intends to require all mLTSS companion D-SNPs to have obtained prior approval from the Centers for Medicare and Medicaid Services (CMS) to default enroll members enrolled in its aligned mLTSS Medicaid plan. All D-SNPs required to default enroll mLTSS members must coordinate with the State throughout CY2023 to achieve this approval as outlined under 42 CFR §422.66(c) and 42 CFR §422.68. Qualifying D-SNPs

must engage the state to begin the planning process for default enrollment readiness no later than thirty (30) days after securing an Indiana mLTSS contract;

I. At mLTSS go-live, the State will require the exclusively aligned D-SNPs to demonstrate a fully operational integrated grievances and appeals process that conforms to all CMS requirements outlined under 42 CFR §§ 422.629 - §422.634, 438.210, 438.400, and 438.402;

J. In subsequent contract years, the State intends to be a more active partner with the MAO in determining its supplemental benefit offerings and better capturing the value of supplemental benefits to Indiana members. The State intends to collaborate with MAOs to develop and provide D-SNP supplemental benefit offerings that are well-aligned with Indiana's mLTSS Medicaid benefit.

K. Prior to mLTSS go-live, the State intends to continue to develop and enhance State Medicaid Agency Contract (SMAC) requirements for all D-SNPs operating in the State. The State will work to build robust partnerships with all Indiana D-SNPs and increase its levels of collaboration with them. The State's work will aim to advance its stated integration and alignment goals; to improve health outcomes for its members; and to drive sustained mLTSS program success.

2. BACKGROUND

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

Contracts with the Centers for Medicare & Medicaid Services (CMS) to sponsor Medicare Advantage Organizations (MAO) under Title XVIII of the Social Security Act, including Medicare Advantage Dual-eligible Special Needs Plan(s) (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 MAO enter into a contract with the State Medicaid Agency to coordinate benefits and/or services for Members of MAO's D-SNP(s) within the State.

The Balanced Budget Act of 2018 and its implementing regulations issued by CMS require the MAO D-SNP to maintain a level of integration between Medicaid and Medicare.

The MAO and the State desire to enter into an arrangement regarding the provision of Medicare benefits by the MAO'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. 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.

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.

High-Risk Member: An Indiana Medicaid member who is enrolled with Aged and Disabled (A&D) Waiver services.

Aged and Disabled Waiver: Provides an alternative to nursing facility admission for adults and persons of all ages with a disability. 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.

Qualified Medicare Beneficiary (QMB) Only: The member's benefits are limited to payment of the member's Medicare Part A (if member is not entitled to free Part A) and Part B premiums as well as deductibles and coinsurance or copayment for Medicare-covered services only.

Qualified Medicare Beneficiary Plus (QMB+): The member's benefits include payment of the member's Medicare premiums, deductibles, and coinsurance or copayment on Medicare-covered services in addition to Traditional Medicaid benefits.

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 throughout each month of eligibility, including deductibles, co-insurance and co-pays (except for Part D).

Qualifying Individual (QI): The member's benefit is payment of the member's Medicare Part B premium. The Eligibility Verification System (EVS) identifies this coverage as Qualified Individual.

Qualified Disabled Working Individual (QDWI): The member's benefit is payment of the member's Medicare Part A premium. The EVS identifies this coverage as Qualified Medicare Beneficiary.

Other Full-Benefit Dually Eligible (FBDE): The member is eligible for Medicaid either categorically or through optional coverage groups but is not enrolled for QMB or SLMB. An FBDE is eligible for Medicaid payment of Medicare premiums, deductibles, co-insurance and co-pays (except for Part D).

Exhibit 1A

ACKNOWLEDGEMENT OF AWARENESS,
SERVICES TO BE PROVIDED

Category	Medicare Part A Premiums	Medicare Part B Premiums	Medicare Cost Sharing (Except Part D)		Other Medicaid Benefits
			Part A	Part B	
QMB Only	**X**	**X**	**X**	**X**	
QMB Plus	**X**	**X**	**X**	**X**	**X**
FBDE	**X**	**X**	**X**	**X**	**X**
SLMB+		**X**	**X**	**X**	**X**
SLMB		**X**			
QI		**X**			
QDWI	**X**				

4. DUTIES OF CONTRACTOR

The Contractor shall provide the following services relative to this Contract:

A. Any policy offered under this Contract must be reviewed by the Centers for Medicare & Medicaid Services (CMS)

B. 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 MAO 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.

Some of the most frequent recurring meetings shall be:

1) Quarterly State and MAO D-SNP Executive Update
2) Bi-weekly D-SNP/Area Agency on Agency (AAA) Care Coordination Workgroups
3) Monthly D-SNP/State Compliance Updates
4) Annual Contract Year State Medicaid Agency Contract (SMAC) Kickoff

The MAO will also be expected to participate and commit sufficient time and staff for supporting initiatives and projects that support the implementation of SMAC requirements. The MAO shall also attend ad-hoc meetings as requested by the State. The State reserves the right to request and require specific MAO D-SNP staff members to attend the above-listed meetings, and shall reasonably accommodate MAO D-SNP staff schedules and needs as much as practicable when scheduling requested ad hoc meetings.

Information Sharing

C. Upon learning a member, who is identified as High-Risk under Section L of this clause and in the Contract Definitions above, 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 FSSA:

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.

In the event the MAO delegates its responsibility for notifying FSSA under this clause to a subcontractor, the MAO shall retain responsibility for compliance with the notification requirements in this clause.

D. The State shall provide the MAO with the file format, data fields, and Secure File Transfer Protocol (SFTP) access to submit the notifications required under Section C of this contract. The MAO shall engage the State to establish access no later than one hundred and twenty (120) days prior to January 1 of the contract year. The MAO must demonstrate readiness to submit required notifications to the State no later than January 1 of the contract year.

E. 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 Division of Aging and the member's designated Aged and Disabled (A&D) Home and Community-Based Service (HCBS) Waiver service coordinator (henceforth referred to as "service coordinator"). 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 (including other A&D waiver services).

F. 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.

G. 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 MAO 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 MAO shall maintain the capability to refresh its eligibility and enrollment data on a weekly basis to ensure an accurate count of its current High-Risk membership. The State will provide ongoing guidance and assistance to the MAO to identify accurately all relevant data fields and information received through the eligibility and enrollment file exchange process to enhance its existing data collection and analytical systems to identify High-Risk Members.

Coordination of Care, Services, and Payments

H. The MAO 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 MAO's Medicare Advantage health benefit plan. For those who enroll in the MAO's D-SNP, the MAO shall be responsible for coordinating the Plan benefits with the Medicaid covered services as set forth in **ATTACHMENT B** to this Exhibit 1, entitled **MEDICAID SERVICES**.

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

J. 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 MAO 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 MAO through its Plans, will sometimes pay after third party resources other than Medicaid and nothing in this Contract shall prevent the MAO from enforcing its rights with regard to payments of and by any non-Medicaid third party.

K. The MAO 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.

L. The Contractor shall be responsible for providing care coordination for all Medicare and Medicaid services for all members the State has designated as High-Risk. For the purposes of this contract, FSSA defines a High-Risk member as any member who is currently enrolled in the Aged and Disabled (A&D) waiver program.

M. The MAO shall develop written care coordination policies for members identified as High-Risk under Section L of this clause and the definitions above. 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 MAO shall incorporate the care coordination policies developed under this Section in its D-SNP Model of Care (MOC) which shall be reviewed and approved as part of the State's annual MOC review. The State shall work in good faith with the MAO on the most efficient and effective incorporation of this information in its MOC and other relevant plan documents as indicated in Section EE of this Contract.

N. The MAO 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 A&D waiver. To this end, the MAO—to the greatest extent possible—shall:

1) Make good faith efforts to enroll all High-Risk Members into case management and to designate for each High-Risk Member an assigned D-SNP care manager who provides longitudinal care coordination that includes coordination with the member's waiver service coordinator;

2) Incorporate the A&D waiver service coordinator into the structure of the D-SNP interdisciplinary care team (ICT) to the highest degree appropriate and possible;

3) Make good faith efforts to incorporate High-Risk Members' A&D waiver service plans into their D-SNP care plan and to operationalize the project plan to demonstrate readiness no later than one hundred and eighty days (180) from January 1 of the contract year. The State shall assist the MAO with accessing the A&D waiver service plans through a State-designated system into its existing systems and processes;

4) 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; and

5) 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 MAO 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).

The MAO is required to outline in its D-SNP MOC all appropriate structures, processes, and assessments outlined above in Section M of this Contract. All details and descriptions must be reviewed and approved as part of the annual State review of the D-SNP MOC. The State shall work in good faith with the MAO on the most efficient and effective incorporation of this information in its MOC and other relevant plan documents as indicated in Section EE of this Contract.

O. The MAO shall also offer referral within two (2) business days to the appropriate Indiana Area Agency on Aging (AAA) any member identified as having strong predictors of needing LTSS but who may not already be enrolled in the A&D waiver or may not be receiving any LTSS currently. Strong predictors of needing LTSS shall be identified through MAO 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.

P. The State shall establish procedures, the levels of communication, and data submission systems to support the referrals made under section O of this clause. These shall be continuously developed as part of regular care coordination meetings with the MAO, the State, and Indiana AAAs. The State shall consider all MAO feedback and shall have final approval authority. The MAO shall implement the State-approved procedures established from these meetings. The State will work in good faith with the MAO to ensure any new procedures, data systems, and communications don't conflict with CMS regulations and requirements.

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

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

Q. For members identified as having strong predictors of needing LTSS under Section O of this clause, in addition to offering a referral to the appropriate AAA, the MAO 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 MAO system capabilities and capacity;

2) Work in good faith with the State to develop dementia education and supports for its 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. The MAO shall submit a draft plan for dementia education and supports to the State for approval one hundred and twenty (120) days prior to January 1 of the contract year. 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 MAO timelines of training, system capabilities, and staffing capacity in order for successful implementation. The MAO shall make good faith efforts to operationalize the plan for dementia education and supports by January 1 of the contract year.

3) The MAO shall use data and information sharing to enhance the coordination of Medicare and Medicaid services for members identified under Section O of this clause. 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 MAO 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 MAO shall incorporate all processes developed under Sections N – P of this clause into the D-SNP MOC which will be reviewed and approved as part of the State's annual MOC review. The State shall work in good faith with the MAO on the most efficient and effective incorporation of this information in its MOC and other relevant plan documents as indicated in Section EE of this Contract.

R. The MAO 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 MAO's IHIE access shall include at a minimum:

1) Exchange and receipt of daily transmission of IHIE Admission, Discharge, and Transfer (ADT) Alerts Standard Report file; and

2) D-SNP care manager access to CareWeb and continued education to support D-SNP care management for dual-eligible members that also receive Medicaid HCBS services through community organization such as AAAs and other CBOs.

The MAO shall use the IHIE data it receives through the Admissions, Discharges, and Transfers file to populate fields in the information sharing file submitted pursuant to Sections C – G of this clause. To the greatest extent possible, the MAO shall use IHIE data that is as close to real-time as possible. The MAO shall develop written policies and procedures for how it will use CareWeb data/information to supplement member care plans and to populate the High-Risk Member data feeds outlined in Sections C – G of this Contract.

If the MAO does not already have access to IHIE's ADT feeds and CareWeb, the MAO shall engage with IHIE to initiate the process to acquire access. MAOs without prior access must demonstrate full functionality and access to IHIE data feeds and CareWeb by January 1 of the contract year.

Social Determinants of Health (SDOH) and Supplemental Benefits

S. The MAO 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 MAO shall use SDOH assessment to advance person-centered care for its membership.

T. The MAO shall collaborate with the State to develop the SDOH assessment tool. The MAO is required to share all information and data collected through SDOH assessments. The State reserves the right to require the tool, domains, questions, process of collection, as well as the file and data sharing procedures required for SDOH assessments.

U. The MAO shall account for State goals and initiatives in the SDOH assessment. The State shall provide information and guidance to the MAO on its broader goals and specific initiatives. The State reserves the right to require specific areas of focus in the SDOH assessment.

V. The MAO 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.

W. The MAO shall submit its final SDOH assessment tool for state approval no later than sixty (60) 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 MAO submission, it will be deemed approved.

X. The MAO shall collaborate with the State on its supplemental benefit offerings [as 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] and the development process for its supplemental benefit offerings in order to achieve the goals outlined in Section I of the "Acknowledgement of Awareness" in this Contract and to align with member benefits offered through Indiana Medicaid. The parties' collaboration shall account for internal MAO timelines and CMS deadlines around supplemental benefit offerings. This collaboration requirement shall not apply to the MAO's supplemental benefit offerings for CY2023.

   The MAO and the State shall mutually agree on the type and format of any information or materials requested by the State that the MAO agrees to provide. Before submitting to the State any information or materials that the MAO regards as proprietary or confidential, the MAO shall label all such information and materials as proprietary and 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 MAO 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 MAO 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).

Y. The MAO shall collaborate with the State in planning and development of supplemental benefit offerings to align with its members' benefits offered through Indiana Medicaid. This collaboration will take into account internal MAO timelines and CMS deadlines around supplemental benefit offerings. This requirement shall not impact the MAO's D-SNP supplemental benefit choices for CY2023.

Z. The MAO shall determine where its supplemental benefits overlap with Medicaid benefits covered under Indiana's State Medicaid Plan or Medicaid Waiver and their potential impact on coordination of benefits, third-party liability, and HCBS access.

   In areas where service overlap occurs, the MAO 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 State Medicaid Plan.

AA. The MAO shall provide a written report and analysis of the overlap and interaction between MAO supplemental benefit offerings and comparable Indiana Medicaid benefits. The structure and format of this report shall be developed in consultation with and be approved by the State and shall be submitted to the State no later than thirty (30) days after January 1, 2023.

State Review of Model of Care (MOC)

BB. The MAO must submit its MOC to an annual State review process. 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 MAO's Indiana dually-eligible population. The population description must specifically account for key characteristics and the realities of the care experience for the MAO'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 including its Aging members, Developmentally Disabled members, Physically Disabled members, and members with a Serious Mental Illness or a Substance Use Disorder;
    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) The frequency of member change and transitions between Indiana Medicaid eligibility status; between partial and full dual eligibility status; and between Medicaid LOC statuses;
    h) Prevalence of Activities of Daily Living (ADLs) deficiencies in their Indiana population;
    i) The identification of members living with dementia, their informal caregivers, and other supports; and a detailed description of what defines their experiences of care;
    j) Prevalent trends in utilization including hospital, SNF, home health, physician, and emergency department (ED) visits; and
    k) Qualitative data that provides member perspectives, relevant stakeholder feedback, and provider insights.

    The MAO 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 MAO 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 MAO to attain those data fields. The MAO should seek to avoid broad generalizations and should ultimately reflect in its MOC a thorough and meaningful understanding of the MAO's Indiana D-SNP membership. The MAO 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 L of this clause;
    b) Members identified as having strong predictors of needing LTSS under Section O of this clause; and
    c) Summary care coordination policies and procedures for the upcoming calendar year.

3) A detailed description of how the MAO will align its Health Risk Assessment (HRA) model with existing State LTSS assessments and information to better identify member risks and needs.

CC. The MAO shall submit the D-SNP MOC to the State review concurrently with its submission to NCQA.

DD. The State shall make good faith efforts to ensure its MOC review process does not interfere with the MAO submission of its MOC for NCQA review. The State's annual MOC review process shall run concurrently. The State, however, reserves the right to require an off-cycle submission of MOC changes if deemed appropriate.

EE. The State shall make good faith efforts to assist the MAO in meeting the requirements under Sections BB – DD of this Contract and will take into account the MAO's specific circumstances as they pertain to its MOC in order to evaluate compliance. This includes but is not limited to consideration of the date of its MOC submission; NCQA approval status and the length of its MOC approval period; the availability of MOC mid-cycle review process; as well as the availability of other avenues of achieving the State goals outlined in Sections BB – DD. The default State preference is to include information requested should be included in the MOC absent its approval.

FF. The MOA shall notify the State within fifteen (15) business days of receipt of initial MOC approval and acceptance by NCQA and/or within fifteen (15) business days of NCQA approval of any subsequent redline changes. The MOA shall also notify the State within fifteen (15) business days of receipt of approval of a MOC mid-cycle submission.

GG. Members will be enrolled in the MAO dual-eligible program effective the month after enrollment application is submitted by the enrollee.

HH. The MAO will verify, prior to enrollment of a potential Qualified Recipient, the individual's Medicare eligibility. The MAO 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 MAO as soon as reasonably possible. For those enrollees who are not certified as eligible by the State and for which CMS records indicate that the recipient should be eligible, it will be the responsibility of MAO 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.

II. All MAO agents that enroll dual-eligible members for the MAO's Indiana D-SNP during the contract year must complete a three (3) hour D-SNP course developed and approved by the Indiana Department of Insurance (IDOI) that will count for three (3) Continuing Education Unit (CEU) credits. The course must be completed by all MAO agents doing work for the MAO before the end of CY2023.

Upon completion of the course, the MAO must require its agents to maintain a record of successful course completion and to be able to make that available upon MAO request. The MAO and the State shall subsequently make good faith efforts to establish an appropriate method of tracking and auditing course completion for its agents for CY2023. The State reserves the right to request access to these records at any time and for any purpose.

All MAO agents enrolling members into an Indiana D-SNP during the current contract year must complete the required D-SNP course within the contract year regardless and must retake it every two years thereafter.

JJ. The MAO 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 (Chapter 2, *Medicaid Managed Care Manual*, §50.2.5 – "Loss of Special Needs Status" found at https://www.cms.gov/files/document/cy2021-ma-enrollment-and-disenrollment-guidance.pdf).

KK. To mitigate Medicaid eligibility churn and ensure continuity of care, the MAO 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 MAO staff with direct member interaction—including care management and call center staff—in maintaining the knowledge and capacity to assist members with how they connect with Medicaid navigators; where they can access the Medicaid eligibility application; what members need to know about the State redetermination processes; and what are the State 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.

The State shall provide the MAO with education opportunities and training on Medicaid eligibility processes and requirements. The State reserves the right to establish additional review of MAO systems, processes, and staff education to assess effectiveness and sufficiency.

LL. The MAO may enroll dual-eligible persons in D-SNP for the following dual-eligible categories, as defined above:

1) QMB

2) QMB+

3) FBDE

4) SLMB+

5) SLMB

6) QI

7) QDWI

The MAO may, with CMS and State approval, enroll dual-eligible persons using some, but not all of the categories above. The MAO may, with CMS and State approval, later expand to enroll dual-eligible persons using additional categories from the list above or request to enroll using fewer of these categories. The MAO shall submit to the State in writing all subsequent requests to change enrollment categories.

5. REPORTING REQUIREMENTS

A. The MAO shall submit the following to FSSA within the timeframes indicated below, and in the manner and format specified and/or subsequently agreed upon by the State:

1) Monthly D-SNP enrollment and disenrollment reports submitted to CMS within seven (7) business days of submission.

2) The Monthly Membership Report (MMR) file received from CMS with all fields included within thirty (30) business days of receipt.

3) Weekly Medicare encounter claims data 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.

If the MAO does not already submit encounter claims data to the State, the MAO shall engage the State no later than one hundred twenty (120) days prior to January 1 of the contract year to establish a project plan and timelines for submitting to the State all encounter claims data required under this section.

The MAO and the State shall make good faith efforts to operationalize the project plan and to demonstrate readiness to submit Medicare encounter data files no later than one hundred and eighty days (180) after January 1 of the contract year. The MAO must also submit all historical Medicare encounter claim files dating back to January 1 of the contract year.

4) 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 MAO is required to submit to National Committee for Quality Assurance (NCQA) and CMS respectively;
- The final NCQA HEDIS Compliance Audit Report provided to the MAO by the NCQA-licensed audit firm;
- All Medicare Health Outcomes Survey (HOS) data feedback reports provided to the MAO by CMS; and
- Any reports or materials pertaining to annual MAO participation in the Medicare Advantage and Prescription Drug Plan (MA & PDP) Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

5) Significant changes to the terms of the Medicare contract with CMS, including D-SNP non-renewals, terminations, and service area reductions within fifteen (15) business days of approval by CMS.

6) Audit findings and corrective action plans, within fifteen (15) business days of either being notified by CMS or submitting them to CMS.

7) Any changes made to the use of projected Medicare savings and rebates within fifteen (15) business days of CMS approval of the changes.

8) Notices of non-compliance from CMS within fifteen (15) business days of the notification.

9) Sanctions of any kind imposed by CMS within fifteen (15) business days of the notification.

10) Performance information, including CMS warning letters, deficiency notices, and notices of Medicare star ratings less than 3.0, within fifteen (15) business days of the notification.

11) Member newsletters must be submitted to the State—for informational purposes—within fifteen (15) business days of date of being provided to members.

12) 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 days (30) of CMS approval.

13) The State may request any communication or marketing materials from the MAO to review for informational purposes and MAO will send to FSSA fifteen (15) calendar days after request from FSSA.

B. Materials that contain reference to Indiana Medicaid program benefits or any Indiana Medicaid program must be submitted to FSSA for review and written approval prior to submission to CMS. The MAO shall provide for at minimum thirty (30) calendar days for the State to review and to request modifications. In its submission, the MAO 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 to promote them. During the State review process, the MAO shall respond to all State requests for additional information and fully address any State-identified issues and/or requested modifications.

   The State and the MAO 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 MAO does not receive written approval from the State within the previously mentioned thirty (30) calendar day requirement—and the MAO is at risk of not meeting a CMS submission deadline—the MAO shall adhere to the CMS submission deadline in the absence of the State's written approval. The MAO shall provide concurrent notice to the State in such a scenario

C. The MAO 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 MAO. The contractor must fulfill these requests within thirty (30) calendar days of the date of the agreed upon business requirements unless otherwise agreed upon by FSSA and the MAO.

Exhibit 1A Attachment A
KEY RESOURCES

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 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-tools2/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/

Exhibit 1A Attachment B
MEDICAID SERVICES

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Institutional and Clinic Services					
Clinic Services, by an organized facility or clinic not part of a hospital: Freestanding Ambulatory Surgery Center					
Yes				Fee for service, with surgical procedures grouped using Medicare methodology	CN
Clinic Services, by an organized facility or clinic not part of a hospital: Public Health and Mental Health Clinics					
Yes				Fee for service or reasonable charge	CN
Federally Qualified Health Center Services					
Yes				Prospective cost based rate/encounter	CN
Inpatient Hospital Services, other than in an Institution for Mental Diseases					
Yes		Specified admissions, including to rehab and burn centers	Second opinions required for specified procedures, LOS less than 24 hours considered outpatient except for newborns, substance abuse treatment limited to detoxification	Prospective payment/discharge using DRG, prospective per diem for rehab and burn centers	CN
Outpatient Hospital Services					
Yes	$3/non-emergency visit in ER			Fee for service, with surgical procedures grouped using Medicare methodology	CN
Rehabilitation Services: Mental Health and Substance Abuse					
Yes		Yes	14 therapeutic leave days/year in psychiatric residential treatment facilities	Fee for service with services of specified mid-level practitioners paid 75% of physician fee, prospective cost based per diem for psych residential treatment facilities	CN
Rural Health Clinic Services					
Yes				Prospective cost based rate/encounter	CN
Practitioner Services					
Certified Registered Nurse Anesthetist Services					
Yes				Fee for service at 60% of physician fee	CN
Chiropractor Services					
Yes			50 therapeutic physical medicine treatments/year including up to 5 office visits	Fee for service	CN
Dental Services					
Yes		Specified services including non-emergency inpatient procedures and oral surgery	$1000 maximum benefit/year included with denture services, exam and cleaning 1/year (2/year for nursing facility residents), frequency of x-rays limited by type, periodontia limited, second opinions required for specified procedures	Fee for service	CN
Medical and Remedial Care - Other Practitioners					
Medical/Surgical Services of a Dentist					
Yes		Specified services including non-emergency services provided on an inpatient hospital basis and oral surgery	Second opinions required for specified procedures, ambulatory services limited	Fee for service	CN
Nurse Midwife Services					
Yes				Fee for service	CN
Nurse Practitioner Services					
Yes				Fee for service at 75% of physician fee	CN
Optometrist Services					
Yes			1 refractive exam/2 years	Fee for service	CN
Physician Services					
Yes		Specified surgical procedures, procedures exceeding specified cost limits	30 visits/year	Fee for service, services performed with assistance of second surgeon or in outpatient setting rather than office paid reduced fee	CN
Podiatrist Services					
Yes		Inpatient hospital services and specified services associated with orthopedic shoes and appliances	Routine foot care covered only for specified systemic conditions at 6 visits/year, second opinion required for specified services	Fee for service	CN
Psychologist Services					
Yes		Specified services including psychological testing	20 service/time units/year	Fee for service	CN
Prescription Drugs					
Prescription Drugs					
Yes	$3/Rx	Specified drugs		AWP-16% for brand Rx, AWP-20% for generic Rx, plus $4.90 dispensing fee for each	CN

Exhibit 1A Attachment B
MEDICAID SERVICES

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Physical Therapy and Other Services					
Occupational Therapy Services					
Yes		Therapy not following hospital discharge or after 30 days of discharge	30 therapy sessions/month in combination with other therapy providers if ordered by physician prior to hospital discharge	Fee for service	CN
Physical Therapy Services					
Yes		Therapy not following hospital discharge or after 30 days of discharge	12 hours/30 days or 30 therapy sessions/month in combination with other therapy providers if ordered by physician prior to hospital discharge	Fee for service	CN
Services for Speech, Hearing and Language Disorders					
Yes		Specified services including therapy not following hospital discharge or after 30 days of discharge	1 audiological testing and evaluation/3 years, 30 therapy sessions/month in combination with other therapy providers if ordered by physician prior to hospital discharge	Fee for service	CN
Products and Devices					
Dentures					
Yes		Yes	$600 maximum benefit/year included with dental services	Fee for service	CN
Eyeglasses					
Yes			1 pair eyeglasses/5 years, age-specific minimum diopter correction required for initial and replacement eyeglasses	Fee for service	CN
Hearing Aids					
Yes		Yes	1 hearing aid/5 years	Fee for service	CN
Medical Equipment and Supplies					
Yes		Specified med equipment and med supply items	$1950 maximum benefit/year for incontinence products and products must be obtained from a contracted vendor	Fee for service using historical Medicare payment rates	CN
Prosthetic and Orthotic Devices					
Yes		Yes		Fee for service	CN
Transportation Services					
Ambulance Services					
Yes	$.50-$2/non-emergency transport, depending on payment	Non-emergency transports or transports greater than 50 miles		Fee for service	CN
Non-Emergency Medical Transportation Services					
Yes	$.50-$2/trip, depending on payment		20 one-way trips less than 50 miles/year	See service-specific FN	CN

Exhibit 1A Attachment B
MEDICAID SERVICES

Is the Benefit Covered?	Copayment Requirement	Prior Approval Requirement	Coverage Limitations	Reimbursement Methodology	Populations Covered
Other Services					
Diagnostic, Screening and Preventive Services					
Yes				Dependent upon service and billing provider	CN
Early and Periodic Screening, Diagnosis and Treatment					
See service-specific FN.					
Extended Services for Pregnant Women					
Family Planning Services					
See service-specific FN.					
Laboratory and X-Ray Services, outside Hospital or Clinic					
Yes				Fee for service	CN
Targeted Case Management					
Yes			Quantity and frequency limits vary by group served	Fee for service	CN
Long-Term Care Services					
Community Based Care					
Home and Community Based Services Waiver					
Yes		Yes	Services for the	Dependent upon the services provided	CN
Home Health Services, includes nursing services, home health aides, and medical supplies/equipment					
Yes			120 hours of care within 30 days of hospital discharge if ordered by physician, 30 therapy sessions/month in combination with other therapy providers if ordered by physician prior to hospital discharge	Prospective cost based rates	CN
Hospice Care					
Yes		Yes		Prospective rates based on Medicare methodology	CN
Personal Care Services					
No					
Private Duty Nursing Services					
No					
Program of All-Inclusive Care for the Elderly					
No					
Institutional Care					
Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services In Institutions for Mental Diseases, age 65 and old					
Yes		Yes for elective admissions	Services limited to hospital settings, 60 therapeutic leave days/year	Prospective cost based per diem, leave days paid at 50% of facility's rate	CN
Inpatient Psychiatric Services, under age 21					
Yes		Yes	14 therapeutic leave days/year	Prospective cost based per diem, leave days paid at 50% of facility's rate	CN
Intermediate Care Facility Services for the Mentally Retarded					
Yes		For LOC determination upon admission	15 hosp leave days/hospitalization, 60 therapeutic leave days/year	Prospective cost based per diem, leave days paid at 50% of facility's rate	CN
Nursing Facility Services, other than in an Institution for Mental Diseases					
Yes		For LOC determination upon admission, therapies, specified prescription drugs	15 consecutive hosp leave days/hosp, 30 therapeutic leave days/year	Prospective per diem based on cost, leave days paid at 50% of facility's rate if 90% occupancy requirement met	CN
Religious Non-Medical Health Care Institution and Practitioner Services					
Yes			Practitioner services not covered	Prospective cost based per diem	CN

Exhibit 2A

DUAL ELIGIBILITY CATEGORIES AND SERVICE AREA

The MAO is filing the D-SNP under the following categories for the following counties:

Categories:XXXXXXX

Counties:XXXXXXX