Managed Long-Term Services and Supports Scope of Work Draft Excerpts

The following managed long-term services and supports (MLTSS) scope of work (SoW) excerpts are near-final drafts. These excerpts have been assembled for the benefit of stakeholders who have supported the design of this program from the outset. Developing a SoW for a new program that will be subject to competitive procurement necessarily requires materials be kept confidential and free from the influence of potential bidders, but at the same time the State wishes to show clear examples of how the stakeholder design inputs have translated into actual contract language. Broadly, this material reflects requirements that will be placed on Managed Care Entities (MCEs) that will serve Hoosiers under this program in the future. The material was drafted based on extensive discussions with stakeholders and with a constant eye toward ensuring Hoosiers served under the program will be better able to receive quality, person-centered, coordinated care that helps them age in the place of their choosing. Excerpts are not necessarily reflective of the full language within each numbered contract section but are examples highlighting requirements relevant to this stakeholder engagement and previously expressed topics of interest. Note that the future program name (e.g., Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, in the case of our three existing managed care programs) has not been determined at this time and is reflected in these excerpts as "[MLTSS Program Name]". Additionally, please note that references in the excerpts to “the State” mean FSSA and references to “the Contractor” mean the MCE that would enter into a contract with FSSA to participate in the program.

Member Services Excerpts Related to April 14th, 2022 Information Sharing Presentation

5.1 Marketing and Outreach

Limited marketing efforts will be permitted at the sole discretion of the State of Indiana. Marketing efforts shall be targeted to the general community in the State of Indiana in accordance with 42 CFR 438.104, and the requirements outlined in Section 5.7, the Contractor must submit requests for approval on marketing materials allowing the State of Indiana a minimum of thirty (30) calendar days to review and the Contractor must obtain State approval for all marketing materials prior to distribution. All marketing materials must be distributed to the Contractor’s entire service area and shall comply with the information requirements delineated at 42 CFR 438.10. Such materials shall be in a manner and format that is easily understood and meet the general communication material requirements discussed further in Section 5.7. Marketing materials should include the requirements and benefits of the Contractor’s health plan, as well as the Contractor’s provider network.

The Contractor may market via digital, mail and mass media advertising such as digital media, radio, television and billboards. Community oriented marketing such as participation in community health fairs is encouraged. Tokens or gifts of nominal value may be distributed at such events to potential members, so long as the Contractor acts in compliance with all marketing provisions provided for in 42 CFR 438.104, and other federal and state regulations and guidance regarding inducements in the Medicare and Medicaid programs. Any marketing activities (written and oral) shall be presented and conducted in an easily understood manner and format, at a fifth-grade reading level or lower. Upon request by member(s), marketing materials shall be available in the member’s preferred language and/or format. The Contractor shall document the member’s preferred language and/or format and deliver all future materials to the member in the preferred manner. The Contractor shall submit product naming and associated domains to FSSA for review and approval to minimize confusion for members and providers

The contractor must ensure that a potential member or their legal representative can make their own decision as to whether or not to enroll. Marketing materials and plans shall be designed to reach a broad

distribution of potential members across age and gender categories. The Contractor must conduct marketing and advertising in a geographically balanced manner, paying special attention to rural areas of the State. The Contractor must provide information to potentially eligible individuals who live in medically underserved rural areas of the State. Potential members may not be discriminated against on the basis of health status or need for health care services, or on any other basis inconsistent with state or federal law, including Section 1557 of the Affordable Care Act / 45 CFR 92.1.

5.2 Member Enrollment and Contractor Selection

[MLTSS Program Name] applicants have an opportunity to select an MCE on their application or by calling the enrollment broker within sixty (60) days of the coverage start. MCEs are expected to conduct marketing and outreach efforts to raise awareness of the [MLTSS Program Name] program and their product. The Enrollment Broker is available to assist members in choosing an MCE. Applicants who do not select an MCE on their application will be assigned to an MCE according to the State's assignment methodology after sixty (60) days. The Contractor's companion D-SNP must be exclusively aligned with its [MLTSS Program Name] Medicaid plan and will only be allowed to enroll dual eligible members who are also enrolled in its [MLTSS Program Name] Medicaid plan. Members enrolled in the Contractor's [MLTSS Program Name] Medicaid plan who later become Medicare-eligible for the first time will be default enrolled into the Contractor's companion D-SNP.

The State reserves the right to amend the assignment logic and may incorporate HEDIS or other quality indicators into the assignment logic at a future date. Member assignment will not be available to any MCE who does not successfully complete readiness review. Default assignment will not be available for any plan that has an associated D-SNP that fails to meet the minimum Medicare Star rating of three (3) stars as defined in 42 CFR 422.252. Information about member enrollment and contractor selection shall be subject to the requirements as described in Section 5.4 Member Information, Education, and Outreach.

Members will have the opportunity to change their MCE at the following intervals:

1. Within sixty (60) days of starting coverage,
2. At any time their Medicare and Medicaid plans become unaligned,
3. Once per calendar year for any reason
4. At any time using the just cause process (defined below)
5. During the Medicare open enrollment window (mid-October-mid December) to be effective the following calendar year.

Any Medicaid member may change their MCE for Just Cause. The "for cause" reasons are described in 42 CFR 438.56(d)(2)(iv). Determination as to whether a member has met one of these reasons is solely the determination of the Enrollment Broker and FSSA. The reasons include, but not limited to, the following:

- Receiving poor quality of care;
- Failure to provide covered services;
- Failure of the Contractor to comply with established standards of medical care administration;
- Lack of access to providers experienced in dealing with the member's health care needs;

- Significant language or cultural barriers;
- Corrective action levied against the Contractor by the office;
- Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence;
- A determination that another MCE's formulary is more consistent with a new member's existing health care needs;
- Lack of access to medically necessary services covered under the Contractor's contract with the State;
- A service is not covered by the Contractor for moral or religious objections, as described in Section 7.8.2;
- Related services are required to be performed at the same time and not all related services are available within the Contractor's network, and the member's provider determines that receiving the services separately will subject the member to unnecessary risk;
- The member's primary healthcare provider disenrolls from the member's current MCE and reenrolls with another MCE; or
- Other circumstances determined by the office or its designee to constitute poor quality of health care coverage.

5.3 Member-Contractor Communications

The Contractor will be responsible for developing and maintaining member education programs designed to provide members with clear, concise and accurate information about the Contractor's program, the Contractor's network and the [MLTSS Program Name] program. This should be delivered in a multimedia format that does not exclusively consist of telephonic and written correspondence outreach. The State encourages the Contractor to incorporate community advocates, community-based organizations, community health workers, support agencies, health departments, other governmental agencies and public health associations in its outreach and member education programs.

The Contractor shall maintain strategies for communicating with members. Contractor communication strategies must meet the requirements under Section 5 Member Services and provide innovative approaches to ensure member understanding of the [MLTSS Program Name] program. The Contractor shall also develop approaches to share resources related to the member's goals which may include information about the member's health condition(s), treatment protocols and the importance of preventive care.

5.3.1 Member Services Helpline and 24-Hour Nurse Line

The Contractor shall maintain a statewide toll-free telephone helpline staffed with trained personnel knowledgeable about the [MLTSS Program Name] program equipped to handle a variety of member inquiries, including the ability to address member questions, concerns, complaints and requests for PMP changes. The same helpline shall be available to [MLTSS Program Name] members, so that members may call one number to answer questions about all the IHCP programs the Contractor is contracted as an MCE for. The helpline shall be available to individuals who are authorized to speak to customer service on behalf of a member (e.g. a family member, informal caregiver, supported decision maker(s), legal guardian, or other designated representative). Indiana based helpline staff must take at least seventy percent (70%) of the

member helpline calls, except when an emergency rollover is required. The State must be notified if such an emergency is taking place. A minimum of fifty percent (50%) of helpline staff must be employees of the prime Contractor.

The Contractor shall staff the member services helpline to provide sufficient "live voice" access to its members during, at a minimum, a twelve (12)-hour business day, from 8 a.m. to 8 p.m. Eastern, Monday through Friday. The call center shall open 60 days prior to the Contractor's go live date, with State approval. The Contractor shall provide a voice message system that informs callers of the Contractor's business hours and offers an opportunity to leave a message after business hours. Calls received in the voice message system shall be returned within one (1) business day.

The member services helpline shall offer language translation services for members whose primary language is not English and shall offer automated telephone menu options in English and Spanish. A member services messaging option shall be available after business hours in English and Spanish. The Contractor shall provide Telecommunications Device for the Deaf (TDD) services for hearing impaired members. There must also be at least one (1) fluent Burmese speaker and one (1) fluent Spanish speaker physically present (i.e., not via a language translation line) to answer member calls during all "live" operating hours.

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

The Contractor shall maintain a system for tracking and reporting the number and type of members' calls and inquiries it receives during business hours and non-business hours. The Contractor shall monitor its member services helpline service and report its telephone service level performance to FSSA in the timeframes and specifications described in the [MLTSS Program Name] MCE Reporting Manual.

The Contractor's member services helpline staff shall be prepared to efficiently respond to member concerns or issues including, but not limited to the following:

- Access to health care services;
- Identification or explanation of covered services;
- Special health care needs;
- Procedures for submitting a member grievance or appeal;
- Potential fraud or abuse including adult protective services;
- Changing PMPs;
- Incentive and enhanced benefit programs;
- Disease management, care coordination, and service coordination services;
- Balance billing issues;
- Referrals to local services or community-based organizations for assistance; and

- Health crises, including but not limited to suicidal callers.

Upon a member's enrollment with the Contractor, the Contractor shall inform the member about the member services helpline. The Contractor shall encourage its members to call the member services helpline as the first resource for answers to questions or concerns about [MLTSS Program Name], PMP issues, benefits, Contractor policies, etc.

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

- For any calendar month, at least ninety-seven percent (97%) of all phone calls to the helpline must reach the call center menu within thirty (30) seconds.
- For any calendar month, at least eighty-five percent (85%) of all phone calls to an approved automated helpline must be answered by a helpline representative within thirty (30) seconds after the call has been routed through the call center menu. Answered means that the call is picked up by a qualified helpline staff person.
- For any calendar month, at least ninety-five percent (95%) of all phone calls to an approved automated helpline must be answered by a helpline representative within sixty (60) seconds after the call has been routed through the call center menu. Answered means that the call is picked up by a qualified helpline staff person.
- If the Contractor does not maintain an approved automated call distribution system, for any calendar month, at least ninety-five percent (95%) of all phone calls to the helpline must be answered within thirty (30) seconds.
- Hold time does not exceed one (1) minute in any instance, or thirty (30) seconds, on average.
- For any calendar month, the lost call (abandonment rate) associated with the helpline does not exceed five percent (5%).

In addition to the member services helpline, which is staffed during regular business hours, the Contractor shall operate a toll-free twenty-four (24) hour nurse call line. The Contractor shall provide nurse triage telephone services for members to receive medical advice twenty-four (24) hours-a-day/seven (7)-days-a-week from trained medical professionals. The twenty-four (24) hour nurse call line should be well publicized and designed as a resource to members to help discourage inappropriate Emergency room use. The twenty-four (24) hour nurse call line must have a system in place to communicate all issues with the member's providers. In addition, as set forth in Section 3.4, the 24-Hour Nurse Call Line must be equipped to provide advice for [MLTSS Program Name] members seeking services from hospital Emergency departments.

5.4 Member Information, Education, and Outreach

The Contractor shall provide the information listed under this section within a reasonable timeframe, following the notification from the State fiscal agent of the member's enrollment in the Contractor. This information shall be included in the member handbook.

The Contractor shall notify all members of their right to request and obtain information in accordance with 42 CFR 438.10. In addition to providing the specific information required at 42 CFR 438.10(f) upon enrollment in the Welcome Packet as described in Section 5.7 the Contractor shall notify members at least once a year of their right to request and obtain this information. Individualized notice shall be given to each member of any significant change in this information at least thirty (30) days before the intended effective date of the change. Significant change is defined as any change that may impact member accessibility to the Contractor's services and benefits.

The Contractor shall comply with the information requirements at 42 CFR 438.10. All enrollment notices, informational and instructional materials must be provided in a manner and format that is easily understood. This means, to the extent feasible, written materials shall not exceed a fifth-grade reading level and be in plain language. All written materials for members or potential members shall be in a font size no smaller than 12-point

In accordance with 42 CFR 438.10(e), the State must provide potential members with general information about the basic features of managed care and information specific to each MCE operating in the potential member's service area. At minimum, this information will include factors such as MCE service area, benefits covered, and network provider information. The State shall provide information on [MLTSS Program Name] MCEs in a comparative chart-like format. Once available, the State also intends to include Contractor quality and performance indicators on materials distributed to facilitate MCE selection. The State reserves the right to develop a rating system advertising Contractor performance on areas such as consumer satisfaction, network access and quality of care and services. To facilitate State development of these materials, the Contractor must comply with State, or its designee, requests for information needed to develop informational materials for potential members.

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

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

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

5.5 Member and Stakeholder Education and Engagement

- The Contractor must convene a minimum of four regional member and informal caregiver advocacy committees at least quarterly. These regional meetings shall occur in separate areas of the state, a minimum of sixty (60) miles from each other regional meeting occurring that quarter.
- The purpose of the committees is to provide member, informal caregiver, and advocate input into program development and feedback on the member experience. The Contractor shall present information to the committee and seek its advice regarding: the experience of members and their informal supports service gaps, approaches to member outreach and education, reinvestment opportunities, and regarding Contractor's proposed approaches to initiatives and interventions Contractor will implement to improve quality of care.

- The committee shall review member materials, including the member handbook and website, and review the Contractor's Health Equity and Cultural Competency plan. The Contractor shall have a feedback loop with the committee on recommendations taken and not taken.
- The committee shall review trends and summaries of member grievances and appeals. The committee shall be asked to provide advice to the Contractor on how the Contractor can resolve common member concerns.
- Every effort shall be made to include a cross representation of members, families/representatives, and advocacy groups that reflect the population and community served. Sub-committees may be created to focus on specific topics such as LTSS or Behavioral Health.
- The Contractor shall facilitate member participation providing transportation, interpretation services, compensation, virtual connectivity, meetings conducted in the prevalent non-English languages of the membership, and personal care assistance. The contractor shall provide thirty (30) days advance notice to participants. Meetings shall be conducted in various formats such as informational or decision-making meetings, or focus groups.
- The Contractor shall have member advocacy organizations as standing members of the committee, especially organizations with a focus on special health care needs, individuals with disabilities, and social determinant of health organizations.
- FSSA compliance staff shall be informed of each meeting time and location at least two weeks in advance, so they may plan to attend. Minutes from the meetings shall be provided to the MCE's Board of Directors and to FSSA within one month of the meeting date.
- The Contractor shall report back to the committee on what actions the Contractor has taken as a result of committee feedback.

The Contractor shall also develop a formal process for ongoing education of stakeholders prior to, during and after implementation of the [MLTSS Program Name]. This includes publicizing methods by which members can ask questions regarding the [MLTSS Program Name] program. Stakeholders include, but are not limited to, providers, advocates and members. The Contractor shall submit this formal process to FSSA for review and approval in the timeframe and manner determined by the State.

5.7 Member Materials

The Contractor shall distribute member materials as required by this Contract. Required materials, described below, include member handbooks, provider directories, quarterly member newsletters and identification cards at a minimum. The Contractor may distribute additional materials and information, other than those required to members in order to promote health and/or educate enrollees provided the materials are State approved. Materials, to the extent possible, shall be in plain language including the Member Welcome Letter and Member Handbook.

5.7.1 Member Welcome Letter

Within five (5) calendar days of a new member's full enrollment with the Contractor, the Contractor must send the member a Welcome Letter. The Welcome Letter shall include:

- Education confirming the member's enrollment with Contractor as part of the [MLTSS Program Name] Contractor contact information with an explanation as to how can access information
- Specific information on coordination of care with current providers and how members can receive care coordination assistance
- Member's effective enrollment date with Contractor

5.7.2 Member Handbook

Within five (5) calendar days of a new member's full enrollment with the Contractor in accordance with Section 5.8, the Contractor shall develop and send the member a Member Handbook developed using the state's model handbook. The Contractor's member handbook shall be submitted annually for FSSA's review, and any time changes are made. The member handbook shall include the Contractor's contact information and Internet website address and describe the terms and nature of services offered by the Contractor, including the following information required under 42 CFR 438.10(f), which enumerates certain required information. The member handbook may be offered in an electronic format as long as the Contractor complies with 42 CFR 438.10(c)(6). The [MLTSS Program Name] MCE Policies and Procedures Manual outlines the member handbook requirements.

The [MLTSS Program Name] member handbook shall include the following:

1. Contractor's contact information (address, telephone number, TDD number, website address);
2. The amount, duration and scope of services and benefits available under the Contract in sufficient details to ensure that members are informed of the services to which they are entitled, including, but not limited to the differences between the benefit options;
3. The procedures for obtaining benefits, including authorization requirements;
4. Contractor's office hours and days, including the availability of a 24-hour Nurse Call Line;
5. Any restrictions on the member's freedom of choice among network providers, as well as the extent to which members may obtain benefits, including family planning services, from out-of-network providers;
6. How emergency care is provided, that an authorization is not required, and that the enrollee has a right to use any hospital or other setting for emergency care;
7. The extent to which, and how, after-hours and emergency coverage are provided, as well as other information required under 42 CFR 438.10(f), such as what constitutes an emergency;
8. The post-stabilization care services rules set forth in 42 CFR 422.113(c);
9. The extent to which, and how, urgent care services are provided;
10. Applicable policy on referrals for specialty care and other benefits not provided by the member's PMP, if any;
11. Information on available Home and Community Based Services (HCBS) benefits and education on how to access HCBS;
12. Information on long-term services and supports and education on how to access long-term services and supports;
13. Information about the availability of pharmacy services and how to access pharmacy services;
14. Information about all relevant or applicable State ombudsman programs.
15. Member rights and protections, as enumerated in 42 CFR 438.100, which relates to enrollee rights. See Section 5.11 for further detail regarding member rights and protections;
16. Information about the member's right to choose between nursing facility and HCBS.
17. A description of the Care Coordinator and Service Coordinator role and responsibilities
18. Responsibilities of members;
19. Special benefit provisions (for example, co-payments, deductibles, limits or rejections of claims) that may apply to services obtained outside the Contractor's network;

20. Procedures for obtaining out-of-network services;
21. Standards and expectations to receive preventive health services;
22. Policy on referrals to specialty care;
23. Procedures for notifying members affected by termination or change in any benefits, services or service delivery sites;
24. Procedures for appealing decisions adversely affecting members' coverage, benefits or relationship with the Contractor;
25. Information on how to access non-emergency medical transportation and how the member can access assistance with their responsibilities for scheduling, using, and cancelling rides through the Contractor's transportation broker or care management;
26. Procedures for changing PMPs;
27. Standards and procedures for changing MCEs, and circumstances under which this is possible, including, but not limited to providing contact information and instructions for how to contact the enrollment broker to transfer MCEs due to one of the "for cause" reasons described in 42 CFR 438.56(d)(2)(iv), including, but not limited to, the following:
    a. Receiving poor quality of care;
    b. Failure to provide covered services;
    c. Failure of the Contractor to comply with established standards of medical care administration;
    d. Lack of access to providers experienced in dealing with the member's health care needs;
    e. Significant language or cultural barriers;
    f. Corrective action levied against the Contractor by the office;
    g. Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence;
    h. A determination that another MCE's formulary is more consistent with a new member's existing health care needs;
    i. Lack of access to medically necessary services covered under the Contractor's contract with the State;
    j. A service is not covered by the Contractor for moral or religious objections, as described in Section 7.8.2;
    k. Related services are required to be performed at the same time and not all related services are available within the Contractor's network, and the member's provider determines that receiving the services separately will subject the member to unnecessary risk;
    l. The member's primary healthcare provider disenrolls from the member's current MCE and reenrolls with another MCE; or
    m. Other circumstances determined by the office or its designee to constitute poor quality of health care coverage.
28. The process for submitting disenrollment requests. This information shall include the following:
    a. When members may change MCEs (as detailed in Section 5.2)
    b. Members may submit requests to change MCEs to the Enrollment Broker verbally or in writing
29. The MCE shall provide the Enrollment Broker's contact information and explain that the member must contact the Enrollment Broker with questions about the process. The process by which an American Indian/ Alaska Native member may elect to opt-out of managed care pursuant to 42 USC § 1396u–2(a)(2)(C) and transfer to fee-for-service benefits through the State;
30. Procedures for making complaints and recommending changes in policies and services;
31. Grievance, appeal and fair hearing procedures as required at 42 CFR 438.10(g)(2)(xi), including the following:

a. The right to file grievances and appeals;
b. The requirements and timeframes for filing a grievance or appeal;
c. The availability of assistance in the filing process;
d. The toll-free numbers that the member can use to file a grievance or appeal by phone;
e. The fact that, if requested by the member and under certain circumstances: (1) benefits will continue if the member files an appeal or requests a State fair hearing within the specified timeframes; and (2) the member may be required to pay the cost of services furnished during the appeal if the final decision is adverse to the member.

32. For a State hearing, describe (i) the right to a hearing, (ii) the method for obtaining a hearing, and (iii) the rules that govern representation at the hearing.
33. Information about advance directives;
34. How to report a change in income, change in family size, etc.;
35. Information about the availability of the prior claims payment program for certain members and how to access the program administrator;
36. Information on alternative methods or formats of communication for visually and hearing-impaired and non-English speaking members and how members can access those methods or formats;
37. Information on how to contact the Enrollment Broker;
38. Information on Medicare eligibility and when to enroll;
39. Statement that Contractor will provide information on the structure and operation of the health plan; and
40. In accordance with 42 CFR 438.10(f)(3), that upon request of the member, information on the Contractor's provider incentive plans will be provided.

5.10 Member-Provider Communications

The Contractor shall comply with 42 CFR 438.102, which relates to provider-enrollee communications. The Contractor must not prohibit or otherwise restrict a health care professional, acting within his or her lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient regarding the following:

i. The member's health status, medical care, treatment options, or social supports including any alternative treatment that may be self-administered, regardless of whether benefits for such care are provided under Medicaid;

ii. Any information the member needs in order to decide among all relevant treatment and service options;

iii. The risks, benefits, and consequences of treatment or non-treatment; and

iv. The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

This provision does not require the Contractor to provide coverage for a counseling or referral service if the Contractor objects to the service on moral or religious grounds in accordance with 42 CFR 438.102. The Contractor may not take punitive action against a provider who requests an expedited resolution or supports a member's appeal.

5.11 Member Rights

The Contractor shall guarantee and have written policies guaranteeing the following rights protected under 42 CFR 438.100 to its members:

1. The right to receive information in accordance with 42 CFR 438.100, which relates to information on the managed care program and plan in which the member is enrolled

2. The right to be treated with respect and with due consideration for the member's dignity and privacy;

3. The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;

4. The right to participate in decisions regarding the member's health care, including the right to refuse treatment;

5. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion;

6. The right to request and receive a copy of the member's medical records, and request that they be amended or corrected, as specified in the HIPAA Privacy Rule set forth in 45 CFR parts 160 and 164, subparts A and E, which address security and privacy of individually identifiable health information; and

7. The right to be furnished health care services in accordance with 42 CFR 438.206 through 438.210, which relate to service availability, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.

8. For those members who are receiving HCBS, the right to have and review their service plan (of care) as outlined in 42 CFR 441.301(b)(1)(I).

9. The right to review their care plan for all members as described in Section 4.9 For those members who are receiving home and community based long-term services and supports, the right to request a fair hearing outlined in 42 CFR 431 Subpart E when an individual is not given the choice of home and community-based waiver services as an alternative to institutional level of care, who are denied the service(s) of their choice or the provider(s) of their choice, or whose services are denied, suspended, reduced, or terminated. The right to request a fair hearing includes providing a notice of action per 42 CFR 431.210.

The Contractor shall also comply with other applicable state and federal laws regarding member rights, as set forth in 42 CFR 438.100 The Contractor shall have a plan in place to ensure that its staff and network providers take member rights into account when furnishing services to the Contractor's members. Members shall be free to exercise protected member rights, and the Contractor shall not discriminate against a member that chooses to exercise his or her rights.

5.14 Member Inquiries, Grievances & Appeals

The Contractor shall establish written policies and procedures governing the resolution of inquiries, grievances and appeals. At a minimum, the grievance system must include a grievance process, an appeals process, expedited review procedures and access to external grievance procedure, as well

as the State's fair hearing system. The Contractor shall maintain records of grievances and appeals in accordance with 42 CFR 438.416 which includes the following:

- A general description of the reason for the appeal or grievance;
- The date received;
- The date of each review or, if applicable, review meeting;
- Resolution at each level of the appeal or grievance, if applicable;
- Date of resolution at each level, if applicable;
- Name of the covered person for whom the appeal or grievance was filed;
- The record must be accurately maintained in a manner accessible to the state and available upon request to CMS.

The State will review this information as part of the State's quality strategy. The Contractor's grievances and appeals system, including the policies for recordkeeping and reporting of grievances and appeals, must comply with law, including 42 CFR 438, Subpart F as well as IC 27-13-10 and IC 27-13-10.1 (if the Contractor is licensed as an HMO) or IC 27-8-28 and IC 27-8-29 (if the Contractor is licensed as an accident and sickness insurer). The Contractor shall operate unified appeals and grievance processes with their companion DSNP plan, meeting the requirements in 42 CFR 422.629 through 42 CFR 422.634.

The term *inquiry* refers to a concern, issue or question that is expressed orally by a member that will be resolved by the close of the next business day.

The term *grievance,* as defined in 42 CFR 438.400(b), is an expression of dissatisfaction about any matter other than an "adverse benefit determination" as defined below. This may include dissatisfaction related to the quality of care of services rendered or available, aspects of interpersonal relationships, such as rudeness of a provider or employee or the failure to respect the member's rights.

The term *appeal* is defined as a request for a review of an action. An *adverse benefit determination,* as defined in 42 CFR 438.400(b) is any of the following:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service excluding the denial of a claim that does not meet the definition of a clean claim. A "clean claim" is one in which all information required for processing the claim is present;
- Failure to provide services in a timely manner, as defined by the State;
- Failure of a Contractor to act within the required timeframes;
- For a resident of a rural area with only one Contractor, the denial of a member's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network (if applicable); or
- Denial of a member's request to dispute a financial liability including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

The Contractor must notify the requesting provider, and give the member written notice, of any decision considered an "adverse benefit determination" taken by the Contractor, including any decision by the Contractor to deny a service authorization request (a request for the provision of a service by or on behalf of a member), or to authorize a service in an amount, duration or scope that is less than requested. The notice must meet the requirements of 42 CFR 438.404 and must include:

- The adverse benefit determination the Contractor has taken or intends to take;
- The reasons for the adverse benefit determination;
- The member's or the provider's right to file an appeal and the procedure for requesting such an appeal;
- The procedure to request an external grievance procedure (External Review by Independent Review Organization) following exhaustion of the Contractor appeals process;

- The procedure to request a State fair hearing following exhaustion of the Contractor appeals process;
- The circumstances under which expedited resolution is available and how to request it; and
- The member's right to have benefits continue pending resolution of the appeal, how to request continued benefits and the circumstances under which the member may be required to pay the costs of these services.

5.14.3 Grievance Processing Requirements

In accordance with 42 CFR 438.402, members must be allowed to file grievances orally or in writing. Members may file a grievance regarding any matter other than those described in the definition of an adverse benefit determination as described in Section 5.14. Grievances must be filed within sixty (60) calendar days of the occurrence of the matter that is the subject of the grievance.

The Contractor must acknowledge receipt of each grievance within three (3) business days. For grievances, the Contractor is not required to acknowledge receipt of the grievance in writing, however, if the member requests written acknowledgement, the acknowledgement must be made within five (5) business days of receipt of the request. The Contractor must make a decision on non-expedited grievances as expeditiously as possible, but not more than thirty (30) calendar days following receipt of the grievance. This timeframe may be extended up to fourteen (14) calendar days if resolution of the matter requires additional time. If the timeframe is extended, for any extension not requested by the member, the Contractor must give the member written notice of the reason for the delay. The Contractor shall provide the member with a written notice of any extension within two (2) calendar days of the extension, including the reason for the extension and the member's right to file a grievance if they disagree with the extension.

The Contractor shall provide an expedited grievance review if adhering to the resolution timeframe of thirty (30) calendar days would seriously jeopardize the life or health of a member, or the member's ability to regain maximum function, or by the member's request. Expedited grievances must be resolved within forty-eight (48) hours of receipt. If the Contractor denies a request for an expedited review, the Contractor shall transfer the grievance to the standard grievance timeframe. Further, the Contractor must make a reasonable effort, including a phone call to the member, to provide the member with prompt oral notification of the denial for an expedited review, and shall follow up with a written notice to the member and, where appropriate, the provider within two (2) calendar days.

The Contractor shall respond in writing to a member within five (5) business days after resolving a grievance or expedited grievance. The resolution includes notice of the member's right to file an appeal, the process for requesting an appeal, the expedited review options, the right to continue benefits during the appeal (as long as the request complies with timeliness standards), and an explanation that the member may have to pay for care received if an adverse appeal decision is made. For grievances related to a member's request to change MCEs, information on how to request a plan change must be included in the notice. The Contractor must make a reasonable effort, including a phone call to the member, to provide oral notification of expedited grievance resolution. For grievances related to violations of the setting rule (42 CFR 441.301(c)) the Contractor shall report to their OMPP contact the outcome of the Contractor's grievance review.

5.14.8 Member Notices of Action & Grievance, Appeal and Fair Hearing Procedures

The Contractor must provide specific information regarding member grievance, appeal, external grievance procedure (External Review by Independent Review Organization), and State fair hearing procedures and timeframes to members on a yearly basis by mail, as well as providers and subcontractors at the time they enter into a contract with the Contractor. This information

shall also be included in the Member Handbook as described in Section 5.7.2. The information provided must be approved by FSSA in accordance with Section 5.8 and, as required under 42 CFR 438.10(g)(2)(xi), include the following:

- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- Ombudsman and independent advocacy services available as sources of advice, assistance and advocacy;
- The toll-free numbers that the member can use to file a grievance or appeal by phone;
- The fact that, if requested by the member and under certain circumstances: 1) benefits will continue if the member files an appeal or requests a State fair hearing within the specified timeframes; and 2) the member may be required to pay the cost of services furnished during the appeal if the final decision is adverse to the member; and
- In the case of an FSSA fair hearing:
  - The right to a hearing;
  - The method for obtaining a hearing; and
  - The rules that govern representation at the hearing.

5.14.9 Ombudsman

The State shall operate or contract with a statewide Ombudsman program for the benefit of individuals in the [MLTSS program name]. The Ombudsman is available to help these individuals, their informal caregivers, and families resolve questions or problems and serve as a source of assistance, advice, and advocacy.

The Contractor shall identify and dedicate specific staff to serve as contacts for the State's Ombudsman program. The Contactor shall respond directly to Ombudsman inquiries. The Contractor shall not interfere with a member's use of the Ombudsman program, including the Ombudsman involvement with member grievances and appeals.

5.16 Health Equity and Cultural Competency

In accordance with 42 CFR 438.206, the Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Per 42 CFR 438.204, at the time of enrollment with the Contractor, the State shall provide the race, ethnicity and primary language of each member. This information shall be utilized by the Contractor to ensure the delivery of services in a culturally humble way. Furthermore, the Contractor will ensure all services are delivered through a health equity lens, meaning the Contractor is able to address barriers experienced and identified by specific populations.

Contractor shall create and submit a Health Equity and Cultural Competency plan for FSSA approval which incorporates the Office of Minority Health's National Standards on Culturally and Linguistically Appropriate Services (CLAS). The plan shall be reviewed by the member and informal caregiver advisory committee as described in Section 5.5 The CLAS standards are available at https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf.

The plan shall include at a minimum:

- The creation of a Health Equity and Cultural Competency Workgroup that includes the Contractor's Equity Officer, and members of the Contractor representing the diversity of the MCE's membership, including individuals with disabilities. This workgroup shall provide input to the Contractor relative to equity and cultural competency for the plan and shall be actively involved in initiatives to reduce disparities in services and outcomes for the Contractor's membership. Individuals participating shall be compensated for their time.

- Incorporation of the CLAS enhanced standards adopted by the Department of Health and Human Services and linked to herein.
- A foundational assessment of health equity within the Contractor's membership population, including detail on inequities in accessing care in the member's setting of choice.
- A description of how the health plan will ensure that services are provided in a culturally competent and trauma-informed manner to all members so that all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, understand their condition(s) or needs, the recommended treatment(s), and the effect of the treatment or service on their condition, including side effects. See additional details set forth in Section 6.1.2 Access to Culturally and Linguistically Competent Providers.
- A description of how the health plan will effectively provide services to people of all cultures, races, ethnic backgrounds and national origins, geographies, sexual orientations, gender identities, abilities, and religions in a manner that recognizes, affirms and respects the worth of the individual members and protects and preserves the dignity of each member.
- Identification of inequities and their root causes for the Contractor's membership including inequities that arise with certain diagnoses (such as dementia), the development of targeted interventions that are trauma informed and measures to reduce these inequities, and a description of how to evaluate progress in disparity reduction efforts will be collected and analyzed.
- The utilization of Community Health Workers as part of broader community health integration initiatives and promotion of culturally competent care.
- A training plan in equity and cultural competency for the Contractor's staff. Documentation of periodic training shall be provided in the annual assessment.

The plan shall be assessed by the Contractor annually and submitted to FSSA The assessment shall provide the outcome measures used to measure progress in the prior year, and any new interventions the Contractor will incorporate in the next year.

The MCE shall follow the guidance provided by the National Committee for Quality Assurance (NCQA) regarding the stratification of HEDIS measures by race and ethnicity.

The Contractor shall ensure that all subcontractor's services and sites are accessible and that all subcontractors are culturally competent.