

Attachment L: Case Scenarios

Scenario #1 Response

At Maximus, we understand great service comes from understanding the individual and taking a person-centered approach with every interaction. With this, we view guiding members through the grievance process as something of high importance. Below, we provide our step-by-step process for meeting the needs of the individual in Scenario 1. This scenario focuses on a member, who sends an email to Member Support Services over a weekend. The email states that the member is unhappy with the quality of care they received from their service coordinator under their Pathways for Aging managed care entity (MCE). The member states they are deaf, and they are concerned the service coordinator did not respect them or provide them with quality care.

	How the Enrollment Services Program Would Respond
a. How the Member Support Services Contractor will follow up with this member and in what timeframe	<p>A Member Support Specialist will respond to the member's email within one business day of receipt, by the end of the day on Monday, August 19, 2024. Upon receipt, the Member Support Specialist will search for the member in ConnectionPoint customer relationship management (CRM) system to determine if the member has an existing record. If a record does not exist, the Member Support Specialist will create a new member record.</p> <p>The Member Support Specialist will document the receipt of the email and our response in the member record. In our email response to the member, we convey a welcoming demeanor and take the opportunity to form a connection with the member. We provide a recap of the issue, include a description of the grievance/complaint process along with next steps, and ask the member how they would prefer to continue to communicate or if their current communication method is sufficient. We also inform the member that they have the options of calling into the helpline using the State-provided TTY relay system to communicate in real time, meeting with a Member Support Specialist in-person, or designating an Authorized Representative to relay information to us via the helpline. With each member interaction, our Member Support Specialists treat members with dignity and respect each member's right to privacy and confidentiality in compliance with HIPAA requirements.</p>
b. How the Contractor will engage interpretive or assistive communication as preferred by the member	<p>Our Member Support Specialist will review the member record in ConnectionPoint to identify the member's preferred communication method. If this is our first interaction with the member, we inform the member of the different ways they can communicate with a Member Support Specialist, and ask the member for their preferred communication method, and document it in ConnectionPoint. This information follows the individual throughout their interactions with us, permitting subsequent interactions with members to be conducted in the method preferred by the individual, such as email, Indiana's TTY system, in-person, or via an Authorized Representative over the phone. If the Authorized Representative requires an interpreter, we will use the LanguageLine to provide over-the-phone translation services. We also record the details for the specific grievance/complaint and what we communicate to the member. We use this information to produce internal and FSSA reports.</p>
c. How the Contractor or their representative will work with the member to develop a plan of action for resolution of the Issue that facilitates communication between the member and their MCE	<p>Our first step is to acknowledge the member's issue and repeat back their concern to confirm that we understand their issue. We also take time to explain:</p> <ul style="list-style-type: none"> ■ Who we are and our role in the grievance/complaints process ■ Their right to file a grievance/complaint with their health plan and how to proceed with filing it ■ What the health plan will do once they receive the grievance/complaint, and provide them with the appropriate health plan contact ■ That we will continue to follow up with the member and oversee that they have received a response from the health plan within the required time frames. If they do not receive a response within the expected timeframe, we will follow up with the health plan on their behalf

	How the Enrollment Services Program Would Respond
	The Member Support Specialist will also ask the member if they have any immediate care needs for the purpose of escalating the case if they do.
d. How the Contractor or their representative may educate or inform the member about the Grievance process	<p>In our email response, a Member Support Specialist will:</p> <ul style="list-style-type: none"> ■ Describe the grievance process with members ■ Explain the member's role and responsibilities in the process ■ Explain the role we play as they navigate the process ■ Encourage the member to submit any required documentation to the health plan ■ Provide them with their health plan's contact information if we are referring them to their plan <p>If the member has an alternate preferred communication channel and we talk to them via TTY or through their Authorized Representative, we will perform a warm transfer to their health plan. We will also give them the contact information for their health plan in case they need to reach back out to their plan, or they get disconnected.</p> <p>Member Support Specialists will access grievance-related educational materials and processes in our Panviva knowledge management system (KMS) to provide members with the most up-to-date and complete information. With each member interaction, our Member Support Specialists treat members with dignity and respect each member's right to privacy and confidentiality in compliance with HIPAA requirements.</p>
e. How the Contractor or their representative may assist the member in navigating and/or filing a Grievance	Our Member Support Specialists assist members in navigating and filing a complaint by describing each step of the grievance process and explaining what the member can expect and their role in the process. We will follow up with the member following specific health plan deadlines to make sure they receive a timely response and feedback from their health plan.
f. How the Contractor may ensure continued support for this member should they wish to file a Grievance (assume the member determines they will file a Grievance)	If a member chooses to file a grievance, we track their decision in ConnectionPoint and set an alert to follow up with the member after a specific time to determine if they heard back from the health plan and if their grievance was resolved. If the grievance has not been resolved and the member did not receive a response within the health plan's required response timeframe, we will reach out to the health plan on the members behalf. Member Support Specialists will document these activities in ConnectionPoint to support future reporting to track health plan response times and other related information.
g. Timeline for every action	<p>A Member Support Specialist will:</p> <ul style="list-style-type: none"> ■ Respond via email to the member's email within one business day, by the end of the day on Monday, August 19, 2024 ■ Close the case if the member chooses not to proceed with a grievance and remind them they can contact us should they need further assistance ■ Track follow-up timeframes in ConnectionPoint, based on when the member files a grievance initially with the plan and the plan's required response time
h. Any resource referral supports offered, to include date of referral and manner of referral	

Scenario #2 Response

This scenario focuses on a member enrolled in both an MLTSS plan and Medicare plan. The dually enrolled member calls the Contractor during normal business hours because they were denied a HCBS waiver service they believe they need to reside safely at home. The member speaks limited English and requests a Spanish-speaking interpreter.

In responding to this scenario, we assume that the unified appeals process in Federal regulations at 42 CFR §422.629-§422.634 applies and the member goes through one Medicare/Medicaid appeal process at the health plan level rather than filing separate appeals with the Medicaid plan and the D-SNP plan. Further, because the scenario states that the denied service is a home and community based waiver service, but does not specify if the service being denied is a Medicare benefit (for example, skilled nursing or therapies) or Medicaid only benefit (for example, personal care), or both, we discuss below the state fair hearing process and the federal independent contractor review process in the event that the health plan upholds its denial of service at the health plan appeal level.

	How the Enrollment Services Program Would Respond
a. How the Member Support Services Contractor will receive the call from the member	Our Member Support Specialist will answer calls to the Member Support Services hotline promptly. Our IVR will provide the member with the option of being routed to a Spanish-speaking Member Support Specialist. If one is not available, the member will be routed to another Member Support Specialist who will use the LanguageLine to interact with the member. Member Support Specialists convey a welcoming demeanor and take the opportunity to form a connection with the caller.
b. How the Member Support Services Contractor will provide Spanish translation services for the member	A member may choose to speak with a bilingual Spanish-speaking Member Support Specialist, or we support the member's needs using the LanguageLine.
c. How the Contractor or their representative will work with the member to develop a plan of action for resolution of the Issue that facilitates communication between the member and their MCE	<p>Our first step is to acknowledge the member's issue and repeat back their concern to confirm that we understand their issue. We also take time to explain:</p> <ul style="list-style-type: none"> ■ Who we are and our role in the appeal process ■ Their right to request an expedited appeal under the D-SNP unified appeal process with their health plan since the member expresses that the services are needed to remain safely at home and how to proceed with filing ■ Their right to request that services continue while they are appealing the decision ■ The steps that will be taken by the health plan once they receive the appeal and how long those steps may take ■ That we will continue to follow up with them to confirm they received a response or resolution from their health plan <p>The Member Support Specialist will also ask the member if they have any immediate care needs for the purpose of escalating the case if they do.</p>
d. How the Contractor or their representative may educate or inform the member about the Appeals process	<p>In all interactions, our staff are professional and take a conflict-free and person-centered approach. A Member Support Specialist will:</p> <ul style="list-style-type: none"> ■ Describe the appeals process with member ■ Explain the member's role and responsibilities in the process, including the timeframe in which they must appeal, and the help we can provide as they navigate the process ■ Explain the role we play as they navigate the process ■ Encourage the member to submit any required documentation to the health plan ■ Provide them with their health plan's contact information if we are referring them to their plan ■ Help the member understand their rights to filing an appeal and how they can continue to receive services during the appeal process

	How the Enrollment Services Program Would Respond
e. How a representative will assist the members in filing an Appeal (see note below)	<p>Our Member Support Specialists assist members in navigating and filing an appeal by:</p> <ul style="list-style-type: none">■ Describing each step of the appeal process■ Explaining what the member can expect and their role in the process■ Informing the member of their right to file an appeal and ability to continue receiving services while they appeal their decision <p>We also offer in-person assistance if preferred. We will follow up with the member after specific health plan deadlines to make sure they received a timely response and feedback from their health plan.</p>
f. Timeline for every action	<p>We will promptly answer incoming calls and track follow-up timeframes in ConnectionPoint. We set specific timelines based on when the appeal is initially filed with the plan and the plan's required response time. If the member does not receive a response from their health plan within the required timeframe, the Member Support Specialist will outreach to member to confirm health plan responded, and educate them about the next steps available to them and how to pursue a state fair hearing if the plan upholds its denial of services.</p>
g. Any resource referral supports offered, to include date of referral and manner of referral	