August 10, 2012

Jay R. Easterling
Deputy Director
ODJFS/OCA
30 East Broad Street, 31st Floor
Columbus, Ohio 43215-3414

RE: Request for Additional Information
RFA#: JFSR1213-07-8038
Ohio Integrated Care Delivery System (ICDS)

Dear Mr. Easterling:

Molina Healthcare of Ohio, Inc. (Molina) respectfully submits this letter to the Ohio Department of Jobs and Family Services (ODJFS) in response to its request for additional information regarding Molina's application to the above reference RFA.

Specifically, ODJFS requested additional information regarding Molina's claim of:

1. Behavioral health experience in Ohio – Appendix B, Part 1.

2. Long-term institutionalized care in Ohio Medicare, Texas Medicaid, Texas Medicare and Washington Medicare lines of business.

Behavioral health experience in Ohio – Appendix B, Part 1:

Appendix B, Part 1, Item 4, requests that the applicant check the box for any service that it provided under contract in the applicable calendar year. The Appendix defines "behavioral health" services as "providing **access to** mental health and substance abuse services including, but not limited to, acute/sub-acute psychiatric inpatient, medication management, day/residential rehabilitation, intensive outpatient, day treatment, partial hospitalization, crisis stabilization, opioid maintenance therapy."

Molina's response to Appendix B, Part 1, Item 4, correctly reflects Molina's behavioral health experience for Ohio Medicaid. Molina listed Ohio Medicaid behavioral health experience affirmatively in Appendix B because of the historical requirement that, if a plan member cannot or will not access the services of the community behavioral health system, Molina provides **access to** medically necessary behavioral health services through independent behavioral health providers. Corroboration of this requirement is evident in the capitation rates ODJFS provides to Molina for coverage of these services. For both Age, Blind and Disabled and Covered Families and Children populations, two separate category of service rates are included for Mental Health

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and Substance Abuse benefits; "IP Psychiatric/Substance Abuse" and "Other Mental Health/Substance Abuse". Using the same logic provided by ODJFS to define these categories of service rates, Molina's relevant claims experience in Ohio is summarized below for 2009 through 2011 dates of service.

CFC Outpatient Mental Health and Substance Abuse -Ohio paid claims summary-		
Dates of Service	# claims	$ paid
2009	10,529	$ 562,808
2010	10,142	$ 532,860
2011	13,137	$ 686,344

ABD Outpatient Mental Health and Substance Abuse -Ohio paid claims summary-		
Dates of Service	# claims	$ paid
2009	7,607	$ 391,716
2010	8,352	$ 429,603
2011	9,274	$ 464,251

CFC Inpatient Health and Substance Abuse -Ohio paid claims summary-		
Dates of Service	# claims	$ paid
2009	1,248	$ 4,355,169
2010	1,477	$ 5,291,673
2011	1,552	$ 5,986,975

ABD Inpatient Mental Health and Substance Abuse -Ohio paid claims summary-		
Dates of Service	# claims	$ paid
2009	1,298	$ 5,189,218
2010	1,800	$ 7,775,429
2011	2,015	$ 9,234,026

Molina also provides transportation services and coordinates appointments for outpatient and inpatient behavioral health treatment and also partial hospitalization if requested by member or provider. Accordingly, Molina checked the behavioral health box in Appendix B, Part 1, Item 4, for its Ohio Medicaid line of business, as it provides access to all the mental health and substance abuse services listed in the definition.

Long term institutionalized care in Ohio Medicare, Texas Medicare-Medicaid, and Washington Medicare-Medicaid lines of business:

Appendix D, Part A, Item 2, requires the applicant to enter whether it has at least 12 months experience as of March 31, 2012, providing comprehensive integrated care management for enrollees receiving long term institutional care (i.e., enrollees resided or remained long term in an institutional setting). This section of the RFA requests applicant's experience in **comprehensive integrated care management** for those enrollees receiving long term institutional care. It does not request information on applicant's experience in providing long term institutional care as a covered benefit. That type of experience was already requested in Appendix B.

"Care management" is defined in Section III.A. of the Actual RFA as "a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services (both Medicare and Medicaid) required to meet an enrollee's health care needs across the continuum of care. It is characterized by advocacy, communication, and resource management to promote quality, cost-effective, positive outcomes."

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The term "LTC Institutional" is defined in Appendix B as "long-term nursing facility services which are designed to meet an individual's medical, personal, social and safety needs." Presumably, the same definition applies in Appendix D.

Molina's response to Appendix D, Part A, Item 2, correctly reflects its experience of at least 12 months as of March 31, 2012, providing comprehensive integrated care management for enrollees receiving long term institutional care (i.e. enrollees resided or remained long term in an institutional setting). For Ohio, Molina answered affirmatively for its Medicare line of business; for Texas, its duals (Medicare-Medicaid) line of business; and for Washington, its duals (Medicare-Medicaid) line of business. Each line of business provides **comprehensive integrated care management** for enrollees receiving long term institutional care. Further, Molina's Texas and Washington plans also provide long term institutional care as a covered benefit. Below is a description of Molina's experience in each line of business.

1. **Ohio Medicare**

   Molina Care Management Program 2011 description, which was included in Molina's RFA response to address VII Health Risk Assessment, VII Individualized Care Plan, and X Integrated Care Management for the Most Vulnerable Subpopulations, provides a road map of care coordination services to its Medicare members to improve their functional capacity and regain optimum health. Care management methods include comprehensive assessment, care planning and interdisciplinary care conferences for coordination of acute and long term care services needs. The care management goal is to maximize the member's independence and ability to live in a setting of their choice. Using an integrated and individualized approach to each member by an assigned Care Manager the program is a result of the dynamic relationship of stratification of acuity and intensity of needs, treatment and outcome evaluation. Care management facilitates the process which involves the member, the family or caregivers, treating providers, therapists, counselors, social workers and other community partners involved in the members care. Where community based services coincide with medical conditions, Molina Healthcare's care coordination helps to achieve the balance between resource utilization, coordination and communication to achieve the member's desired outcomes. The Care Management staff maintains responsibility of coordination of acute medical, long term care and behavioral health services through the member's continuum of care, including for those members receiving long term institutional care.

2. **Texas Medicare-Medicaid**

   Molina's Texas Long Term Services Program (STAR+ PLUS) began in 2007. The STAR+PLUS Program is designed to keep the Medicaid-Medicare beneficiary in the least restrictive environment and maintained in the community rather than in a facility

which then qualifies them for Long Term Support Services (LTSS). The state sponsored program allows managed care organizations to provide home and community-based services to Medicaid-Medicare recipients who would otherwise require nursing home or other forms of institutionalized care. Through this waiver, Texas Health & Human Services Commission (HHSC) provides 1915(c) STAR+PLUS Waiver (SPW) program services to STAR+PLUS clients. The SPW program is operated by HHSC and combines the 1915(b) and 1915(c) waiver authorities.

Service coordination is an integral STAR+PLUS service. Health plans coordinate all STAR+PLUS acute and long-term services and supports for each STAR+PLUS client who needs them, including those who are receiving long term institutional care.

Molina Healthcare of Texas is required under its contract with HHSC to provide comprehensive integrated care management for enrollees receiving long term institutional care. Molina is required to provide discharge planning when long-term care is needed, a transition plan when an enrollee is receiving long-term care at the time of enrollment, nursing facility care for a total of four months (which is a long term care institutional benefit), assessment instruments, nursing facility waiver services if approved, and other care coordination activities, including transition of the enrollee back into the community. Applicable provisions of HHSC Uniform Managed Care Contract Terms & Conditions are attached to this letter as **Exhibit A**.

3. Washington Medicare-Medicaid

Washington State's Medicaid Integration Partnership (WMIP) was initiated in 2005. The program focuses on better coordination of primary care, mental health, substance abuse, and long-term care for categorically needy aged, blind and disabled beneficiaries. Under the intervention, these services (previously provided separately) were integrated under one contract with a single health plan (Molina Healthcare of Washington), on a phased basis, including health risk assessment, monitoring of patient symptoms, provider education, and coordination of services, which is particularly intense for those with extensive needs. All eligible beneficiaries were automatically enrolled though they had the option to opt out. The targeted population included aged, blind, and disabled clients many of who are Medicare beneficiaries. The program coordinates community outreach and provision of services to the member where they reside utilizing a variety of caregivers to meet individual needs such as social workers, community outreach workers, nurses. Community based partners are a major participant in the integrated partnership in coordinating acute and long term care services.

Molina Healthcare of Washington is required under its contract with the State of Washington to provide comprehensive integrated care management for enrollees receiving long term institutional care. Molina is required to provide (i) care

coordination services to ensure integration and access to long term care services in a well-coordinated system, (ii) long term care screenings and assessments, and (iii) personal care hours as authorized. Applicable provisions of the contract with State of Washington with respect to WMIP (including long term care institutional as a benefit – see sections 23.16.2.18-20 and 23.18.2) are attached to this letter as **Exhibit B**.

Please let me know if you need any additional information from Molina in your review of the protests and applications, or if you have any questions. Specifically, Molina is aware that Wellcare's protest requests validation of Molina's Medicare membership based on the CMS Enrollment File dated April, 2012. The CMS file is inaccurate, and we have documentation supporting Molina's membership in the counties reported on Appendix B, Part II, if needed.

Sincerely,

Amy Schultz Clubbs
Plan President

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Texas Long Term Care State Contract Requirements

Contract Language

8.3.2.3 Discharge Planning

The HMO must have a protocol for quickly assessing the needs of Members discharged from a Hospital or other care or treatment facility.

The HMO's Service Coordinator must work with the Member's PCP, the hospital discharge planner(s), the attending physician, the Member, and the Member's family to assess and plan for the Member's discharge. When long-term care is needed, the HMO must ensure that the Member's discharge plan includes arrangements for receiving community-based care whenever possible. The HMO must ensure that the Member, the Member's family, and the Member's PCP are all well informed of all service options available to meet the Member's needs in the community.

8.3.2.4 Transition Plan for New STAR+PLUS Members

The HMO must provide a transition plan for Members enrolled in the STAR+PLUS Program. HHSC, and/or the previous STAR+PLUS HMO contractor, will provide the HMO with detailed Care Plans, names of current providers, etc., for newly enrolled Members already receiving long-term care services at the time of enrollment. The HMO must ensure that current providers are paid for Medically Necessary Covered Services that are delivered in accordance with the

Member's existing treatment/long-term care services plan after the Member has become enrolled in the HMO and until the transition plan is developed.

The transition planning process must include, but is not limited to, the following:

1. review of existing DADS long-term care services plans;
2. preparation of a transition plan that ensures continuous care under the Member's existing Care Plan during the transfer into the HMO's Network while the HMO conducts an appropriate assessment and development of a new plan, if needed;
3. if durable medical equipment or supplies had been ordered prior to enrollment but have not been received by the time of enrollment, coordination and follow-through to ensure that the Member receives the necessary supportive equipment and supplies without undue delay; and
4. payment to the existing provider of service under the existing authorization for up to six (6) months, until the HMO has completed the assessment and service plans and issued new authorizations.

Except as provided below, the HMO must review any existing care plan and develop a transition plan within 30 days of receiving the Member's enrollment. For all existing care plans received prior to the Operational Start Date, the HMO will have additional time to complete this process, not-to-exceed 120 days after the Member's enrollment. The transition plan will remain in place until the HMO contacts the Member and coordinates modifications to the Member's current treatment/long-term care services plan.

The HMO must ensure that the existing services continue and that there are no breaks in services. For initial implementation of the STAR+PLUS program in a Service Area, the HMO must complete this process within 90-days of the Member's enrollment.

The HMO must ensure that the Member is involved in the assessment process and fully informed about options, is included in the development of the care plan, and is in agreement with the plan when completed.

8.3.2.6 Nursing Facilities

Nursing facility care, although a part of the care continuum, presents a challenge for managed care. Because of the process for becoming eligible for Medicaid assistance in a nursing facility, there is frequently a significant time gap between entry into the nursing home and determination of Medicaid eligibility. During this gap from entry to Medicaid eligibility, the resident has Contractual Document (CD) Responsible Office: HHSC Office of General Counsel (OGC) **Subject: Attachment B-1 – HHSC Joint Medicaid/CHIP HMO RFP, Section 8** Version 1.19 **8-106** "nested" in the facility and many of the community supports are no longer available. To require participation of all nursing facility residents would result in the HMO maintaining a Member in the nursing facility without many options for managing their health. For this reason, persons who qualify for Medicaid as a result of nursing facility residency are not enrolled in STAR+PLUS.

The STAR+PLUS HMO must participate in the Promoting Independence initiative for such individuals. Promoting Independence (PI) is a philosophy that aged and disabled individuals remain in the most integrated setting to receive long-term care services. PI is Texas' response to the U.S. Supreme Court ruling in *Olmstead v. L.C.* that requires states to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services, when:

- the state's treatment professionals determine that such placement is appropriate;
- the affected persons do not oppose such treatment; and
- the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are receiving state supported disability services.

In accordance with legislative direction, the HMO must designate a point of contact to receive referrals for nursing facility residents who may potentially be able to return to the community through the use of 1915(c) Nursing Facility Waiver services. To be eligible for this option, an individual must reside in a nursing facility until a written plan of care for safely moving the resident back into a community setting has been developed and approved.

A STAR+PLUS Member who enters a nursing facility will remain a STAR+PLUS Member for a total of four months. The nursing facility will bill the state directly for covered nursing facility services delivered while the Member is in the nursing facility. See **Section 8.3.2.7** for further information.

The HMO is responsible for the Member at the time of nursing facility entry and must utilize the Service Coordinator staff to complete an assessment of the Member within 30 days of entry in the nursing facility, and develop a plan of care to transition the Member back into the community if possible. If at this initial review, return to the community is possible, the Service Coordinator will work with the resident and family to return the Member to the community using 1915(c) Waiver Services.

If the initial review does not support a return to the community, the Service Coordinator will conduct a second assessment 90 days after the initial assessment to determine any changes in the individual's condition or circumstances that would allow a return to the community. The Service Coordinator will develop and implement the transition plan.

The HMO will provide these services as part of the Promoting Independence initiative. The HMO must maintain the documentation of the assessments completed and make them available for state review at any time.

It is possible that the STAR+PLUS HMO will be unaware of the Member's entry into a nursing facility. It is the responsibility of the nursing facility to review the Member's Medicaid card upon Contractual Document (CD) Responsible Office: HHSC Office of General Counsel (OGC) **Subject: Attachment B-1 – HHSC Joint Medicaid/CHIP HMO RFP, Section 8** Version 1.19 **8-107** entry into the facility and notify the HMO. The nursing facility is also required to notify HHSC of the entry of a new resident.

Section 8.3.2.7 Modified by Version 112

8.3.2.7 HMO Four-Month Liability for Nursing Facility Care

A STAR+PLUS Member who enters a nursing facility will remain a STAR+PLUS Member for a total of four months. The four months do not have to be consecutive. Upon completion of four months of nursing facility care, the individual will be disenrolled from the STAR+PLUS Program and the Medicaid Fee-for-Service program will provide Medicaid benefits. A STAR+PLUS Member may not change HMOs while in a nursing facility.

Tracking the four months of liability is done through a counter system. The four-month counter starts with the earlier of: (1) the date of the Medicaid admission to the nursing facility, or (2) on the 21st day of a Medicare stay, if applicable. A partial month counts as a full month. In other words, the month in which the Medicaid admission occurs or the month on which the 21st day of the Medicare stay occurs, is counted as one of the four months.

The HMO will not be liable for the cost of care provided in a nursing facility. For Medicaid-only Members, the cost of all other Covered Services will be included in the capitation payment analysis. The HMO will not maintain nursing facilities in its Provider Network, and will not reimburse the nursing facilities for Covered Services provided in such facilities. Nursing facilities will use the traditional Fee-for-Service (FFS) system of billing HHSC rather than billing the HMO.

8.3.3 STAR+PLUS Assessment Instruments

The HMO must have and use functional assessment instruments to identify Members with significant health problems, Members requiring immediate attention, and Members who need or are at risk of needing long-term care services. The HMO, a subcontractor, or a Provider may complete assessment instruments, but the HMO remains responsible for the data recorded.

HMOs must use the DADS Form 2060, as amended or modified, to assess a Member's need for Functionally Necessary Personal Attendant Services. The HMO may adapt the form to reflect the

Section 8.3.3 Modified by Versions 1.5, 1.6, 1.11, and 1.12 Contractual Document (CD) Responsible Office: HHSC Office of General Counsel (OGC) **Subject: Attachment B-1 – HHSC Joint Medicaid/CHIP HMO RFP, Section 8** Version 1.19 **8-108**

HMO's name or distribution instructions, but the elements must be the same and instructions for completion must be followed without amendment.

The DADS Form 2060 must be completed if a need for or a change in Personal Attendant Services is warranted at the initial contact, at the annual reassessment, and anytime a Member requests the services or requests a change in services. The DADS Form 2060 must also be completed at any time the HMO determines the Member requires the services or requires a change in the Personal Attendant Services that are authorized.

HMOs must use the Texas Medicaid Personal Care Assessment Form (PCAF Form) in lieu of the DADS Form 2060 for children under the age of 21 when assessing the Member's need for Functional Necessary Personal Attendant Services. HMOs may adapt the PCAF Form to reflect the HMO's name or distribution instructions, but the elements must be the same and instructions for completion must be followed without amendment. Reassessments using the PCAF Form must be completed every twelve months and as requested by the Member's parent or other legal guardian. The PCAF Form must also be completed at any time the HMO determines the Member may require a change in the number of authorized Personal Attendant Service hours.

For Members and applicants seeking or needing the 1915(c) Nursing Facility Waiver services, the HMOs must use the Community Medical Necessity and Level of Care Assessment Instrument, as amended or modified, to assess Members and to supply current medical information for Medical Necessity determinations. The HMO must also complete the Individual Service Plan (ISP), Form 3671 for each Member receiving 1915(c) Nursing Facility Waiver Services. The ISP is established for a one-year period. After the initial ISP is established, the ISP must be completed on an annual basis and the end date or expiration date does not change. Both of these forms (Community Medical Necessity and Level of Care Assessment Instrument and Form 3671) must be completed annually at reassessment. The HMO is responsible for tracking the end dates of the ISP to ensure all Member reassessment activities have been completed and posted on the LTC online portal prior to the expiration date of the ISP. Note that the HMO cannot submit its initial Community Medical Necessity and Level of Care Assessment Instrument cannot be submitted earlier than 120 days prior to the expiration date of the ISP. An Initial Community Medical Necessity and Level of Care determination will expire 120 days after it is approved by the HHSC Claims Administrator. The HMO cannot submit a renewal of the Community Medical Necessity and Level of Care Assessment Instrument earlier than 90 days prior to the expiration date of the ISP. Such renewal will expire 90 days after it is approved by the HHSC Claims Administrator.

8.3.4 1915(c) Nursing Facility Waiver Service Eligibility

Recipients of 1915(c) Nursing Facility Waiver services must meet nursing facility criteria for participation in the waiver and must have a plan of care at initial determination of eligibility in which the plan's annualized cost is equal to or less than 200% of the annualized cost of care if the individual were to enter a nursing facility. If the HMO determines that the recipient's cost of care will exceed the 200% limit, the HMO will submit to Health Plan Operations a request to consider the use of State General Revenue Funds to cover costs over the 200% allowance, as per HHSC's policy and procedures related to use of general revenue for 1915(c) Nursing Facility Waiver participants. If HHSC approves the use of general revenue funds, the HMO will be allowed to provide waiver services as per the Individual Service Plan, and non-waiver services (services in excess of the 200% allowance) utilizing State General Revenue Funds. Non-waiver services are not Medicaid Allowable Expenses, and may not be reported as such on the FSRs. The HMO will

submit reports documenting expenses for non-waiver services in accordance with the requirements of the **Uniform Managed Care Manual**. HHSC will reimburse the HMO for such expenses in accordance with the procedures set forth in the **Uniform Managed Care Manual**.

8.3.4.1 For Members

Members can request to be tested for eligibility into the 1915(c) STAR+PLUS Waiver (SPW). The HMO can also initiate SPW eligibility testing on a STAR+PLUS Member, if the HMO determines that the Member would benefit from the SPW services.

To be eligible for the SPW, the Member must meet risk criteria, Medical Necessity/Level of Care, the cost of the Individual Service Plan (ISP) cannot exceed 202% of cost of providing the same services in a nursing facility, and the HMO must be able to demonstrate that that Member has a minimum of one (1) unmet need for at least one (1) SPW service. The HMO must apply risk criteria as illustrated in Section 3242.3 of the STAR+PLUS Handbook, "Risk Assessment."

If the HMO determines that a Member does not meet the risk criteria for SPW eligibility, the HMO must notify HHSC's Administrative Services Contractor. The Administrative Services Contractor will notify the Member that he or she did not meet the eligibility criteria for the SPW, and the right to Appeal the Adverse Determination.

If the HMO determined that the Member meets risk criteria for SPW eligibility, the HMO must complete the Community Medical Necessity and Level of Care Assessment Instrument for Medical Necessity/Level of Care determination, and submit the form to HHSC's Administrative Services Contractor. The HMO is also responsible for completing the assessment documentation, and preparing a 1915(c) STAR+PLUS Waiver ISP for identifying SPW services. The ISP is submitted to the State to ensure that the total cost does not exceed the 202% cost limit. The HMO must complete these activities within 45 days of receiving the State's authorization form for eligibility testing.

HHSC will notify the Member and the HMO of the eligibility determination, which will be based on results of the assessments and the information provided by the HMO. If the STAR+PLUS Member is eligible for SPW services, HHSC will notify the Member of the effective date of eligibility. If the Member is not eligible for SPW services, HHSC will provide the Member information on right to Appeal the Adverse Determination. Regardless of the SPW eligibility determination, HHSC will send a copy of the Member notice to the HMO.

8.3.4.2 For Medical Assistance Only (MAO) Non-Member Applicants

Non-Member persons who are not eligible for Medicaid in the community may apply for participation in the 1915(c) STAR+PLUS Waiver (SPW) program under the financial and functional eligibility requirements for MAO. HHSC will inform the non-member applicant that services are provided through an HMO and allow the applicant to select the HMO. HHSC will provide the selected HMO an authorization form to initiate pre-enrollment assessment services required under the SPW for the applicant. The HMO's initial home visit with the applicant must occur within 14 days of the receipt of the referral. To be eligible for SPW, the applicant must meet financial eligibility, risk criteria, Medical Necessity/Level of Care, the cost of the Individual Service Plan (ISP) cannot exceed 202% of cost of providing the same services in a nursing

facility, and the HMO must be able to demonstrate that the applicant has a minimum of one (1) unmet need for at least one (1) SPW service. The HMO must apply risk criteria as illustrated in Section 3242.3 of the STAR+PLUS Handbook, "Risk Assessment."

If the HMO determines that the applicant does not meet the risk criteria for SPW eligibility, the HMO must notify HHSC's Administrative Services Contractor. The Administrative Services Contractor will notify the applicant that he or she did not meet the eligibility criteria for the SPW, and the right to Appeal the Adverse Determination.

If the HMO determined that the applicant meets risk criteria for SPW eligibility, the HMO must complete the Community Medical Necessity and Level of Care Assessment Instrument for Medical Necessity/Level of Care determination, and submit the form to HHSC's Administrative Services Contractor. The HMO is also responsible for completing the assessment documentation, and preparing a 1915(c) STAR+PLUS ISP for identifying the needed SPW services. The ISP is submitted to the State to ensure that the total cost does not exceed the 202% cost ceiling. The HMO must complete these activities within 45 days of receiving the State's authorization form for eligibility testing.

HHSC will notify the applicant and the HMO of the results of its eligibility determination. If the applicant is eligible, HHSC will notify the applicant and the HMO will be notified of the effective date of eligibility, which will be the first day of the month following the determination of eligibility. The HMO must initiate the Individual Service Plan (ISP) on the date of enrollment.

If the applicant is not eligible, the HHSC notice will provide information on the applicant's right to Appeal the Adverse Determination. HHSC will also send notice to the HMO if the applicant is not eligible for 1915(c) Nursing Facility Waiver services.

8.3.4.3 Annual Reassessment

Prior to the end date of the annual ISP, the HMO must initiate an annual reassessment to determine and validate continued eligibility for 1915(c) Nursing Facility Waiver services for each Member receiving such services. The HMO will be expected to complete the same activities for each annual reassessment as required for the initial eligibility determination.

Washington Long Term Contracted Requirements: Care Coordination and Health Integration

24.1 The Contractor shall provide care coordination services that ensure integration of and access to preventive, primary, acute, post acute, mental health, chemical dependency and long term care services into a well-coordinated system. In addition to coordinating the services covered by this contract, the Contractor shall coordinate contracted services with services enrollees receive from other care systems.

24.1.1 The Contractor shall provide a Care Coordination system designed to:

24.1.1.1 Ensure communication and coordination of an enrollee's care across network provider types and settings;

24.1.1.2 Ensure smooth transitions for enrollees who move among various care settings; and

24.1.1.3 Assist enrollees in maintaining program eligibility, within the limitations of available data.

24.1.2 The Contractor shall provide each enrollee with a primary contact person who will assist the enrollee in accessing services and information. The system shall promote and assure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, and culturally appropriate care.

24.1.3 The Contractor shall ensure that all enrollees have access to a Chemical Dependency Professional (CDP) if the enrollee requests, or, if during the initial assessment it is determined that the enrollee needs the services. Referral to a certified and/or contracted CD agency is sufficient to meet this requirement.

24.1.4 The Contractor shall conduct a screening for new enrollees to determine the enrollee's needs and to develop an Integrated Care Plan (ICP) that addresses those needs. The Contractor shall provide a copy of the ICP to the enrollee and all providers involved in the enrollee's care, and work with those providers to ensure the ICP is being met. The Contractor will regularly communicate with the enrollee and the enrollee's providers to update the ICP as needed.

Screening. The Contractor shall:

24.2.1 Attempt to screen new enrollees within forty-five (45) days of enrollment to assign risk level and determine the need for services. If the Contractor is unable to conduct the initial screening within 45 days, the Contractor shall continue to make efforts to conduct the screening for up to 60 days after enrollment. The Contractor shall document the results of the screening and, based on the results of the initial screening, the Contractor conduct a secondary screening within 30 days. If the Contractor is unsuccessful in contacting the enrollee, the Contractor shall document efforts made to contact the enrollee and conduct the screening.

24.2.2 Client records for enrollees who have screened as high risk for chemical dependency, and are referred for a chemical dependency assessment shall reflect that the referral was made and the reasons for making the referral for an assessment. Client records for enrollees who have screened as high risk for chemical dependency but are not referred for a chemical dependency assessment

shall reflect the reason that the referral for chemical dependency services was not made.

24.2.3 The ICP shall include all care the enrollee is receiving, along with provider contact information, accurate enrollee contact information at the time of contact and ICP initiation/updates, screening assessment scores and interpretation and recommendations for improved care coordination and additional services needed. Chemical Dependency will be included only if a signed Release of Information (ROI) from the enrollee is on file with the Contractor. The Contractor shall work with the enrollee's providers to ensure that they are aware of changes in the enrollee's health condition. The Contractor shall coordinate its assessment with required assessments conducted by DSHS staff.

24.2.4 The Contractor's assessment shall be based on medical necessity and take into account the client's goals and preferences. If the assessment determines that the enrollee needs services covered under this Contract, the Contractor shall ensure coordination of referrals to the appropriate provider. If the service is covered by DSHS on a fee for service basis, the Contractor shall coordinate with appropriate service provider to ensure the enrollee receives the needed service. If the Contractor is unable to conduct the assessment, the Contractor shall document efforts to do so in the enrollee's file.

24.2.5 Enrollees determined to have mental health needs will be provided access to an intake evaluation by a Mental Health Professional (MHP). The Contractor shall also ensure reassessment at a minimum of every 180 days for enrollees with mental health needs, annually for enrollees receiving Long Term Care services, or as determined necessary by a significant change in the enrollee's condition. The reassessment will include an evaluation of supports and services, based on the Enrollee's strengths, needs, choices, and preferences for care.

24.3 **Integrated Health Management**: The Contractor shall provide enrollees with Integrated Health
Management, whereby WMIP staff work with enrollees to address the underlying principles of disease management (treatment and prescription adherence, self-management, self-efficacy, prevention, etc.). Staff will also provide disease specific education, both verbally and through printed materials that are appropriate for the WMIP population. All diseases will be addressed, but the following diseases will be emphasized: Mental Illness, Diabetes, Asthma, Chronic Obstructive Pulmonary Disease (COPD) and Substance Abuse

Long-Term Care: For enrollees who have been determined eligible for Long-Term Care services by the Aging and Disability Services Administration/Area Agency on Aging (ADSA/AAA), the Contractor shall provide the following:
24.4.1 An initial screening and assessment within thirty (30) days of the enrollee's enrollment into the WMIP, OR determination of eligibility for long term care services. The assessment provided to long term care-eligible enrollees shall include all the components described in Section 24.2.3 and must be face-to-face assessment unless the Contractor can document that all efforts to provide the assessment on a face-to-face assessment within the 30 day timeframe failed. DSHS shall provide assistance to the Contractor in locating and/or contacting the enrollee if the Contractor is unable to locate the enrollee. Once the client is located the

assessment must be completed.

24.4.2 The initial screening shall include:

24.4.2.1 A screening for dementia using the Contractor's Departmentapproved dementia screening tool. The Contractor shall document in the enrollee's care plan the steps taken once an enrollee is found to have a positive dementia screening result.

24.4.2.2 A Functional Status Assessment at initial enrollment and thereafter at least annually or when there is a significant change in the enrollee's condition.

24.4.3 The Contractor shall offer at least the number of personal care hours authorized in the CARE assessment or a significant change review completed by the Home and Community Services/Area Agency on Aging (HCS/AAA) or the Division of Developmental Disabilities (DDD), including any approved Exceptions to Policy, unless the enrollee chooses an alternative proposed by the Contractor. The enrollee's choice must be documented in writing in the enrollee's file and must include the enrollee's signature or that of the enrollee's authorized representative.

24.4.4 The Contractor shall:

24.4.4.1 Assist enrollees in providing the necessary information to allow Home and Community Services financial staff to determine if the enrollee is eligible for a Medical Institutional Income Exemption (MIIE). The MIIE provides money for rent or bills to keep an enrollee's residence if the enrollee is admitted to a nursing or other residential facility for a short period of time;

24.4.4.2 Ensure Pre-Admission Screening and Resident Reviews (PASRR) are completed prior to all nursing facility admissions for WMIP enrollees. The PASRR determines whether the nursing facility can appropriately manage the enrollee being admitted.

24.4.4.3 Notify DSHS, HCS/AAA/DDD staff when the Contractor's staff becomes aware of enrollee address changes, income or asset changes, and moves from one living environment to another. DSHS shall make every effort to notify the Contractor when these changes are discovered or reported to DSHS or AAA staff.

24.4.4.4 Both DSHS and the Contractor shall make every effort to notify the other party when either party discovers that an enrollee who is receiving LTC services through the WMIP ends enrollment from the program for any reason. DSHS and the Contractor shall coordinate to ensure continuity of care in the enrollee's LTC services.

11 WMIP integrated managed care – Client Service Contract

23.17. **Long-Term Care Services**: The Contractor shall provide the following long-term care services including:

23.17.1. **Adult Day Care**: A supervised daytime program for adults with medical or disabling conditions that do not require the level of care provided by a registered nurse or licensed rehabilitative therapist. Services include personal care, social services and activities, education, routine health monitoring, general therapeutic activities, a nutritious meal and snacks, supervision and/or protection for adults who require it, coordination of transportation, and first aid and emergency care.

23.17.2. **Adult Day Health**: A supervised daytime program that provides skilled nursing and **Special Terms and Conditions**
rehabilitative therapy services in addition to adult day care. An adult day health center provides skilled nursing services, rehabilitative therapy such as physical therapy, occupational therapy or speech-language therapy and brief psychological and/or counseling services and all of the services listed for adult day care above. Adult day health services shall only be authorized for in-home clients.

23.17.3. **Caregiver/Recipient Training Services**: Training services are mandated for each COPES paid caregiver and provide instruction in either a one-to-one situation or in a group setting. Each caregiver shall receive a two (2) hour orientation and additional twenty-eight (28) hours basic training, and ten (10) hours continuing education. Contractor is responsible for payment of Training Services for those Caregivers who are providing care solely to Contractor's enrollees. Contractor is responsible for continuing education of Caregivers providing at least 50% of employed caregiver services to Contractors' enrollees.
The caregiver training curriculum includes: use of special or adaptive equipment or medically related procedures required to maintain the recipient in the home or community-based setting; and, activities of daily living. In addition, caregiver training teaches critical care giving skills including: client rights and abuse reporting; observation and reporting changes in client condition; infection control, accident prevention, food handling and other tips on providing a safe environment; emergency procedures and problem solving.
Recipient training needs are identified in the comprehensive assessment or in a professional evaluation. This service is provided in accordance with a therapeutic goal in the plan of care and includes e.g., adjustment to serious impairment; maintenance or restoration of physical functioning and management of personal care needs, i.e., the development of skills to deal with care providers.

23.17.4. **Environmental Modifications/Assistive Technology**: Physical adaptations, for example: ramp installation, grab-bars, widening doorways, modifying bathrooms, or installing special systems to accommodate medical equipment. Assistive Technology includes any item, piece of equipment, or product system whether acquired commercially off the shelf, modified, or customized that is used to increase, maintain, or improve the functional capabilities of a client.

23.17.5. **Home Health Care**: In-home health care (monitoring, treatment, therapies, medications, exercises) as authorized by a physician and provided by nurses, therapists, or trained aides.

23.17.6. **Minor Household Repairs**: Home or apartment repairs/modifications made to maintain the enrollee's health and safety.

23.17.7. **Nurse Delegation:** Training and supervision of a nursing assistant to do routine health care tasks by a registered nurse delegator. The trained nursing assistant shall provide care in the enrollee's home setting. The nursing assistant shall only perform those tasks described in RCW 18.88A.210 and shall successfully complete Nurse Delegate training prior to providing delegated services.

23.17.8. **Personal Care Services**: Services provided for enrollees who are functionally unable to perform all or part of such tasks, or for enrollees who cannot perform the tasks without specific instructions. Personal care services do not include assistance

Special Terms and Conditions

with tasks that are performed by a licensed health professional. Personal Care Services may include physical assistance, and/or prompting and supervising the enrollee in performance of direct personal care tasks and household tasks. Individual or agency providers perform these duties. Personal Care tasks include, but are not limited to:

23.17.8.1. Assistance with walking/locomotion;
23.17.8.2. Bathing;
23.17.8.3. Bed Mobility, i.e. repositioning enrollee in chair or bed;
23.17.8.4. Body Care;
23.17.8.5. Dressing;
23.17.8.6. Eating;
23.17.8.7. Essential shopping;
23.17.8.8. Housework;
23.17.8.9. Laundry;
23.17.8.10. Meal preparation;
23.17.8.11. Personal Hygiene;
23.17.8.12. Self-medication administration;
23.17.8.13. Supervision;
23.17.8.14. Toileting;
23.17.8.15. Transfer; i.e. assisting enrollee to move from bed to chair, etc;
23.17.8.16. Travel to medical services; and
23.17.8.17. Wood supply.

23.17.9. **Personal Emergency Response System (PERS)**: An electronic device is provided that allows clients to get help in an emergency. The system is connected to a phone or the enrollee may also wear a portable "help" button. When activated, staff at a response center will call 911 and/or take whatever action has been set-up ahead of time.

23.17.10. **Self-Directed Care**: An adult with a functional disability, living in his/her own home can direct and supervise a paid personal care aide to help them with health care tasks that he/she can't do because of his or her disability. Examples of self-directed care tasks include medications, bowel programs, bladder catheterization, and wound care. Self directed care supports an individual's autonomy and choice and often allows him/her to stay in his/her own home longer.

23.17.11. **Home Delivered Meals**: Nutritious meals and other dietary services are provided in

a group setting or delivered to home-bound persons.

23.17.12. **Residential Programs**: The Contractor shall provide the following Long Term Care residential programs to enrollees who have been determined eligible.

23.17.13. **Adult Family Homes**: Adult family homes are residential, neighborhood homes licensed by Washington State to care for two to six people. Adult family homes provide lodging, meals, laundry, and organized social activities or outings. If it is needed, they also provide necessary supervision, assist with personal care (getting dressed, bathing, etc.) and help with medications. Some provide nursing care or may specialize in serving people with mental health problems, developmental disabilities, or dementia.

23.17.14. **Boarding Homes**: Boarding homes are larger facilities licensed by Washington State to care for seven or more people. Boarding homes provide lodging, meal services, assistance with personal care, and general supervision of residents. Some provide limited nursing care or may specialize in serving people with mental health problems, developmental disabilities, or dementia.
Boarding homes that provide care for state-funded clients are contracted under the following categories:

23.17.14.1. **Adult Residential Care (ARC)**: services include lodging, meal services, general supervision of residents, and assistance with personal care.

23.17.14.2. **Enhanced Adult Residential Care (EARC)**: Includes everything provided through an ARC contract (See above) plus limited nursing services.

23.17.14.3. **Assisted Living (AL)**: Includes everything provided through an EARC contract (see above) plus offering residents private apartmentlike units with a private bath and kitchen area.

23.17.15. **Nursing facilities (Homes)**: Provide 24-hour a day supervised nursing care, personal care, therapy, nutrition management, organized activities, social services, room, board, and laundry. Nursing facilities also offer short-term rehabilitation services. The Contractor shall notify DSHS if the rehabilitation stay exceeds 30 days.

23.17.16. **Individual Providers**: The Contractor shall ensure that all Individual Providers (IPs) meet the minimum qualifications for care providers in home settings as described in WAC 388-71 before they provide the following services to enrollees:

23.17.16.1. Assist, as specified by the client, with those personal care services, authorized household tasks, and/or nurse delegated or self-directed health care tasks, which are included in the enrollee's service plan.

23.17.16.2. Perform all services in a manner consistent with protecting and promoting the client's health, safety and well-being.

23.17.16.3. No Individual Provider will perform any task requiring a registration,

certificate or license unless he or she is registered, certified or licensed to do so, is a member of the enrollee's immediate family, or is performing self-directed health care tasks. RCW 18.79, 19.88 and 74.39 provide more information about regulations related to nursing care, Registered Nurse Delegation and self-directed health care tasks.

23.17.17. **Community Transition Services**: Services designed to assist enrollees who are returning to the community on waiver services from institutional settings such as hospital or nursing homes. These services may include one-time expenses required to set up a home or apartment in the community, such as safety deposits, utility set up fees or deposits, health and safety assurances such as pest eradication, allergen control or one time cleaning prior to occupancy, moving fees, furniture, essential furnishings, and basic items essential for living in a community setting. Community transition services do not include rent or recreational items such as TV, cable or VCRs.

23.17.18. **Skilled Nursing**: Services described in the plan of care that are within the scope of the State's Nurse Practice Act and that are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse licensed to practice in the State of Washington. Services may be provided in the enrollee's home or in an Adult Family Home setting.

23.17.19. **Clients receiving services through the Division of Developmental Disabilities (DDD)**:

23.17.19.1. The Contractor shall be responsible for providing all services under this contract to DDD clients who receive Medicaid Personal Care (MPC) services from DDD and the Division of Behavioral Health and Recovery. Other services provided by DDD, such as supported employment, will be covered by DSHS on a fee for service basis.

23.17.19.2. DDD clients who receive services through DDD's Basic Waiver, Basic Plus Waiver, or Core Waiver shall be eligible to receive medical, mental health and chemical dependency services through the WMIP but will receive all long term care and other DDD services on a fee for service basis via the appropriate waiver.

23.17.20. **Enrollee Participation in Cost of Care**: The Contractor shall collect, or deduct from the enrollee's long-term Care provider's rate the amount determined by HCS staff to be the enrollee's contribution to his or her cost of care. HCS staff shall determine what, if any, amount the enrollee must pay towards his or her cost of care. This determination is completed during the initial eligibility process and at least annually thereafter. The enrollee participation amount shall be used as the first payment source for long-term care services. DSHS shall notify the Contractor of the participation amount via a copy of the ACES award letter or other mutually agreeable method of communication. If the amount for which the enrollee is responsible has not been exhausted prior to the enrollee's death the Contractor can only collect or deduct the amount up to the amount of long-term care services that had been provided at the time of the enrollee's death.