Version 2 Section	Submitted By	Comment	Version 3 Section	Disposition
1.28	MCO's	The contract indicates that only QMB+ and SLMB+ are eligible -- what about the other categories of duals?	1.28	Not all dual eligibles receive full Medicaid coverage, even though they may be referred to as duals. For purposes of Strategy two, HCA and ADSA will only enroll those duals who receive full Medicaid coverage, which includes our state cost-sharing obligations, mandatory Medicaid benefits and optional Medicaid benefits as listed in the State Plan Amendment.
1.47	MCO's	Allows Mental Health Therapists as providers -- CMS is very specific in not allowing payment to therapists except under specific circumstances. Will this provider be allowed payment for Medicare benefits as well?	1.47	updated
2.16.2	MCO's	Record retention is 6 years, but CMS has a 10 year retention requirement	2.16.2	Updated
3.1.1.1	MCO's	Would there be annual monitoring done in conjuction with TEAMonitor or at a separate time?	3.1.1	Annual monitoring will be conducted in conjunction with TEAMonitor if resources are available and it reduces administrative burden on the health plans, HCA and ADSA. If the necessary resources are not availible through the TEAMonitor process or does not meet a CMS need, then monitoring will be conducted at a different time with a goal to reduce administrative burden on HCA and ADSA and MCO resources.

3.1.1.5	MCO's	Issue with the wording -- the sanctions section does not refer to termination as an option and no advance notice requirement is included here. Proposed edit: “In accordance with section 2.34.3” Also, "provided in" what?	3.1.9	HCA does not consider "termination" of a contract, in whole or in part, as a "sanction," thus sanctions and termination will remain discreet from one another.
3.2	MCO's	Should add reasonable notice/turn-around time related to requests	3.2	updated time frame for turnaround
3.2.1.1	MCO's	Need additional information on the referenced "reports"	3.2.1	Reports to inform and support contract compliance and ongoing performance reporting and quality improvement.
4.2	MCO's	Section 4.2 and 4.5-4.6 don't appear to align...4.2 follows existing CMS timeframes and appears to include HCA's review within those timeframes (concurrently), but 4.5 and 4.6 describe a consecutive review process. Need to shorten the timeframes, or material could potentially be under agency review for 65 days which could delay getting timely information to enrollees.	4.1.3	The review of materials is consecutive with HCA as the first entry point for all material review. The contract language supports a 20 day time period for HCA to review and approve the material and then send to CMS for their review. There is potential for 65 days to pass before the material can be used. If there are revisions necessitated by HCA or CMS, the review could be longer than 65 days. For this to be a shorter time period, HCA would need to shorten their timeframe from 20 days to less than 20 days. This will be taken under advisement with HCA/ADSA staff to determine the ability to shorten our timeframe.
4.2.3	MCO's	"File and use" is a Medicare term, should be defined in Section 1	4.1.3.3	The definition has been added to Section 1.
4.8.2.3	MCO's	Will plans be required to have a dedicated web page for this Duals demo? Or use our current State or Medicare sites which may currently be separated?	4.1.11.3	The MCOs should have a dedicated website for the duals demonstration. Providing health plan information on the web is a standard practice and this demonstration is sufficiently different from Healthy Options and Medicare Advantage.
4.9.1	MCO's	Please provide additional guidance around the intention of this section.	4.2.1	The intent of this section is to inform state specific staff of potential increases in their work activities for planning purposes.
4.9.3.4	MCO's	The $10 nominal value limit for a promotional item needs to align with the CMS nominal value requirement of $15 or less. Suggest standardizing to the $15.	4.2.3.4	Agree and have changed language.
4.10.2	MCO's	Will model documents be provided as in the Medicare Advantage program?	4.3.2	Neither HCA nor ADSA have developed any model documents for the duals contract. We currently use a check list and check list process to determine if materials meet Medicaid rules. We would be willing to discuss materials that may complement the CMS system for "file and use," to reduce administrative burden.

4.10.5	MCO's	Will all of the content in this section be covered in the some sort of Member Handbook, much like the draft version distributed by ACAP?	4.3.5	I do not know what ACAP stands for but will try to answer this question in general. HCA/ADSA can investigate the potential of a joint member handbook which contains all the necessary information on the program, much like the current Healthy Options handbook. If a joint handbook is feasible it would be supported by funds from both HCA/ADSA and the health plans. The availability of information on the program in one place should reduce administrative burden and enrollee confusion.
5.2	MCO's	wA prospective withhold against sanctions for non-performance seems arbitrary. It would be helpful to see a matrix that identifies how the sanctions would be determined. Such information would help compliance to develop monitoring systems that target the most important performance indicators. wThere is a reference to a “notice of deficiency as described in Section 2.25.11,” but no such section exists. w§ 5.2.8 refers to a “minor deficiency.” What is a minor deficiency, and what distinguishes it from a defect that warrants a written notice of deficiency? *Generally, significant concerns about this section*	5.2	Will be addressed by discussions with CMS
5.2.2	MCO's	References section 3.6, which doesn't appear to exist	5.2.2	This language has been removed.
5.2.3	MCO's	References section 2.25.11 , which doesn't appear to exist	5.2.3	This language has been removed.
5.2.10	MCO's	References a permanent withhold if withhold goes on for six consecutive months. This seems overly punative without giving weight to the compliance violation. Also the "same or similar" condition could be very openly interpreted.	5.2.10	This language has been removed.
5.3	MCO's	What are the "ten at-risk performance indicators"? Are plans required to track & capture the data for the indicators? How does the 5% risk relate to the 10% withhold?	5.3	This language has been removed.
5.3.1	MCO's	Define "FSR" or spell it out	5.3	This language has been removed.
5.3.1	MCO's	Where are the "ten at-risk performance indicators" referenced in this section?	5.3	This language has been removed.
5.4	MCO's	First line MLR is 85%, further below are two references in this section to 83%. The 83% MLR is preferred.	5.4	The correct amount is 83%. This has been corrected.
5.5	MCO's	Need clarification.	5.5	Will address at a later date
5.6.1	MCO's	Recognizing that this language exists in the curent HO-BH contract, we would like to have some say in what constitues a material change.	5.6.1	Thank you for your comment.
5.9	MCO's	Is the Hosptial Safety Net language valid to this contract?	5.9	This has been removed from the contract.
5.9.2	MCO's	Will rates solely be tied to HCA published rates?	5.9.2	Rates will be negotiated with CMS.
5.11.1	MCO's	Need more information on this section.	5.13.1	Checking with Kara and Glenn
5.12	MCO's	How are Sanctions different from non-compliant? What are the deficiencies that will trigger the withhold? More detail is needed.	5.14	Deleted
6.15	MCO's	Detail is needed about how eligible clients will be assigned to qualified health plans? What algorithm will be used?	6.15	This needs to be determined
6.12	MCO's	Is any reporting for these items required?	6.12	Will be addressed during the readiness review.
6.5.5	MCO's	What does this section mean -- direct the individual to services or provide the services?	6.5.5	Contract language should reflect that the plan is responsible to link the member to the existing MH crisis system however the plan cannot ensure that this system responds within 2 hours.
6.7.1.1	MCO's	It’s not always within the plan's control whether hospital discharge personnel can/will work with our care coordinator	6.7.1.1	MCO should have an agreement with the hospitals
6.7.11	MCO's	Strike sentence "enrollees shall ensure that timelines for accessing urgent and emergent services are met"	6.7.11	Agreed with comment and stuck language in contract.

7.2	MCO's	Could the clinical PIP overlap with the PIP being done for the HO-BH contract?	7.2	Discussion needed with counties
7.6	MCO's	Does the "100% staff" mean all staff or just clinical staff?	7.6	100% of the health plan's staff should be trained in cultural competency. Those staff that have more a direct relationship with the beneficiary, such as clinical care managers and customer service staff should receive higher intensity training.
7.8.4	MCO's	Need more information on what "Mental Health" means here	7.8.4	Do we delineate the MH screenings we are going to expect?
7.13	MCO's	More info please.	7.13	Updated
7.14	MCO's	More info please.	7.14	Reviewed
7.14.4.1	MCO's	Please clarify. Is this a requirement to be included in provider subcontracts?	7.14.4.1	The state will require the entity who saw the incident report to the state and the plan.
7.14.5	MCO's	What defines an incident?	7.14.5	Needs to be reviewed again
7.16.1.10	MCO's	Need confirmation that ASAM guidelines must be used for coverage decisions	7.17.1.12	Yes- we agree.
7.17	MCO's	Please provide more infomration on how this process works	7.18	This will be detailed in a P&P
8.2	MCO's	Date will need to be updated.	8.2	We have updated the date.
11.4	MCO's	Does "behavioral health" include both mental health and chemical dependency?	11.4	Yes, that's what Behavioral Health means.
13.2.7	MCO's	Allows 45 days for resolution of grievance which is longer than CMS at 30 days	13.2.7	HCA is working with HHS on this issue. The grievance process is an intregration of the Medicaid and Medicare processes.
13.2.8	MCO's	Would require resolution letters to be modified to include this language (a covered person has a right to a second opinion) and refiled with CMS	13.2.8	Not clear on what "refiled with CMS means"-- most likely the MCOs will need to create templates to meet the contract requirements.
13.2.9	MCO's	Five days to mail resolution letter is different from CMS requirement	13.2.9	HCA is working with HHS on this issue. The grievance process is an intragration of the Medicaid and Medicare processes.
13.3.3	MCO's	Enrollee has 90 days to file the appeal -- CMS allows 60	13.3.3	This is to be consistent with RCW 74.09.741. It does provide an additional 30 days.
13.3.4	MCO's	This provision for appeals for “continuation of services” is not differentiated in the CMS regs. The enrollee has ten days to file this.	13.3.4	This topic is addressed in 42 CFR 431 Part E.
13.3.7	MCO's	Oral inquiries to an appeal have to be confirmed in writing -- does this mean we have to accept oral appeals?	13.3.7	Yes, the language requires acceptance of our appeal.
13.3.12.3	MCO's	Requires a written statement of the clinical rationale for the decision, including how the requesting provider or enroll may obtain the Utilization Management clinical review or decision making criteria -- this is not required by CMS	13.3.12.3	This is an intrgration of the Medicaid and Medicare processes.
13.5.2.1	MCO's	Administrative hearings must be held within 90 days -- these hearings are external for Medicare Advantage (MA)	13.5.2.1	We have reorganized the sections. We will be working closely with CMS to flush out the Medicare external hearings and appeals processes.
13.5.2.2	MCO's	Continuation of services during hearing period -- not required for MA	13.5.2.2	Continuation of services for Medicare services will be limited to the plan level appeal. We are working with CMS.
13.5.3	MCO's	Contractor must provide all documents related to the hearing to the HCA -- not required for MA	13.5.3	Correct, HCA will not be contracting with another state agency to conduct the Medicare federal administrative hearings. This is only for Medicaid state fair hearings.
13.5.5	MCO's	The medical director shall review all cases where a hearing is requested and any related appeals when medical necessity is an issue -- not currently required for MA	13.5.5	Thank you for letting us know that it is not currently required for Medicare.

13.7.3	MCO's	Is the reference to "73" hours an error?	13.7.3	Yes, we believe it is an error. We are working with CMS to review the appeals processes.
14.15	MCO's	14.15.2.5 is used twice	14.4	Will be corrected
14.16	MCO's	Numbering is off beginning at 14.12.2.3.1 -- should be 14.16.2.3.1	14.5, 15.1	Will be corrected
14.16.12	MCO's	Does the Health Home payment structure have to be used here or would we have the ability to negotiate a separate structure?	15.2.7	Health plans will have the ability to negotiate their health home rate structure.
14.16.17	MCO's	Need confirmation that the intent is for every individual to be *assigned* to a Care Manager, even though they may opt out of case management	14.9.4	The intent is provide comprehensive care management to all beneficiaries. If they decline to participate in a health home, they are still eligible to receive high intensity care management services. An assessment of need is part of the Contractor's requirements which should be the guide to the type and intensity of care management. A care manager should be assigned to work with the beneficiary when the need arises.
14.17.1.6	MCO's	This section needs clarification -- is the intent that information from other screenings/assessments should roll up to the Care Plan?	15.3.6	Positive screening results should be reflected in the care plan.
14.18.3	MCO's	Will there be flexibility on the 50:1 ratio if other care team members are being utilized?	15.4.3	The language has been revised to more accurately reflect HCA/ADSA intent.
14.22.3	MCO's	Who's responsible for setting up the Health Home governing and advisory boards? QHPs or others?	15.2.11	The health plan is responsible for setting up demonstration governing and advisory boards.
14.23	MCO's	Ths	16.1.14	This contract language is for changes in a beneficiary's functional or medical status that may necessitate a review of the beneficiary's need for mental health treatment through the RSN system and/or home and community based services for long-term care services and supports. This section does not apply to their Medicare or Medicaid eligibility.
14.35	MCO's	Is the intent for the Centralized Enrollee Record to be a centralized EMR where all involved parties have access OR a place where the information is sent to plans and maintained by the plans?	14.9.9	The centralized enrollee record language is replaced with Electronic Health Record where information is collected, housed and maintained by plans.
14.37	MCO's	Will the State be providing a "Centralized Enrollee Record" or if health plans already have a system can that system be used?	17.2	The state will not be providing an Electronic Health Record. MCOs may use existing systems as long as those systems meet the contractual requirements.
14.38.2	MCO's	Reference to the M.G.L., which is “Massachusetts General laws"	17.3.1	This language has been removed.
14.38.6	MCO's	What is "DMA"? Looks like an acronym for another state agency. Should this say "…at the request of HCA or CMS…"?	17.3.5	This language has been revised to reference HCA, ADSA and CMS.
14.40	MCO's	Numbering is off -- 14.50.2.9.1 and 14.50.2.9.2 should be 14.40.2.11.1 and 14.40.2.11.2	14.11	Will be corrected
1.4	WCMHA	There is no mention of Mental Health Advance Directives. This needs to be included here or as a separate definition with reference to RCW 71.32	1.4	Kara will find MH Advance Directives language to add to the definitions section.
1.9	WCMHA	Definitions make a distinction between care coordinator and care manager, but do not provide a corresponding definition for care coordination. This is confusing.	1.9	Updated
1.12	WCMHA	Again, confusing. Care management is to be provided by care coordinators? Yet in 1.10 care managers are linked to provision of care management services	1.12	Updated
1.36	WCMHA	What does this mean, ‘highest 40%’?	1.36	This language has been revised.

1.47	WCMHA	This is a master's level mental health credential in our state	1.47	Comment in V.3- the examples of health care professionals listed is not inclusive of many MH treatment providers in community MH agencies.
1.92	WCMHA	ADD: Several other terms that are used in various places throughout the contract document are not defined here. These include Care Coordinating Organization (CCO – pp. 127, 129) Care Coordination (see comment on p.1) Mental Health Care Provider (MHCP – p. 41) Mental Health Professional (MHP – pp. 41, 58, 64, 139) Regional Support Network (RSN – pp. 140, 146)	ADD NEW: 1.XX	Updated
4.10.5.17	WCMHA	Change: 4.10.5.17 A statement about an enrollee's right to make decisions concerning an enrollee's medical care, accept or refuse surgical or medical or psychiatric treatment, execute an health care or mental health advance directive, and revoke an health care or mental health advance directive at any time.	4.3.5.16.1	Change made.
5.11.1	WCMHA	Need to ensure that room and board is covered for care in residential treatment beds as this is not covered by Medicaid – treatment in residential beds is covered under the modality "mental health provided in residential settings" but room and board is not (p. 17 of design proposal, 4/25/12 HealthPath WA proposal). What does this mean? "residential beds" . The Pay the MCO for supervision of residential beds?	5.11.1	We need to ensure that the dollar amount is sufficient and to identify which "residential beds" we mean.
6.1.1	WCMHA	Where is list of covered benefits? Need to ensure that full range of covered mental health and chemical dependency services are listed (p. 17 of design proposal, 4/25/12 HealthPath WA proposal), and that CO network has capacity to provide this range of services. MCOs have little history or experience with the community based providers that are qualified to deliver these services; traditional outpatient mental health provider networks offer a very narrow range of services not sufficient for the dually eligible population	ADD NEW: 6.XX	DBHR agrees with this comment.
6.1.1	WCMHA	Change: 6.1.1 The Contractor shall maintain and monitor an appropriate provider network, supported by written agreements, sufficient to serve enrollees enrolled under this Contract and to provide the full range of services included in covered benefits (42 CFR 438.206(b)(1)).	6.1.1	Change made.
6.2.8	WCMHA	Strongly recommend language that promotes continuity of care with this complex high risk population. This would be consistent with smart assignment approach being implemented with health homes (see p. 127) Add: 6.2.8 Continuity of existing established relationship with health care provider .	ADD NEW: 6.2.X	Thank you for your comment
6.5.1	WCMHA	Change: 6.5.1 Health and behavioral healthcare advice for enrollees from licensed health care professionals concerning the emergent, urgent or routine nature of the enrollee's condition, including the ability to connect with mental health crisis services when necessary.	6.5.1	Change made.
6.5.2	WCMHA	Change: Triage concerning the emergent, urgent, or routine nature of medical and behavioral health conditions by licensed health care professionals.	6.5.2	Change made.
6.7.7	WCMHA	Why would private practice providers have a different access standard than other mental health providers? What distinguishes a private practice provider fro the mental health professional s referenced in 6.7.6 above?	6.7.7	This language looks like it's originally from the WMIP contract. Do we want to continue this practice? AR - this language, or some version of it, is useful because MCOs can contract with providers other than those allowable under the RSN system - that might include private providers who don't have the means to meet the 10 day wait time.
6.7.8	WCMHA	Are the terms initial assessment and intake evaluation being used interchangeably? This is confusing.	6.7.8	We agree and attempted to use "mental health intake assessment".
6.7.11.5	WCMHA	Medically necessary voluntary or involuntary hospitalization must be available prior to an intake evaluation. Add: 6.7.11.5 Psychiatric Hospitalization	ADD NEW: 6.7.11.X	Change made.
6.9.5.2	WCMHA	This standard will be impossible to meet in some rural/frontier communities.	6.9.5.2	Comment noted

7.3.5	WCMHA	Need to include coordination with DBHR re: mental health system data, specifically the Mental Health Consumer Information System (MH-CIS).	7.3.5	Need further discussion on MH data collection methods.
7.8.3	WCMHA	Need to ensure that MCOs make full range of covered chemical dependency services available. Change: Number of Enrollees who received treatment and range of covered services provided	7.8.3	Change made.
7.8.5	WCMHA	This should be a separate section, not part of chemical dependency. "Mental Health"	7.8.5	Change made.
7.8.7	WCMHA	Need to ensure that MCOSs make full range of covered mental health services available. Change: Number of Enrollees who received treatment and range of covered services provided	7.8.7	Change made.
7.18	WCMHA	Change: The Contractor shall submit its drug formulary, for use with enrollees covered under the terms of this Contract, to HCA for review and approval by January 31 of each year of this Contract or upon HCA's request. HCA shall ensure that the formulary is adequate to meet the needs of beneficiaries, including adequate coverage of psychotropic medications which shall be at least as comprehensive as the HCA formulary (Preferred Drug List). The formulary shall be submitted to:	7.19	Change made.
9.7.6.1	WCMHA	This needs to be broadened to include all provider types that are qualified health home providers, i.e. not limit to primary care	9.7.3.1	Deleted
9.10	WCMHA	Change: The Contractor will maintain records of the number and type of providers and support staff participating in contractor-delivered provider education, including evidence of assessment of participant satisfaction with the training process.	9.10	Updated
9.10.1.11	WCMHA	Change: Educational opportunities for primary care and other providers, such as those produced by the Washington State Department of Health Collaborative, the Washington State Medical Association or the Washington State Hospital Association, etc.	9.10.1.11	Change made.
10.3.2	WCMHA	Change: The Contractor's health care and mental health advance directive policies and procedures shall be disseminated to all affected providers, enrollees, HCA, and, upon request, potential enrollees (42 CFR 438.6(i)(3)).	10.3.2	Change made.
10.3.3	WCMHA	Change: The Contractor's written policies respecting the implementation of advance directive rights shall include a clear and precise statement of limitation if the Contractor cannot implement an health or mental health advance directive as a matter of conscience (42 CFR 422.128). At a minimum, this statement must do the following:	10.3.3	Change made.
10.3.4	WCMHA	Change: 10.3.4 If an enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the Contractor may give health care and mental health advance directive information to the enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated enrollee or to a surrogate or other concerned persons in accord with State law. The Contractor is not relieved of its obligation to provide this information to the enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.	10.3.4	Change made.
10.3.5	WCMHA	Change: The Contractor must require and ensure, that the enrollee's medical record documents, in a prominent part, whether or not the individual has executed an health or mental health advance directive.	10.3.5	Change made.
10.3.6	WCMHA	Change: The Contractor shall not condition the provision of care or otherwise discriminate against an enrollee based on whether or not the enrollee has executed an health or mental health advance directive.	10.3.6	Change made.
10.3.7	WCMHA	Change: The Contractor shall ensure compliance with requirements of State and Federal law (whether statutory or recognized by the courts of the State) regarding health and mental health advance directives.	10.3.7	Change made.
10.3.8	WCMHA	Change: The Contractor shall provide for education of staff concerning its policies and procedures on health care and mental health advance directives.	10.3.8	Change made.

10.3.9	WCMHA	Change: The Contractor shall provide for community education regarding advance directives that may include material required herein, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the Contractor. The same written materials are not required for all settings, but the material should define what constitutes an health care or mental health advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable State and Federal law concerning advance directives. The Contractor shall document its community education efforts (42 CFR 438.6(i)(3)).	10.3.9	Change made.
10.3.10	WCMHA	Change: 10.3.10 The Contractor is not required to provide care that conflicts with an health care or mental health advance directive; and is not required to implement an health care or mental health advance directive if, as a matter of conscience, the Contractor cannot implement an advance directive and State law allows the Contractor or any subcontractor providing services under this Contract to conscientiously object.	10.3.10	Change made.
13.8	WCMHA	Please move to a section before discussing the Medicare process. It was confusing seeing the process so blended. Made it seem like clients come file a Petition for Review with HCA's BOA after a Medicare IR.	13.8	updated
13.10	WCMHA	Seems like this section should be moved up to after the state Petition for Review Process before Medicare appeal process. This only applies to Medicaid appeal process	13.10	updated
13.10.3	WCMHA	At focus group, legal advocates questioned whether this comports with limit of recovery (not sure if there was some past case law?) Needs follow-up. Suggest leaving it as is, but under review.	13.10.3	More discussion needed
14.18.2	WCMHA	The communication needs to be directly with treating behavioral health providers, NOT authorizing entities. This may make sense for LTSS but is not appropriate for mental health or chemical dependency.	15.4.2	Change made.
14.33.1	WCMHA	Change: Treatment Plans for Enrollees with Mental Health Needs: 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 of treatment plan 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.	14.10.5	This language has already been incorporated into V.3.
14.36.1	WCMHA	The specifications for the centralized comprehensive record with all the elements defined below are the current state of the art. Some of the provisions included below There isn't a readily available electronic record available to subcontractors that could deliver all of the elements below (e.g) s seems impossible to implement given the state of the art of electronic health records for all the different systems, entities and providers involved in providing care to this population. Is premature to be required at this time. Only system entities that currently have this capability are those that are both health plans and healthcare provider systems such as Group Health or Kaiser	17, 17.1.1, 17.1.2, 17.1.3	This language has been revised to support an Electronic Health Record.
14.43.6	WCMHA	Not sure what this means? Provide which staff with information? Need a statement that requires coordination with outpatient mental health providers, e.g. the contract shall coordinate with outpatient mental health providers for discharge planning and aftercare services.	16.7.6	Change made.
Section 1	ADS	Please check all the CFR references many of them seem inaccurate.	ALL	This will be done before the contract is finalized.
1.5	ADS	Ancillary Services What about LTSS services?	1.5	Defined in Benefit appendix
1.9	ADS	What does a care Coordinator do as opposed to a care manager?	1.9	The definition has been revised for more clarity.
1.12	ADS	If this is what a care coordinator does, what does a care manager do? .Care management is only available to high cost high risk clients?	1.12	The definition has been revised for more clarity. Care management is available to any enrollee who needs additional help in managing their health conditions.
1.22	ADS	How is this different from care management?	1.22	Updated
1.36	ADS	Enrollees with chronic condition(s) scoring in the highest forty percent (40%) of dual eligibles How is this different from the PRISM score method?	1.36	This language has been revised.

1.45	ADS	What is the difference between a HAP and and ICP?	1.45	HCA/ADSA envision the Individualized Care Plan and the Health Action Plan being complimentary documents. All enrollees need the ICP which is a requirement of the CMS Model of Care and is used when the enrollee is determined to need a course of treatment or regular care monitoring. Only Level three enrollees need both an ICP and a Health Action Plan. The Health Action Plan is a person-centered self-management plan, with identified short and long-term goals. The Health Action Plan is created by the Health Home Care Coordinators and the enrollee in a face-to-face meeting at the place of the enrollee's choice. Additionally, there is nothing stopping the Contractor using the Health Action Plan as part of their care management toolkit, if this proves valuable in the management of individuals.
1.50	ADS	This definition seems different from other definitions of health homes?	1.50	updated
1.53	ADS	Add: 1.54 Define Long Term Services and Supports, including a list of covered services	ADD NEW: 1.5X	updated
2.33	ADS	).???This refers to 41 USC 423 - Sec. 423. Restrictions on disclosing and obtaining contractor bid or proposal information or source selection information not conflict of interest.	2.33	The conflict of interest is directly relatable to procurement processes.
3.1.1.1	ADS	Monitor compliance with the terms of the Contract. HCA shall be responsible for the day-to-day monitoring of the Contractor's performance and shall periodically report to CMS and the Director of HCA and Assistant Secretary of the Aging and Disability Services Administration (ADSA). HCA and Contractor staff may also meet on a regular basis to discuss issues involved in implementation of the program. CMS shall communicate directly with the Contractor as necessary. What about the role of the implementation team?	3.1.1	Thank you for your comment
3.2.1.2	ADS	Change: Meet with the Contractor at least quarterly to assess the Contractor's performance and discuss areas of interest and discuss and resolve ongoing issues. Meetings will include the implementation team which may includes local counties and providers).	3.2.2	This does not need to be addressed in the contract.
Section 4.10	ADS	What about information about what LTSS are covered and how to access them?	4.3	Already covered in contract
4.11.1.1	ADS	Change: The Contractor shall assure that interpreter services are provided for enrollees and potential enrollees with a primary language other than English, free of charge (42 CFR 438.10(c)(4)). The Contractor must notify all members of their right to access oral interpretation services and how to access them.	4.4.1.1	How to access interpreter services will be part of the written material given to beneficiaries.
Section 4.12	ADS	Add: 4.12 Cultural Comepetency 4.12.1 The Contractor shall have a Cultural Competency Plan which meets the requirements of the DSHS Cultural Competence Guidelines and Policy. An annual assessment of the effectiveness of the plan, along with any modifications to the plan, must be submitted to the HCA, no later than 45 days after the start of each contract year. The Plan should address all services and settings. [42 CFR 438.206(c)(2)] The Contractor shall ensure compliance with the cultural competency plan and all requirements pertaining to Limited English Proficiency. 4.11.2.12 4.12.2 The Contractor shall comply with the National Quality Forum Cultural Competency Implementation Measure (1919).	ADD NEW: 4.X	There are a number of requirements built into the contract that require cultural competency. 1.53 requires the Individualized Care Plan to accommodate specific cultural and linguistic needs of the enrollee. 7.6 requires cultural competency and care planning training for 100% of staff within 6 months. 10.2 requires the contractor to provide services that are appropriate to the culture of the enrollee. Additional requirements for cultural competency that include more reporting and performance measures are resource intensive and may be better applied if a need is discovered.

6.3.1	ADS	Change: 6.3.1 Network providers offer access comparable to that offered to commercial enrollees or, if the Contractor serves only Medicaid and dual eligible enrollees, comparable to fee-for-service Medicaid and other care options available to Medicare clients which ever is greater (42 CFR 438.206(b)(1)(iv) & (c)(1)(ii))).	6.3.1	Thank you for your comment
6.6.4.1	ADS	What is call abandonment?–	6.6.4.1	Call abandoment is when a beneficiary hangs up before their call is answered.
6.6.4.2	ADS	Call response time - average speed of answer less than 30 secondsHow is this defined? Answered and put on hold?.	6.6.4.2	Usually the speed of an answer measurement starts when a call gets into a queue (i.e. Hold music) until customer service staff answer the call. Once the call is answered, the measurement for "speed of answer" stops.
6.7.1.1	ADS	facilities Every person coming out of a hospital gets an assessment and care plan??.	6.7.1.1	Every person coming out of an institutional setting to another setting should have a transition plan, which includes a clinical assessment of their health, to determine if there are additional needs, such as durable medical equipment, and a plan of care for follow-up services.
6.9	ADS	Change: The Contractor's network of providers shall meet the distance standards below in every service area and shall be accepting new patients.. HCA will designate a zip code in a service area as urban or non-urban for purposes of measurement. HCA will provide to the Contractor a list of service areas, zip codes and their designation.	6.9	Adding the requirement that all providers accept new patients may inadvertently reduce the amount of providers who agree to subcontract with the Contractor. There are providers who already have established relationships with patients and may be willing to subcontract with the Contractor but not accept new patients. Excluding those providers does not improve access to care.
6.9.1	ADS	1:1000 members	6.9.1	Please clarify your comment. I think they want us to specify that the ratio is 1:1000
6.10	ADS	RehabilitationSeems like a limited list?.	6.10	Please clarify your question. Should note that this list is the minimum, not the whole array of providers.
6.11	ADS	The state should at least require the minimum standards as established by Wisconsin	6.11	Thank you for your comment.
6.12.3	ADS	Change: 6.12.3 Other LTSS Providers: The Contractor will provide or contract for services as listed in Appendix XX, and will have access to at least one two of each provider type if available in the geographic areas or enough contractors of high use services to ensure clients receive the service within 10 calendar days of referral in the setting most appropriate to their need or to the service. High use services are defined as those that are used more than ????	6.12.3	Updated
Section 7	ADS	See the Wisconsin QAPI requirements as an example as a more comprehensive approach and the Minnesota QAPI Evaluation (7.2.4). http://www.dhs.wisconsin.gov/rfp/DHCF/pdf/Appendix%20A%20-%20Contract%20for%20BadgerCare%20Plus%20HMO%20Services%202010-2013.pdf	7	Thank you for your comment.
7.1.5	ADS	A Quality Improvement (QI) Committee Whose? The MCO or HCA?	7.1.1.2.2	The MCOs.
7.2	ADS	Plans should be required to do a PIP on LTSS. Add: 7.2.1.2 A second clinical PIP if the Contractor's HEDIS rates are below the contractually required benchmarks described in this contract	7.2	We will be engaging in discussions with our DSHS partners to determine if we should be more directive in the selection of a PIP. The best way to focus a PIP is to review the results of required performance measures and determine areas of weakness that could be strengthened through the use of a PIP.

7.3.4.1	ADS	What about the next two years?	7.3.4	It is a standard practice of HCA to require a one year collection period, followed by the results in the next year. Results of HEDIS measures can inform necessary changes needed through a contract amendment.
7.9.6	ADS	Long Term Services and Supports are the rest of these only for enrollees discharged from a NH?	7.9	Will be corrected
7.13.1	ADS	For all others??, call 1-866-END-HARM	7.13.1.1	Updated
7.14.7	ADS	If this information is unavailable, the attempt to retrieve it will be.???	7.14.7	updated
7.16.1	ADS	Change: The Contractor shall adopt physical, behavioral health and long term care practice guidelines. The Contractor may develop or adopt guidelines developed by organizations such as the American Diabetes Association or the American Lung Association.What about existing DSHS guidelines? The Contractor shall adopt preventive and chronic disease practice guidelines appropriate for the various sub-populations of Enrollees, such as children with special needs, elderly, etc.Practice guidelines shall meet the following requirements (42 CFR 438.236):	7.17.1	The development of practice guidelines are rigorously tested before being published and are normally used to guide utilization decisions. Any practice guidelines that DSHS or HCA may use to inform utilization decisions should be readily available to the MCOs, without specifically calling them out. There are a number of practice guidelines for Long-term care published through the National Guideline Clearinghouse.
7.16	ADS	What about HCA/DSHS reviewing and approving the guidelines?	ADD NEW: 7.XX	Reviewing and approving guidelines is resource intensive. Most guidelines undergo rigorous testing before being made available for use. As long as guidelines are evidenced-based and research supported, they should not require HCA/ADSA approval.
8.2	ADS	Why isn't HCA reviewing the P&P instead of their assessment of the P&P?	8.2	Policies and procedures are normally developed for all processes required by contract language. This usually translates into hundreds of P&Ps per health plan. Review and approval of every P&P used by the health plans is resource intensive. A HCA developed self-assessment should provide a checklist of necessary elements in P&Ps and substantially reduce the work involved in a review and approval process. The safe-guard is the annual contract compliance monitoring to determine if the health plans are compliant with contract language and following their P&Ps
9.7.6.1	ADS	The plans pay for infrastructure development to become a HH???.;	9.7.3.1	Yes, HCA/ADSA expect the plans to pay for Health Home infrastruture. Rates will be negotiated with CMS.
9.14	ADS	What about agencies providing in-home services?	9.13.17	Updated
10.1.2	ADS	What about 42 CFR 438.100(a)(2)(i)?	10.1.2	Please clarify the question. This citation references providing information to enrollees - I'm not sure why we'd cite it separately.
13.8	ADS	Please move to a section before discussing the Medicare process. It was confusing seeing the process so blended. Made it seem like clients come file a Petition for Review with HCA's BOA after a Medicare IR.	13.8	updated
13.10.3	ADS	At focus group, legal advocates questioned whether this comports with limit of recovery (not sure if there was some past case law?) Needs follow-up. Suggest leaving it as is, but under review.	13.10.3	Not updated

14	ADS	Care management and coordination shall involve an interdisciplinary and holistic approach that incorporates the unique primary care, acute care, long term care, mental health and social service needs of each Enrollee with appropriate coordination and communication across all Providers	14.1	Thank you for your comment
14.6.10	ADS	Add: 14.6.9 LTSS case managers	ADD NEW: 14.6.3.XX	Updated
14.10.1	ADS	Will the screening tools be standardized?	14.7	Some screening tools will be standardized and approved by HCA/ADSA. But the health plans can use additional screening tools if necessary that will not require standardization and approval.
14.10.1.2	ADS	Change: The IHS screening can be completed in a variety of methods (written, telephonic or in person). If the Contractor is unable to conduct the initial screening within 30 days, the Contractor shall continue to make efforts to conduct the screening for up to 60 days after enrollment. If the Contractor is unsuccessful in contacting the enrollee, the Contractor shall document efforts made to contact the enrollee and conduct the screening.	14.7.1.1	This language change will be made to 14.7.1.1.
14.10.1.3	ADS	The Contractor shall document the results of the screening and, based on the results of the initial screening, the Contractor shall conduct a secondary (Why???)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.	14.7.1.2	Clarity will be added to this language. Secondary screens or assessments can be triggered from initial screens. For example, the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) is a 3 question pre-screen that may trigger additional screens for mental health or substance abuse.
14.11.2.1	ADS	Protocols include(:Is this regarding Care management and Coordination?)	14.8.2	Universal screening
14.12	ADS	Change: 14.12 Health Risk Assessment (HRA): (I think the MCO should be required to evaluate all its enrollees to determine if an enrollee meets the criteria for chronic care management services within 30 days of initial enrollment, as well as on an annual basis, or as requested by the enrollee's primary care physician, or as requested by the enrollee or his authorized representative.) The Contractor shall ensure that the HRA is conducted within 90 days of enrollment when the initial and secondary screening (Why two screenings?)indicates the need for a HRA. The HRA shall determine ongoing need for care coordination services and the need for clinical and non-clinical services, including referrals to clinical consultant services and community resources. The HRA tool and content shall be pre-approved by HCA (Not standardized?)and all information gathered in the HRA shall be entered into the Electronic Medical Record. (Is there any requirement for a re-assessment? Annually? Other?)	14.7.2	This will be synchronized with the MOC
14.12.7	ADS	Change: The Contractor shall establish business rules regarding screening, referral and co-management of individuals with both behavioral health and physical health conditions, including enrollees that have long term services and supports. Both Bbehavioral health, and physical health and LTSS care managers or Disease Management coaches will be trained on the protocols.	14.7.4	This language has been changed.
14.12.7.2	ADS	What about LTSS needs?	14.7.4.2	Not applicable
14.15.4	ADS	Change: 14.15.4 The State will Contractor shall establish policies and criteria for Level Two case load ratios for Care Managers serving all Level Two enrollees.	14.4.5	This language has been changed.
14.15.5	ADS	Add: For those enrollees who are identified to need for long term services and supports refer to section XXXXXXX	ADD NEW: 14.4.X	Updated
14.16.2.2	ADS	Require the primary care provider to identify child or adult enrollees with special health care needs(Based on what?) in the course of any contact or enrollee initiated health care visit and report to the Contractor.	14.5.2.2	Special health care needs is included in the definitions section of the contract. The definition of special health care needs should be included as part of the Contractor's subcontracts.
14.16.15	ADS	Change: . This may include family, caregivers, primary care providers, mental health treatment providers, authorizers of long term services and supports and/or chemical dependency treatment providers. have a The Health Action Plan is reviewed and updated to include reassessment of the enrollee's progress towards meeting clinical and patient-centered health action plan goals.	14.9, 14.9.1, 14.9.2	Some of this language has been changed.

14.17	ADS	Add: T he Contractor shall ensure that an independent resource is assigned to and available to enrollees to assist with the coordination of his/her LTSS needs and to provide expertise and community supports to the enrollee and his/her care team.	15.2.1	Thank you for your comment.
14.1.7.1	ADS	Add: Contractor shall employ or contract for long term service and support coordinators, who shall be members of the multidisciplinary health care team and shall be responsible for: (i) arranging, coordinating and authorizing the provision of community long-term care and social support services with the agreement of other multidisciplinary health care team members designated by the MCO; (ii) coordinating non-covered services and providing information regarding other services, including, but not limited to, housing, home-delivered meals and transportation services; (iii) monitoring the provision and outcomes of community long-term care and support services, according to the enrollee's service plan, and making periodic adjustments to the enrollee's service plan as deemed appropriate by the multidisciplinary health care team; (iv) tracking enrollee transfer from one setting to another; and (v) scheduling periodic reviews of enrollee care plans and assessment of progress in reaching the goals of an enrollee's care plan.	15.3	Thank you for your comment.
14.17.2	ADS	Add: Contractor shall grant long term services and supports coordinators authorizing responsibility over a range and amount of LTSS for specific conditions or circumstances for which agreement of the multidisciplinary health care team would not be required.	ADD NEW: 15.3.X	Thank you for your comment.
14.17.1.3	ADS	Are these screens additional to the other screening?	15.3.3	Yes.
14.18.11	ADS	the enrollee's activation score and level (1-4)??	15.4.7	The activitation score is referencing a Patient Activation level which is used to determine how much coaching a beneficiary may need for self-management.
14.19.4	ADS	Any face-to-face required?	15.5.2.3	We would expect face-to-face interaction with the beneficiary when transitioning from one institutional setting to another setting, such as their home. This may or may not be done by their Health Home care coordinator. If not, we do expect the Health Home coordinator to be kept apprised of the beneficiaries status in order to assist with transitional planning.
14.20.1	ADS	The Contractor shall ensure peer supports, support groups, and self-management programs (are these to be paid for by the contractor?)will be used by the Health Home Care Coordinator	15.6.1	Payment for peer supports is usually supported by mental health rates included in the capitation payment. Support groups can be free, such as AAA or can be part of a treatment benefit. If the support group, such as a counseling session, is part of a treatment benefit, then it is also included in the capitation rate. Self-management programs may or may not be funded, dependent upon their definition.
14.22.1	ADS	, LTSS providers?	14.4.2.6	Already covered in contract
14.22.3	ADS	If the contractor is a HH lead are they required to have a board?	15.2.11	Yes
14.22.4.1	ADS	What about annual reviews and significant changes?	16.1.2	Annual reviews and significant changes will also be done by DSHS or their designee.

14.22.4.3	ADS	Wasn't the CARE assessment just done by DSHS or designee? and development of the Care Plan. How does this Care Plan fit with the HAP and ICP?	16.1.4	Information from the CARE plan should be used to populate the ICP and HAP. Both the ICP and HAP will have other data that is not available in the CARE plan.
14.22.4.4	ADS	Change: Contractor must use the CARE assessment and results as part of the care plan planning process	16.1.5	Thank you for your comment.
14.22.4.7	ADS	How does this relate to the above?	16.1.8	Updated
14.22.4.10	ADS	Where does it require an annual face-to-face? Is there a requirement for an annual reauthorization to be done by the AAA?	16.1.11	Functional eligibility assessment doesn't belong in this contract.
14.22.4.11	ADS	So the contractor does the significant change?	16.1.12	Updated
16	ADS	Add: The following additional supportive functions must be provided LTSS enrolles as needed:	ADD NEW	Updated
16	ADS	· Client Advocacy. Support client self-advocacy. Intervene with agencies or persons to help clients receive appropriate benefits or services. Clients may also request assistance with advocacy from their case manager even when they are able to advocate for themselves.	ADD NEW	Thank you for your comment
16	ADS	· Assistance. Assist clients to obtain a needed service or accomplish a necessary task that, due to physical or cognitive limitations, they cannot obtain independently. Some examples include:	ADD NEW	Updated
16	ADS	o Completing a form.	ADD NEW	Updated
16	ADS	o Researching a living situation.	ADD NEW	Updated
16	ADS	o Assistance with moving arrangements.	ADD NEW	Updated
16	ADS	o Arranging transportation.	ADD NEW	Updated
16	ADS	o Assisting with Medicaid eligibility review.	ADD NEW	Updated
16	ADS	o Other services related to the plan of care.	ADD NEW	Updated
16	ADS	o Assistance with locating, hiring, contracting, and terminating providers of their choice.	ADD NEW	Updated
16	ADS	o Assistance applying for administrative hearings and access to an administrative hearing coordinator.	ADD NEW	Updated
16	ADS	· Referrals. Making and following up on referrals to healthcare providers, including mental health and other services as identified in the assessment.	ADD NEW	This issue is addressed in 14.7.2.3
16	ADS	· Family Support. Assist the family or others in the client's informal support system to:	ADD NEW	Thank you for your comment
16	ADS	§ Make necessary changes in the home environment and/or lifestyle that clients have agreed to;	ADD NEW	Thank you for your comment
16	ADS	§ Encourage changes in high risk behaviors or choices that may improve the stability of the plan of care or improve health and psych/social outcomes;	ADD NEW	Thank you for your comment
16	ADS	§ Plan a move to or from residential care, etc.	ADD NEW	Thank you for your comment
16	ADS	§ Encourage caregiver self-care through support groups, education, and assistance accessing resources.	ADD NEW	Thank you for your comment
16	ADS	· Crisis Intervention. Provide short-term crisis intervention in an emergency situation to resolve the immediate problem before a long-term plan is developed or current plan is revised.	ADD NEW	Thank you for your comment
16	ADS	· Access Resources. Examples of available resources include: discharge resources, local community services, assistive technology and benefits under the Medicaid State Plan.	ADD NEW	Updated
16	ADS	x.1.1 The Contractor shall ensure access to LTSS funded through Medicare and Medicaid, with sufficient appeals, advocacy, and ombudsmen options for consumers that are specifically tailored to LTSS.	ADD NEW	Will be incorporated in Member Handbook
16	ADS	Care Managers/Care Coordinators, who work with enrollees receiving LTSS and coordinate LTSS, must have experience and expertise in LTSS and be community based.	ADD NEW	Thank you for your comment.
16	ADS	X.2 All DSHS, ADSA guidelines, policies and manuals are hereby incorporated by reference into this contract. All guidelines, policies and manuals are available on the DSHS, ADSAwebsite located at www.XXXXX. The Contractor is responsible for complying with the requirements set forth within.	ADD NEW	Will be incorporated in Member Handbook
17	ADS	NEW Section on Consumer Protections	ADD NEW: 10.XX	Thank you for your comment.
17	ADS	x.1 Advisory Council: To promote a collaborative effort to enhance the service delivery system in local communities, the Contractor shall establish an Advisory Council that will participate in providing input on		Thank you for your comment
17	ADS	policy and programs. The council is to be chaired by the Contractor's Administrator/CEO or designee and will		Thank you for your comment

17	ADS	meet at least quarterly. Every effort shall be made to include a cross representation of both enrollee/members/families/significant others, community-based advocacy groups and providers that reflect the population and community served. Enrollees/families/significant others and community/based advocacy groups shall make up at least 50% of the membership. The Contractor shall provide an orientation and ongoing training for council members so they have sufficient information and understanding to fulfill their responsibilities. On an annual basis, the Contractor shall submit a plan to HCA, outlining the schedule of	ADD NEW: 10.XX.X	Thank you for your comment
17	ADS	meetings and the draft goals for the council. HCA shall be included on all correspondence to the Council, including agenda and Council minutes.		Thank you for your comment
17	ADS	The Advisory Council should not be the only venue for the Contractor to communicate and participate in the issues affecting the local communities and enrollees. Contractors should also actively participate with other related organizations, such as the RSN and AAA, so that there can be a better understanding of the longterm care issues in the local community and their impact on enrollees.		Thank you for your comment
17	ADS	x.2 The Contractor will provide each beneficiary with contact information for regulatory agencies. In the case of beneficiaries receiving mental health or long-term care services and supports, the Plan will provide contact information for the appropriate Ombudsman office.	ADD NEW: 10.XX.X	Will be incorporated in Member Handbook
17	ADS	x.3Beneficiaries must be provided access to the full coverage, benefits and appeal rights of Medicare and/or Medicaid, regardless of the delivery system used to provide benefits and regardless of the entity administering the funds.	ADD NEW: 10.XX.X	Will be incorporated in Member Handbook
	SEIU	this contract must include language that clearly requires Contractor to comply with requirements of collective bargaining agreement between the Governor of the State of Washington and SEIU Healthcare 775NW in regards to the employment of individual provider home care workers. Add: "Collective Bargaining Agreements: The Contractor shall comply with all current and future collective bargaining agreements by and between the Governor of the State of Washington and the Service Employees International Union, Local 775, AFL-CIO in accordance with RCW 74.39A.270. DSHS shall provide the Contractor with copies of any new collective bargaining agreements or amendments to existing agreements no less than 60 days prior to the effective date of the new agreement or amendment. Should the terms of any new agreements or amendments be materially different than the 2005-2007 Agreement, Contractor shall have the right to discontinue its responsibility for services upon effective date of such agreement or amendment. DSHS reserves the right to terminate the Long Term Care portion of this program in accordance with Section 2.14, Termination for Convenience, of this Contract, should the Contractor discontinue provision of services."	ADD NEW	Added 2.4.14
2.4	SEIU	Add: "Compliance with Applicable Law" should also include Chapter 74.39A.270 RCW, Chapter 74.39A.360 RCW, Chapter 74.39A.074 and applicable collective bargaining law and Snohomish County Ordinance No. 09-011 relating to contracts for all home care services and for those services funded by revenues derived from the tax imposed by SCC 4.25.010.	ADD NEW: 2.4.XX	Thank you for your comment
2	SEIU	Add: A requirement should be added to Section 2 to require written contracting policies to prevent or mitigate service disruptions caused by labor unrest within private sector providers of health care, long-term services and supports, chemical dependency, and mental health that would harm vulnerable members of the community or compromise the efficient delivery of health care services.	ADD NEW	Thank you for your comment
2	SEIU	Add: A requirement should be added to Section 2 requiring the Contractor to coordinate and cooperate when needed with SEIU Healthcare 775NW on union representation	ADD NEW	Added 2.4.14.1
6.12.2	SEIU	Add: criteria that contractors for in-home personal care must comply with labor harmony provisions in Snohomish County Ordinance No. 09-011.	6.12.2	Thank you for your comment
9	SEIU	Add: subcontracts seems overly broad – should clarify that all subcontractors will be required to comply with same general requirements as in Section 2 of this contract, including labor harmony provisions	9	Already covered in contract 9.4.11
1.10.2	SEIU	Add: Care Manager" definition should include reference to home care aides or individual providers in addition to community health workers as individuals who can facilitate the work of the care manager.	1.10.2	Updated
1.47	SEIU	Definition of "Health Care Professional" (Section 1.47) should include "certified home aide" or "individual provider."	1.47	Thank you for your comment
14.18.3	SEIU	Add: "home care aide" or "individual provider" to Section 14.18.3 as one of the health professionals that can facilitate the work of the assigned Health Home Care Coordinator.	15.4.3	Updated

14	SEIU	Add: should be modified to include language encouraging Contractor to involve home care aides in provision of care coordination services. For example, the following language could be added: "The Contractor must implement procedures to give enrollees the option of including home care aides and other direct care workers in the care team and health home care coordination process. The Contractor has the discretion to authorize LTSS more broadly in terms of criteria, amount, duration and scope."	14.1	Updated 14.9.1 and 14.4.2.6
9.7	SEIU	Add: language to Section 9.7 to encourage Contractors to include "Innovative approach to incorporating home care aides as part of the health home."	9.7	Thank you for your comment.
	SEIU	This contract should incorporate stronger consumer protections, including: Adding a requirement that for geographic areas where there is more than one Contractor available, those individuals who do not decline initial enrollment should be enrolled with the Contractor with the provider network that best matches their current roster of medical care providers. • Adding a requirement that disenrollment rates as well as performance measures be made publicly available to consumers • Adding a requirement that disenrollment rates as well as performance measures be made publicly available to consumers • Clarifying that consumers will have the right to disenroll at any time for cause, e.g., if the plan fails to provide timely access to appropriate medical care. • Establishment and funding of an independent ombudsman to receive and respond to complaints.	ADD NEW: 10.XX	Thank you for your comment
7	SEIU	Requirements should be added to Section 7 to ensure that quality benchmarks include workforce related benchmarks such as what percent of median area wage is paid to direct care workers and what percent of workers have health insurance, what percentage of workers meet training standards, turnover and retention stats within key professions including RNs, LPNS, home care aides.	7	Thank you for your comment.
7.1	SEIU	Clarify that data collected for Quality Assurance and Performance Improvement Program (Section 7.1) and Performance Improvement Projects (Section 7.2) – except personal enrollee or HIPAA protected information - will be available to providers, enrollees, or interested parties upon request.	7.1 & 7.2	Measurements and the results of PIPs are published in an annual External Quality Review Report which can be downloaded from HCA. Some QAPI can be asked for via Public disclosure, but some QAPI is proprietary and can't be released.
7.9.8	SEIU	LTSS utilization data (Section 7.9.8 and 7.10.2) should be made public.	7.9.2	This information is publically disclosable.
7.10.2.1	SEIU	In addition, in Section 7.10.2.1, data should be broken down separately for Personal Care Agency and Individual Provider.	7.10.2	Updated
2.16.3	SEIU	Section 2.16.3, language should be included to clarify that anything submitted to HCA is a public record.	2.16.3	Thank you for your comment
6.2.7	SEIU	Add: gender and age of enrollees to demographic characteristics that Contractor must consider in the maintenance and monitoring of its network.	6.2.7	Updated
6.5	SEIU	Add: language to Section 6.5 to require 24/7 availability for long-term services and supports, particularly home care services	ADD NEW: 6.5.X	Thank you for your comment
6.9.8	SEIU	Add Provider Network – Distance Standards for Individual Provider and Agency Home Care in Section 6.9.8 to ensure that Contractors maintain contracts sufficient to ensure an adequate capacity of both individual provider and agency home care services.	ADD NEW: 6.9.8.X	Thank you for your comment

1.1	NoHLA	We agree with the suggestion by AARP that the creation of an individual care plan should constitute an appealable action. The language we have suggested closely tracks that in the Wisconsin contract, adapted to the types of care plans referred to in this Contract. Add: ; or the failure to provide, arrange for, or approve services or act in a timely manner as required herein (42 CFR 422.561, 42 CFR 438.400(b)), The term action also includes the creation or amendment of an individualized care plan of a type required to be created by this Contract , that is unacceptable to the enrollee because any of the following apply: a) the plan is contrary to the enrollee's wishes insofar as it requires the enrollee to live in a place that is unacceptable to the enrollee; b) the plan does not provide sufficient care, treatment, support or other services to meet the enrollee's needs and support the enrollee's identified outcomes; c) the plan requires the enrollee to accept care, treatment or support that is unnecessarily restrictive or unwanted by the enrollee. Such care plans include, but are not necessarily limited to transition plans for enrollees discharged from a hospital or other institutional setting to the community (Sec. 6.7), care plans for enrollees transitioning from a nursing home to a community placement (Sec. 14.25); individual care plans for enrollees who have long term services and supports (Sec. 14.28), treatment plans for enrollees with mental health needs (Sec. 14.33.1), individualized clinical treatment plans for children with special health care needs (Sec. 14.33.3), with which an enrollee disagrees.	1.1	Updated
1.11	NoHLA	Change: Comprehensive Assessment Report and Evaluation (CARE)" means a person centered, automated assessment tool used for determining Medicaid functional eligibility, level of care for budget and comprehensive care planning, as defined in WAC 388-106 or any successor provisions thereto. HCA shall promptly provide the Contractor notice of any changes to the state rules constituting the CARE algorithm or governing the use of the CARE assessment tool more generally.	1.11	Updated
1.28	NoHLA	The current language seems to imply that only current enrollees in Medicare Advantage plans will be eligible. It is unclear why this should be or why it would be a beneficial policy choice. The definition should be changed to include all who are dually eligible for Medicaid and Medicare.	1.28	more discussion needed
1.30	NoHLA	The definition for EPSDT must indicate clearly the full breadth of services covered/mandated under federal law and the circumstances under which coverage attaches. Unfortunately, the draft description of EPSDT seems very likely to give a cramped impression of the scope of covered treatment services and the conditions of coverage. Specifically, the draft states that "The Contractor shall be responsible for all EPSDT screening and treatment services found to be medically necessary <u>during the EPSDT exam</u> " This seems likely to give the (false) impression that EPSDT covers only treatment found to be medically necessary in what are clearly and explicitly screening exams (e.g., periodic checkups). This is not correct. CMS considers any contact between a Medicaid beneficiary and a health care provider to be an "inter-periodic screening" or exam. So, whenever a child Medicaid recipient's health care provider determines health care services to be medically necessary for the patient, that determination is made in the course of an EPSDT (inter-periodic) screening. Covered EPSDT treatment services thus include any and all health care services to correct or ameliorate a mental/physical/developmental condition that are determined to be medically necessary by a child's health care provider <u>at any time</u>, regardless of the nature or purpose of the visit in which the provider identifies the need for such treatment or prescribes it. The language we have proposed seeks to clarify this	1.30	HCA does not identify inter-periodic screens. Washing is generous in we cover, so families/children do not need to call into consideration EPSDT for most things; however, we require a current and complete EPSDT screening if more unusual services are requested. It is to the advantage of the child to have a complete screening to see what is medically necessary.
1.30	NoHLA	Change: Early, , Periodic Screening, Diagnostic and Treatment (EPSDT) (42 U.S.C. §§ 1396a(a)(43), 1396d(r)) "EPSDT (Early, Periodic Screening, Diagnostic and Treatment)" means a package of screening, diagnostic and treatment services, including health care equipment and supplies, in a preventive (well child) screening covered by Medicaid for children under the age of twenty-one (21) as defined in the Social Security Act (SSA) Section 1905(r) and HCA EPSDT program policy and billing instructions	1.30	Check with Sharon Reddick
1.30.1	NoHLA	Change: 1.30.1 Screening services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for: vision, dental, substance use, mental health and hearing. The Contractor shall offer and make best efforts to ensure that enrollees under the age of 21 receive screening services at least as frequently as the periodicity requirements for such services established by HCA. Screening services are also covered at such other intervals indicated as medically necessary (42 U.S.C. 1396d(r)(1).	1.30	Check with Sharon Reddick

1.30.2	NoHLA	Add: Treatment Services covered by Medicaid include vision dental and hearing services, as well any o+C247/C2:C244ther services prescribed to correct or ameliorate psychological, medical, developmental or other health conditions discovered by and determined to be necessary by a qualified health care provider acting within her or his scope of practice. (42 U.S.C. 1396d(r)(2)-(5))	ADD NEW: 1.30.X	Check with Sharon Reddick
1.30.3	NoHLA	Change: 1.30.3 The Contractor shall be responsible for all EPSDT screening and treatment services found to be medically necessary services during the EPSDT exam. HCA has determined that EPSDT is available to and shall be covered by the Contractor for all children enrollees who are eligible for any of its medical programs	1.30	HCA follows our periodicity schedule for ESPDT screenings; however, we allow for more for children who are in foster care.
1.36	NoHLA	This section would benefit from some clarification. For example, how is it determined that an enrollee scores in the highest 40% of dual eligible if (s)he does not have a PRISM score of 1.5 or greater?	1.36	Deleted
1.41	NoHLA	Change: Grievance" means an expression of dissatisfaction about any matter other than an action, regardless of whether remedial action is requested. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee or other dissatisfaction with a provider or employee's attitude or demeanor, or failure to respect the enrollee's rights, waiting time and delays in obtaining health care services not amounting to an effective denial of services, or other dissatisfaction with service provided by the Contractor or its employees not amounting to an action (42 CFR 422.561, 42 CFR 438.400(b), RCW 48.43.005(21), WAC 284-43-130(11)).	1.41	updated
1.60	NoHLA	Change: "Medically Necessary Services" means: 1.60.1 For enrollees twenty-one (21) years of age or older - services that are "medically necessary" as is defined in WAC 182-500-0070;. 1.60.2 For enrollees under the age of twenty-one – either services that are "medically necessary" as is defined in WAC 182-500-0070, or such other health care, diagnostic services, treatment, and other measures services to correct or ameliorate defects and physical and mental illnesses and conditions discovered by and determined to be necessary by a qualified health care provider acting within her or his scope of practice; and 1.60.3 In addition, medically necessary services shall include sServices related to the enrollee's ability to achieve age-appropriate growth and development.	1.60	These requirements are discussed elsewhere in the contract for children under 21.
1.72	NoHLA	This was developed in response to the Washington State Natural Death Act's direction to DoH. See RCW 43.70.480. It is an alternate means for a patient to direct end of life care, which has the force of a physician's order. Add: Physician's Orders for Life Sustaining Treatment (POLST) "Physician's Orders for Life Sustaining Treatment" or "POLST" means a set of medical orders intended to guide emergency medical treatment for persons with advanced life limiting illness based on their current medical condition and goals. A standard form POLST has been developed by the Washington State Department of Health (DoH) in conjunction with the Washington State Medical Association and is available online at http://www.wsma.org/Media/Patients-pdfs/POLST-PrintDownload.pdf .	1.72	More discussion needed
2.28.3	NoHLA	Contractors should be on notice that what appear to be simple errors, such as possible typographic error or misreport from an individual with cognitive impairment need not automatically and immediately be reported as potential fraud Change: The Contractor shall notify the State of any suspected cases in which the Contractor believes there is a serious likelihood of of enrollee fraud, by reporting this to the Department of Social and Health Services (DSHS) Office of Fraud and Accountability (OFA) (http://www.dshs.wa.gov/fraud/index.shtml) by:	2.28.6	No need to add this language - it's duplication of "suspected enrollee fraud".
3.1.1.5	NoHLA	Add new: Review and approve such other Contractor policies, guidelines, notices, and other materials generated or disseminated by the Contractor as otherwise required by this Contract.	ADD NEW: 3.1.X	Added
4.8.2.1	NoHLA	If another section of the contract is intended to define what are the primary languages for this purpose, it should be listed here. Change: Marketing materials in English must give directions for obtaining understandable materials in the population's primary languages, as identified in Sec. 4.11.2.2 of this Contract	4.1.11.1	The reference has been corrected to 4.4.2.2. References and other identifiers in the contract will not be finalized until the contract is final. Periodically, we will need to find the descrepancy and correct the citation.

4.10.1	NoHLA	Many potential enrollees will have complex health care needs requiring that they see several different health care providers. Many of these will likely also have perceptual, communications or cognitive impairments that will make it difficult for them to determine which of their providers are within which plans' networks and which networks have local providers who seem adequate alternatives to previous providers of theirs who do not contract with one or more of the duals plans. The difficulty many potential enrollees are likely to experience simply determining whether and how their need for services will be accommodated by different plans' provider networks seems likely to be a significant obstacle to enrollment and/or a significant cause of early disenrollment. HCA can substantially avoid this problem by doing the legwork of determining potential enrollees' recent providers and cross-matching them with the provider network databases Contractors are already required to assemble and furnish to HCA. Change: 4.10.1 As determined by HCA, either HCA or the Contractor shall provide sufficient, accurate written information to potential enrollees to assist them in making an informed decision about enrollment in accord with the provisions of this Section (SSA 1932(d)(2) and 42 CFR 438.10 and 438.104(b)(1)(iii)). If the enrollee is not able to understand written information or only understands a language that is not translated, the Contractor will provide the necessary information in an alternative format that is understandable to the enrollee. HCA shall review each potential enrollee's claims data to identify each provider from whom covered services have been furnished to the potential enrollee during the previous twelve (12) months. HCA shall then cross-match this data with the provider network information furnished to HCA by the Contractor and other HealthPath Contractors. HCA shall provide to each potential enrollee a list of these providers indicating in which HealthPath Contractors' provider networks they are included. This information shall be provided to each potential enrollee along with the other information required to be provided under this subsection.	4.3.1	This is too resource intensive at this time.
4.10.2	NoHLA	Change: 4.10.2 The Contractor shall provide enrollees, and potential enrollees upon request, informational materials created by HCA and designed to describe HealthPath Washington.	4.3.2	Revising this language changes the scope of the current requirement. It narrows the requirement so it only applies to HCA created material.
4.10.5.22	NoHLA	Change: 4.10.5.22.1 Availability of ombuds-services through LTC and MH systems, as well as the HealthPath ombuds service..	4.3.5.18	Will be incorporated in Member Handbook
4.11.2.2	NoHLA	Change: If five percent (5%) or more of the Contractor's enrollees speak a specific language other than English, or five percent (5%) or more of the population in the enrollee's service area speak a specific language other than English, generally available materials will be translated into that language	4.4.2.1.1	This is resource intensive and requires the MCO to go beyond their scope of practice by widening it to a larger population.
4.11.2.10	NoHLA	Change: HCA may make exceptions to the sixth grade reading level when, in the sole reasonable judgment of HCA, the nature of the materials do not allow for a sixth grade reading level or the enrollees' needs are better served by allowing a higher reading level. HCA approval of exceptions to the sixth grade reading level must be in writing. HCA shall promptly report to CMS each such exception along with the materials for which such exception has been granted.	4.4.2.3	CMS reporting requirements will be negotiated with CMS.
4.11.2.12	NoHLA	New from prior section: All written materials must have the written approval of HCA prior to use. For client-specific written materials, the Contractor may use templates that have been pre-approved in writing by HCA. The Contractor must provide HCA with a copy of all approved materials in final form	4.4.2.5	This language is currently in the contract.
4.11.2.13	NoHLA	Add: Whenever a Contractor provides written material to an enrollee either in a language other than English or provides the information otherwise contained in written materials in an alternative format, the Contractor shall also provide the enrollee with a copy of the materials in English .	ADD NEW: 4.4.2.X	This is an additional cost and assumes the enrollee wants an English version of the document.
5.2.3	NoHLA	This section is not included in the current draft. (Section 2.25.11 ;)	5.2.3	Updated
5.2.6	NoHLA	This term should be defined in the contract (minor deficiency)	5.2.6	Updated

5.4	NoHLA	Change: The Contractor medical loss ratio for each program is limited to ninety percent (90%) in calendar year 2013. Medical loss ratio shall be as defined by the Office of the Insurance Commissioner (OIC) in RCW 48.43.049 with the additional inclusion of any quality incentive payments made directly to Participating Providers prior to the end of the year. If the Contractor's actual medical loss ratio as determined by HCA and its actuaries using the Contractor's financial information, is less than eighty-eight percent (88%), HCA will calculate an amount due from the Contractor by subtracting the Contractor's actual medical loss ratio related to its performance under this Contract in the calendar year from eighty-eight percent (88%) and multiplying the result by the total premiums paid to the Contractor for the calendar year, including the Delivery Case Rate. The Contractor shall remit to HCA the amount due within ninety (90) calendar days of the date that HCA provides notice to the Contractor of that amount. This provision shall survive the expiration or termination of this Contract.	5.4	HCA's current policy is 83% for MLR. No need to change at this time.
5.10.1	NoHLA	Change: 5.10.1 The Contractor shall limit payment for emergency services furnished by any provider who does not have a contract with the Contractor to the amount that would be paid for the services if they were provided under HCA's, Medicaid Fee-For-Service (FFS) program or the Medicare Fee-For-Service (FFS) program, whichever is greater (Deficit Reduction Act of 2005, Public Law No. 109-171, Section 6085, 42 CFR 422.).	5.10.1	Thank you for your comment
5.10.2	NoHLA	When a Contractor is unable to furnish care from an in-network provider that meets with existing appointment time, travel time and distance standards, the MCO should not be permitted to limit the enrollee's ability to get out-of-network coverage by paying the same low rates that would be permitted in the absence of the Contractor's ability to offer the required care in-network Change: 5.10.2 Except as provided herein for emergency services, the Contractor shall pay a non-participating provider that provides a service to enrollees under this Contract no more than the lowest amount paid for that service under the Contractor's contracts with similar providers in the state. This requirement does not apply to services from a non-participating provider that are covered either a) because the enrollee was not able to obtain an appointment with a participating provider within the timeframes laid out in the Contract's appointment standards in Sec. 6 and where the enrollee has complied with the requirements laid out in that section for non-participating provider coverage at no additional cost; or b) because the non-participating provider is a specialty provider from whom the enrollee requires care, and no in-network provider or facility is available to provide the care within the distance and travel time requirements of Sec. 6 of the contract regarding access to specialty care (Sec. 6.15). For the purposes of this subsection, "contracts with similar providers in the state" means the Contractor's contracts with similar providers to provide services under the HealthPath Washington program when the payment is for services received by a HealthPath Washington enrollee. The Contractor shall track and record all payments to participating providers and non-participating providers in a manner that allows for the reporting to HCA the number, amount, and percentage of claims paid to participating providers and non-participating providers separately. The Contractor shall also track, document and report to HCA any known attempt by non-participating providers to balance bill enrollees.	5.10.2	This language was taken from the HOBH contract and is directly taken from legislation that passed on this issue. I think our care coordination requirements would cover
5.13.1	NoHLA	More detail should be provided about how such payments will be measured. Also, is this meant to read "13,900.00 per month per enrollee"? It's difficult to see why a cap on inpatient care for ALL enrollees should be established.	5.13.1	updated
5.13.2	NoHLA	Residential Care Discharge Allowance: If funding is not available through Community Transition Services (CTS), or the enrollee is not eligible for CTS funds, the enrollee may be eligible to receive funds through the Residential Care Discharge Allowance (RCDA). RCDA funds may be used for rent,	5.13.2	Deleted
6.1.1	NoHLA	This is the primary authority for Medicare C network adequacy standards for Medicare Advantage plans. Change: 6.1.1 The Contractor shall maintain and monitor an appropriate provider network, supported by written agreements, sufficient to: a) serve enrollees enrolled under this Contract (42 CFR 438.206(b)(1)); and b) provide adequate access to covered services to meet the needs of the population served (42 C.F.R. 422.112(a)(1)(i)).	6.1.1	Updated
6.1.2	NoHLA	Add: 6.1.2 The Contractor shall maintain a network of providers that complies with applicable state and federal standards, including:	ADD NEW: 6.1.X	Updated
6.1.2.1	NoHLA	Add: State and federal law standards applicable to managed care Medicaid plans shall apply to facilities and providers furnishing long term services and supports and other services for which Medicaid coverage is exclusive	ADD NEW: 6.1.X.X	Already addressed under 2.4

6.1.2.2	NoHLA	Add: State and federal law standards applicable to Medicare shall be utilized for pharmacy benefits and for other services for which Medicare coverage is exclusive.	ADD NEW: 6.1.X.X	Already addressed under 2.4
6.1.2.3	NoHLA	Add: Any covered services for which Medicaid and Medicare may overlap, regardless of which is primary, shall be subject to whichever standard is more protective, among the state law, Medicaid, and Medicare standards governing managed care health plans.	ADD NEW: 6.1.XX	This will be addressed in the final contract
6.1.2.4	NoHLA	This frequent front-end monitoring is consonant with Illinois' proposal that plans should be required to analyze network adequacy on a weekly basis in the first three months after implementation, monthly in the next three months and quarterly thereafter. Plans will be required to immediately identify gaps and develop recruiting strategies as necessary. Plans will be required to have contingency plans in case of network inadequacy, a provider contract termination, or insolvency. (Illinois proposal at 12) http://dualsdemoadvocacy.org/wp-content/uploads/2012/02/IL-proposal-4.10.121.pdf Add:; The legal standards to which the Contractor must be comply under this subsection include not only the state and federal statutes and rules or regulations governing health plans' provider networks and the adequacy thereof, but subregulatory requirements implemented by the CMS, HCA, DSHS, DoH, including but not limited to CMS's Health Service Delivery (HSD) standards for Medicare Advantage provider networks. The applicable standards for CY2014 may be found at https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html. CMS shall promptly provide HCA and each MCO with copies of any amendments to these standards, or new standards superseding them in whole or in part, as well as any change in CMS's classification of the population of King or Snohomish County, as a result of which a different set of HSD network adequacy criteria would be applicable to the area for which the classification has changed.	ADD NEW: 6.1.XX	Thank you for your comment
6.1.3	NoHLA	Change: 6.1.36.1.4 The Contractor must submit documentation regarding its maintenance, monitoring and analysis of the network to determine compliance with the requirements of this Section , at any time upon HCA requeston a weekly basis for the first three calendar months during which this Contract is in effect, on a biweekly basis for the following three months, and on a monthly basis for the following six months, and quarterly thereafter, as well as at any time HCA requests , or when there has been a change in the Contractor's network or operations that, in the sole judgment of HCA, would affect adequate capacity and/or the Contractor's ability to provide services (42 CFR 438.207(b & c)).	6.1.3	Thank you for your comment
6.1.5	NoHLA	Add new: 6.1.5 HCA shall verify that the Contractor has sufficient capacity to serve the expected enrollment in its service area(s) and offer an adequate coverage of benefits for the anticipated number of enrollees in the service areas by reviewing demographic, utilization and enrollment data for enrollees, as well as the documentation required to be submitted by the Contractor, pursuant to this section, and: a) the number and types of providers available to provide covered services to the potential enrollee population; b) the number of network providers accepting the new potential enrollee population; and c) the geographic location of providers and potential enrollees as shown through Geo Access or similar software or other appropriate methods. HCA shall review and submit documentation of this to CMS in a format approved by CMS on at least a quarterly basis or upon CMS's request .	ADD NEW: 6.1.X	Thank you for your comment
6.2.1	NoHLA	Change: Considerations for network maintenance and monitoring - In the maintenance and monitoring of its network, the Contractor must consider the following (42 CFR 422.112(a), 42 CFR 438.206(b)):	6.2	Added
6.2.8	NoHLA	Add new: The prevailing patterns of community health care delivery in the areas where the network is being offered, including the factors listed in 42 C.F.R. 422.112(a)(10).	ADD NEW: 6.2.X	Thank you for your comment
6.2.2.1	NoHLA	With the exception of MPC and ABA providers, the added provider and facility types are all ones for which the CMS HSD standards for MA plans set out network adequacy criteria. Add new: 6.2.2.1 Acute inpatient hospitals, cardiac surgery programs, cardiac catheterization services, critical care services/ICU's, outpatient dialysis, surgical services (outpatient or ASC), skilled nursing facilities, diagnostic radiology, mammography, physical therapy, occupational therapy, speech therapy, outpatient infusion/chemotherapy, nurse midwives, nurse practitioners, pediatric nurse practitioners, podiatrists, federally qualified health centers, dentists, pharmacy, inpatient psychiatric facilities, other mental health providers, substance abuse providers, allied health professionals, ancillary providers, DME, orthotics and prosthesis providers, home health providers, transportation providers, personal care providers, applied behavioral analysis providers; and	ADD NEW: 6.2.X	Thank you for your comment

6.2.2.2	NoHLA	Add new: 6.2.2.2 All classes of physicians and other medical specialists necessary to furnish covered services, including but not limited to those who provide the following services: primary care, allergy/immunology, cardiology, dermatology, endocrinology, ENT/otolaryngology, gastroenterology, general surgery, OB/GYN, infectious diseases, nephrology, neurology, neurosurgery, oncology (medical, surgical), oncology (radiation), ophthalmology, orthopedic surgery, physiatry/rehabilitative medicine, plastic surgery, podiatry, psychiatry, pulmonology, rheumatology, urology, vascular surgery, cardiothoracic surgery .	ADD NEW: 6.2.X	Thank you for your comment
6.3.2	NoHLA	Change: 6.3.2 Mechanisms are established and documented in writing to ensure and monitor compliance by providers. Such mechanisms and any changes thereto sought by the Contractor must be approved by HCA at all times during which this Contract is in effect. The Contractor shall submit to HCA a written set of such proposed mechanisms at least sixty (60) days prior to the date on which this Contract becomes effective. The Contractor shall submit to HCA any proposed changes to these mechanisms at least sixty (60) days prior to the date on which the Contractor proposes to implement the changes.	6.3.2	Thank you for your comment
6.3.3	NoHLA	Change: 6.3.3 The Contractor shall monitor pProviders are monitored regularly to determine compliance in accordance with the written mechanisms approved by HCA adopted pursuant to Section 6.3.2..	6.3.3	Thank you for your comment
6.3.5	NoHLA	Add new: 6.3.5 The Contractor shall report to HCA the results of its monitoring in a format approved by HCA at least every three calendar months.	ADD NEW: 6.3.X	Thank you for your comment
6.4	NoHLA	Change: The Contractor must require that network providers offer hours of operation for enrollees that are no less than the hours of operation offered to any other patient (42 CFR 438.206(c)(1)(iii)) and are convenient to the population served under the plan and do not discriminate against Medicare enrollees (42 C.F.R. 422.112(a)(6)).	6.4	Added
6.7	NoHLA	Change: he Contractor shall comply with appointment standards that are no longer than those listed below within this subsectione following, including priority appointments for health home enrollees (42 CFR 438.206(c)(1)(i)). If, after making efforts that are reasonable for the individual enrollee to make to obtain an appointment with an in-network provider, an enrollee is unable to obtain an appointment with such a provider within the below-listed appointment, distance and travel time standards, the Contractor shall cover an appointment for the enrollee with an out-of-network provider meeting the relevant certification, licensure or other applicable professional qualification requirements to provide the type of care in question, provided that: a) for urgent care, the enrollee shall make reasonable efforts to contact the Contractor for assistance in facilitating an appointment; and b) for non-urgent, non-emergent care, the enrollee shall make reasonable efforts to contact the Contractor and cooperate with the Contractor's efforts to arrange for an appointment for the enrollee within the appointment, distance, and travel time standards established within this section of the Contract for the relevant provider or facility type. Such coverage shall be provided to enrollees at no greater cost to the enrollees at no greater cost than would have been assessed for coverable care provided by an in-network provider.:	6.7	Thank you for your comment
6.7.1.1	NoHLA	Change: 6.7.1.1 The Contractor shall ensure that a care coordinator works with the hospital or other facility discharge planner to ensure that an enrollee being discharged from inpatient care has a follow-up medical appointment within seven days of release from the facility. If the enrollee <u>does not first requests it</u> , the care coordinator shall <u>offer to, and upon the enrollee's agreement, accompany the enrollee to the appointment,</u> and shall work with the enrollee to ensure that all prescriptions and follow up instructions are followed by the enrollee and that any additional appointments are scheduled and attended. The care coordinator shall also ensure that a clinical assessment is provided and a care plan developed after discharge from one of these facilities.	6.7.1.1	Added the requested language.
6.7.4	NoHLA	The Contract already defines emergency services in a way that mirrors legal requirements and that is substantially broader than "life-threatening." Consequently, "urgent, symptomatic" care must be something of a less emergent nature than emergency Change: 6.7.4 Urgent, symptomatic office visits shall be available from the enrollee's PCP or another provider within forty-eight twenty-four (2448) hours. An urgent, symptomatic visit is associated with the presentation of medical signs that require prompt immediate attention, but are not emergentlife threatening .	6.7.4	Thank you for your comment

	NoHLA	The proposed 3 day post-discharge and 10 calendar day default standards are taken from the Wisconsin Medicaid standards, Contract For BadgerCare Plus, Art. III(H)(3), p. 49-50, (August 1, 2010), available at http://www.dhs.wisconsin.gov/rfp/DHCF/pdf/Appendix%20A%20-%20Contract%20for%20BadgerCare%20Plus Change: Offer of an appointment for the initial mental health intake assessment by a Mental Health Professional within three (3) days of discharge from a psychiatric hospital and within ten (10) working days of any otherthe request for mental health services. A request for mental health services can be made by telephone, referral, clinic walk-in, or in writing, including writing transmitted in hard copy, by fax or email .	6.7.6	The current standard in the RSN contracts is to offer an app't as follow up to hospitalization within 7 days of discharge and to offer MH intake assessment app'ts within 10 days of request. The standard proposed here is different and due to the scope of the project and the likely number of shared MH providers the difference could be problematic.
6.7.7	NoHLA	Contracted private practice mental health providers must offer an appointment as soon as reasonably possible given individual wait times. If provider cannot meet the 3 day post-discharge wait time or the 10 day standard wait time, whichever is applicable under the circumstances, the provider shall refer the enrollee back to the Contractor for additional care management.	6.7.7	The 3 day standard for post hospitalization MH intake from private MH providers is higher than what's been expected of CMHAs under the RSN structure. This language does not address the timeliness of a non-intake MH app't. Is the language re: referral back to Contractor for additional case management consistent with other Health Home requirements?
6.7.12	NoHLA	The Contract does not define or otherwise indicate how “rehabilitation case management” is different from other “case management.” A significant fraction of dual enrollees may well have a serious psychological, neurological and/or developmental condition that is unlikely to improve substantially over time, but who will require prompt case management services. As such, limiting the availability of prompt case management services to “rehabilitation” case management may well deprive these enrollees of services needed to maintain their health and safety and avoid more costly care.	6.7.12	"Rehabilitation Case Management" is a specific MH service described in the MH SPA. Do we want to include the MH SPA treatment modalities (definitions) in the Benefits Appendix?
6.7.12	NoHLA	It is difficult to see why 5 full days should be required for DSHS or the State only to make a referral, Change: Contractor shall make a referral to DSHS or its designee as soon as reasonably possible and in no case later than within five (5) days seventy-two (72) hours or the next business day (whichever is later) following upon identification through the care coordination process or by the enrollee that the enrollee has unmet long term service and support needs	6.7.12	Thank you for your comment. Reasonably possible is too ambiguous and cannot be monitored for contract compliance.
6.8	NoHLA	The existing system under which HO MCO’s each maintain separate provider databases in different formats that may be difficult to access is confusing and makes it difficult for patients to seek out comparative information about which of their providers or prospective providers are part of which plans’ provider networks. Having one source through which a patient or her/his representative can access all this information will facilitate this process considerably. This is also likely to increase enrollment by avoiding situations in which potential enrollees will avoid enrollment because they are not easily able to determine which plans if any will cover their pre-existing providers or at least easily accessible providers they will require. As HCA is already required to collect provider network databases from the plans, it can and should solve this problem by combining these databases into a format that is searchable to patients or their representatives.	6.8	This is too resource intensive at this time.
6.8.1	NoHLA	Add new: 6.8.1 The Contractor shall provide a copy of this database to HCA on a weekly basis for the first three calendar months during which this Contract is in effect, on a biweekly basis for the following three months, and on a monthly basis thereafter, as well as at any time HCA requests it.	ADD NEW: 6.8.X	This is too resource intensive at this time.
6.8.2	NoHLA	Add new: 6.8.2 HCA shall specify the format in which this database shall be submitted by the Contractor.	ADD NEW: 6.8.X	This is too resource intensive at this time.

6.8.3	NoHLA	The existing system under which HO MCO's each maintain separate provider databases in different formats that may be difficult to access is confusing and makes it difficult for patients to seek out comparative information about which of their providers or prospective providers are part of which plans' provider networks. Having one source through which a patient or her/his representative can access all this information will facilitate this process considerably. This is also likely to increase enrollment by avoiding situations in which potential enrollees will avoid enrollment because they are not easily able to determine which plans if any will cover their pre-existing providers or at least easily accessible providers they will require. As HCA is already required to collect provider network databases from the plans, it can and should solve this problem by combining these databases into a format that is searchable to patients or their representatives Add new: 6.8.3 HCA shall create a database consisting of the combined provider network databases submitted by all Contractors furnishing managed care services to dually eligible individuals under this or substantially similar contracts. HCA shall make this database searchable on its website and upon request by its customer service personnel. HCA shall make this database publicly available for searching online and by customer service personnel no later than 30 days before this Contract goes into effect. HCA shall update this database with the updated data provided to HCA by the individual duals MCO's as frequently as reasonably possible and in no event less often than once every calendar month.	ADD NEW: 6.8.X	This is too resource intensive at this time.
6.9	NoHLA	Add new: 6.9 Medicare Advantage Network Standards The Contractor shall comply with network adequacy standards for MA plans found in 42 CFR §§422.112(a), 423.120, including but not limited to CMS's HSD network standards applicable to MA plans operating in King and/or Snohomish counties in Washington State. For CY2014, these standards may be downloaded at [insert] and include standards for the following provider and facility types primary care, allergy/immunology, cardiology, chiropractor, dermatology, endocrinology, ENT/otolaryngology, gastroenterology, general surgery, gynecology, OB/GYN, infectious diseases, nephrology, neurology, neurosurgery, oncology (medical, surgical), oncology (radiation), ophthalmology, orthopedic surgery, physiatry/rehabilitative medicine, plastic surgery, podiatry, psychiatry, pulmonology, rheumatology, urology, vascular surgery, cardiothoracic surgery , acute inpatient hospitals, cardiac surgery programs, cardiac catheterization services, critical care services/ICU's, outpatient dialysis, surgical services (outpatient or ASC), skilled nursing facilities, diagnostic radiology, mammography, physical therapy, occupational therapy, speech therapy, inpatient psychiatric facility services, orthotics and prosthetics, and outpatient infusion/chemotherapy.	ADD NEW: 6.9.X	Will be addressed with CMS
6.9	NoHLA	It is unclear why individual zip codes need be differentiated between urban and non-urban. CMS generally assigns population labels on a county-by-county basis, for the purposes of applying the applicable HSD network standards. As each county must approve the operation of duals MCO's within its jurisdiction, it makes sense to have a uniform and easily intelligible standard for the county. As CMS designates both King and Snohomish counties as "metropolitan" counties, only the urban standards should apply/. Change: Provider Network -– Distance and Travel Time Standards – Additional to Legal Standards In addition to any other network standards applicable to a Medicaid managed care health plan or Medicare Advantage plan, that are established under state or federal law, tThe Contractor's network of providers shall meet the distance standards below in every service area. HCA will designate a zip code in a service area as urban or non-urban for purposes of measurement. HCA will provide to the Contractor a list of service areas, zip codes and their designation.	6.9	More discussion with CMS

6.9.1	NoHLA	The Medicare Advantage and numerous other network adequacy standards employed in other states require that designated provider types not only be located within a certain distance of all or most enrollees but also that they likely travel time for the enrollee to reach that provider be no longer than a certain period of time. This makes sense, as the critical issue is likely to be how long it actually takes for an enrollee to reach a provider using the means of transportation convenient or available to him or her. As such, the network adequacy criteria listed in section 6.9 should include both distance and travel time standards. CMS's MA standards link a 15 minute travel time with a 10 mile standard, which we suggest adopting here. Similarly CMS HSD standards link a 30 minute travel time with a 20 mile provider distance, and a 45 minute travel time with a 30 mile provider distance. Consequently, we suggest a mid-point in these travel time standard to be included here (approx.. 38 minutes) when linked to a 25 mile provider distance. Change: Urban: 2 within 10 miles and 15 minutes for 90% of enrollees in the Contractor's service area	6.9	Thank you for your comment
6.9.1.2	NoHLA	To the extent possible, enrollees should be given a choice of providers (at least two) within the requisite distance/time travel standards. This principal was adopted in the Massachusetts MOU, which requires MCO's networks to include at least two of the following provider types either within 20 minutes travel time in urban areas or 45 minutes travel time in rural areas: PCP's specialists in every medical and surgical specialties, including obstetricians and gynecologists, outpatient MH providers, hospitals, nursing facilities, community LTSS providers per covered service and pharmacies. This information is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassMOU.pdf Change (PCP): Non-urban: 21 within 25 miles and 38 minutes for 90% of enrollees in the Contractor's service area.	6.9.1.2	Thank you for your comment
6.9.2.1	NoHLA	Change (Obstetrics): Urban: 2 within 10 miles and 15 minutes for 90% of enrollees in the Contractor's service area.	6.9.2.1	Thank you for your comment
6.9.2.2	NoHLA	Change (Obstetrics): Non-urban: 21 within 25 miles and 38 minutes for 90% of enrollees in the Contractor's service area	6.9.2.2	Thank you for your comment
6.9.3.1	NoHLA	Change (Pediatrician or Family): Urban: 2 within 10 miles and 15 minutes for 90% of enrollees in the Contractor's service area.	6.9.3.1	Thank you for your comment
6.9.3.2	NoHLA	Change (Pediatrician or Family): Non-urban: 21 within 25 miles and 38 minutes for 90% of enrollees in the Contractor's service area	6.9.3.2	Thank you for your comment
6.9.4	NoHLA	The Massachusetts MOU provides a differential urban/nonurban standard for hospitals, with the urban standard being 2 hospitals within 20 minutes for all enrollees. It is unclear why a longer distance and travel time limit should be provided here for hospitals in urban settings in King and Snohomish counties, especially if this requirement is only applicable to 90% of the enrollees in the service area. Change (hospital): Urban: 2 within 10 miles and 20 minutes for 90% of enrollees in the Contractor's service area . /	6.9.4	Thank you for your comment
6.9.4.1	NoHLA	Change (hospital) Non-urban: 21 within 25 miles and 38 minutes for 90% of enrollees in the Contractor's service area.	ADD NEW: 6.9.4.X	Thank you for your comment
6.9.5.1	NoHLA	Change (pharmacy): 6.9.5.16.10.5.1 Urban: 21 within 10 miles and 15 minutes for 90% of enrollees in the Contractor's service area.	6.9.5.1	Thank you for your comment
6.9.5.2	NoHLA	Change (pharmacy): Non-urban: 21 within 25 miles and 38 minutes for 90% of enrollees in the Contractor's service area	6.9.5.2	Thank you for your comment
6.9.6.1	NoHLA	Change (MH): Urban: 21 within 10 miles and 15 minutes for 90% of dual eligible enrollees in the Contractor's service area.	6.9.6.1	Thank you for your comment
6.9.6.2	NoHLA	Change (MH): Rural: 21 within 25 miles and 38 minutes for 90% of dual eligible enrollees in the Contractor's service area.	6.9.6.2	Thank you for your comment
6.9.7.1	NoHLA	Change (CD): 6.9.7.16.10.7.1 Urban/Rural: 1 within 25 miles and 38 minutes for 90% of dual eligible enrollees in the Contractor's service area	6.9.7	Thank you for your comment
6.9.8.1	NoHLA	Change: Residential Services: The Contractor will maintain contracts sufficient to ensure enough bed capacity that 90% of clients would be able to move into a residential placement within 1 week of referral or request by and would have the choice of 3 different residential options within at least 2 residential licensed categories (AFH, AL) in a 10 mile radius and 15 minute travel time (Urban) or 25 miles and 38 minute travel time (Rural) of their preferred location.	6.9.8.1	Thank you for your comment

6.9.8.2	NoHLA	Change: Skilled Nursing Facilities: The Contractor will maintain contracts sufficient enough to ensure that 90% of clients would be able to move into twoa skilled nursing facilitiesy within 20 miles and 30 minutes travel of their location of choice and receive an initial intake within 10 days for non-urgent concerns, and within 48 hours if symptoms are of a more urgent nature.	6.9.8.2	Thank you for your comment
6.9.9	NoHLA	Change: 6.9.96.10.9 HCA may, in its sole discretion, grant exceptions to the distance standards listed in section 6.10 of the Contract . HCA's approval of an exception shall be in writing. The Contractor shall request an exception in writing and shall provide evidence as HCA may require supporting the request. If the closest provider of the type subject to the standards in this section is beyond the distance standard applicable to the zip code, the distance standard defaults to the distance to that provider. The closest provider may be a provider not participating with the Contractor.	6.9.9	More discussion with CMS
6.10	NoHLA	This provision may be rendered mostly if not entirely unnecessary by compliance with the HSD Medicare Advantage standards, which encompass all of the provider types listed here, except for geriatrics specialists. However, if the State concludes that plan compliance with MA network standards is not legally required, we nonetheless urge the State to make compliance with those standards mandatory under the contract. It is difficult to understand why duals, who on average are less likely to have the financial resources to supplement Medicare coverage and may well be more likely to have intensive health care needs than non-Medicaid Medicare clients should have access to less adequate provider networks in their managed care Medicare plans than Medicare-only enrollees receive. In any event, HCA should establish the requisite distance and travel time standards, rather than leave it to the discretion of the plans to establish them. The current contract language creates incentives for the plans to adopt standards that with which they believe they can comply relatively easily, rather than those which will ensure adequate network access. frequent monitoring and review of these standards should be required in the initial period of the Contract's implementation. Change: 6.106.11 Distance and Travel Time Standards for High Volume Specialty Care Providers HCAThe Contractor shall establish, analyze and meet measurable distance standards for high volume specialty care providers. At a minimum, there shall be two providers of each of the following provider types within the Contractor's network within 25 miles and 38 minutes travel time of each enrollee: the Contractor shall establish, analyze and meet distance standards for Cardiologists, Oncologists, Ophthalmologists, Orthopedic Surgeons, General Surgery, Gastroenterologists, Pulmonologists, Otolaryngologist, Geriatricians, Psychiatrists, and Specialists in Physical Medicine and Rehabilitation. The Contractor shall analyze assess performance against these standards on a weekly basis for the first three calendar months during which this Contract is in effect, on a biweekly basis for the following three months, and on a monthly basis for the following six months, and quarterly thereafter, as well as at any time HCA requestsat least annually. Analyses and documentation for the standards shall be available to HCA upon request. HCA shall review these standards no later than three (3) and (6) months after this Contract is effective, and again at least every six (6) months thereafter, and implement changes to the standards as appropriate to ensure adequate access to providers for enrollees. HCA shall report to CMS any proposed changes to these standards at least thirty (30) days before their planned date of adoption.	6.10	Will be addressed with CMS It should also be noted that we DO monitor these specialty types - and have been for several months.
6.11	NoHLA	As with the previous subsection, CMS HSD minimum provider numbers should be complied with by MCO's either as a matter of law, or as adopted in this contract, effectively creating minimum provider:enrollee ratios. In any event, HCA rather than the Contractor should establish these standards, and frequent monitoring and review of these standards should be required in the initial period of the Contract's implementation. Change: The Contractor HCA shall establish and meet measurable standards for the ratio of both PCPs and high volume Specialty Care Providers to enrollees. The Contractor shall analyze assess performance against standards at minimum on a weekly basis for the first three calendar months during which this Contract is in effect, on a biweekly basis for the following three months, and on a monthly basis for the following six months, and quarterly thereafter, as well as at any time HCA requests. HCA shall review these standards no later than three (3) and (6) months after this Contract is effective, and again at least every six (6) months thereafter, and implement changes to the standards as appropriate to ensure adequate access to providers for enrollees. HCA shall report to CMS any proposed changes to these standards at least thirty (30) days before their planned date of adoption., annually.	6.11	thank you for your comment

6.13.1	NoHLA	Change:The Contractor shall provide all medically necessary specialty care for enrollees in a service area. If an enrollee needs specialty care from a type of specialist who is not available within the Contractor's provider network, the Contractor shall provide the necessary services with a qualified specialist outside the Contractor's provider network at no additional cost to the enrollee.	6.13.1	There is not a cost to dual eligible or Medicaid enrollees.
6.13.2	NoHLA	Add new: Enrollees with special health care needs who need a specialized course of treatment or regular care monitoring shall be provided by the Contractor direct access to specialists, and no referral by a PCP will be required to afford such individuals this access . Enrollees shall be permitted use a specialist as their PCP, at their choice.	6.13.2	Already in the contract at 14.10.4
6.15.1	NoHLA	Change: HCA shall enroll all eligible clients who affirmatively request enrollment with a HealthPath MCO. Each such client shall be enrolled by HCA or through an independent enrollment broker with the Contractor of the client'sir choice, except as provided herein, unless HCA determines, in its sole judgment, that it is in HCA's best interest to withhold or limit enrollment with the Contractor.	6.14.3	thank you for your comment
6.15.2	NoHLA	Change: HCA may suspend enrollment in any service area if, in judgment of CMS and HCA, it is in the best interest of CMS, HCA and/or their clients. The Contractor will present any information CMS and or HCA requires to make such a decision, exercising their judgment within thirty (30) calendar days of the Contractor's receipt of the request for information.	6.14.4	Will be addressed with CMS
6.15.3	NoHLA	Change: 6.15.36.16.3 The Contractor shall accept clients who are enrolled by HCA in accord with this Contract, and Chapter 182-538 WAC, 42 CFR 122, 42 CFR 438.	6.14.5	Added this language.
6.16.1	NoHLA	Change: 6.16.16.17.1 The Contractor shall give CMS and HCA a minimum of ninety one hundred and twenty (1290) calendar days' prior written notice, in accord with the Notices provisions of the General Terms and Conditions Section of this Contract, of the loss of a material provider. A material provider is one whose loss would impair the Contractor's ability to provide continuity of and access to care for the Contractor's current enrollees and potential enrollees	6.15.1	Thank you for your comment
6.16.2	NoHLA	Change: The Contractor shall make a good faith effort to provide written notification to enrollees affected by any provider termination within fifteen (15) calendar days after receiving or issuing a provider termination notice (42 CFR 438.10(f)(5)). Enrollee notices shall have prior approval of CMS and HCA. If the Contractor fails to notify affected enrollees of a provider termination at least sixty ninety (960) calendar days prior to the effective date of termination, the Contractor shall allow affected enrollees to continue to receive services from the terminating provider, at the enrollees' option, and administer benefits for the lesser of a period ending the last day of the month in which ninesixty (960) calendar days elapses from the date the Contractor notifies enrollees or the enrollee's effective date of enrollment with another plan.	6.15.2	No change.
6.16.3	NoHLA	Change: CMS and HCA reserve the right to reduce premiums paid to the Contractor to recover any expenses incurred by CMS and/or HCA as a result of the withdrawal of a material Subcontractor from a Service Area. This reimbursable expense shall be in addition to any other provisions of this	6.15.3	Made this change.
6.17 (after 6.166.17 Provider Network Changes)	NoHLA	A frequent complaint in managed care, and particularly in publicly funded managed care programs, is that providers that are listed in a health plan's network are not actually available to take new public-pay patients and/or have undeclared significant limits on the number of new public-pay patients they will take on. The first two sentences in this proposed subsection are based on 2008 District of Columbia Medicaid managed care contract with DC Chartered Health Plan, Inc., Contract No. DCHC-2008-D-5052, § C.9.1.2.3.1., p. 127. Add new section: 6.18 Provider Commitment for Inclusion in a Network - Providers who are not accepting new patients shall not be considered in determining compliance with the above network adequacy standards. Providers must demonstrate to the Contractor that they can accept patients while maintaining their overall patient load within professional and industry norms and community standards. The Contractor shall monitor compliance with this subsection and report its results to HCA no less frequently than every three (3) calendar months. HCA shall independently monitor compliance with this provision and report the results of this monitoring no less frequently than after this Contact has been effective for three (3) and six (6) calendar months, as well as at least every six (6) months thereafter.	ADD NEW: 6.XX	Thank you for your comment
9.4.12.13	NoHLA	Change: 9.4.12.3 The enrollee's right to request continuation of benefits during an appeal or hearing and, if the Contractor's action is upheld, the enrollee's responsibility to pay for the continued benefits for a maximum of the first sixty (60) days during which such benefits were continued .	9.4.12.3	Updated

9.13	NoHLA	Change: The Contractor's policies and procedures shall follow the requirements related to the credentialing and recredentialing of health care professionals who have signed contracts or participation agreements with the Contractor (42 CFR 422.204(a), 42 CFR 438.12(a)(2), 438.206(a) and (b), and 438.214; 42 CFR 455.410 through 455.412; 42 CFR 455.416 through 455.432; 42 CFR 455.436 through 455.450). The Contractor shall ensure compliance with the requirements described in this Contract.	9.13	42 CFR 422.204(a) is a Medicare Advantage requirement. CMS guidance on credentialing is to use Medicaid's credentialing process.
10.1.1	NoHLA	Change: The Contractor shall comply with any applicable Federal and State laws that pertain to enrollee rights and ensure that its staff and affiliated providers take protect and promote those rights into account when furnishing services to enrollees (42 CFR 438.100(a)(2)).	10.1.1	Thank you for your comment.
10.1.2.7	NoHLA	This right is guaranteed in 42 CFR 438.100(b)(2)(I); however, we would not be averse to the Contract specifying in greater detail the specific requirements of 42 CFR 438.10. Add new: To receive information in accordance with 42 CFR 438.10. (42 CFR 438.100(b)(2)(i))	ADD NEW: 10.1.2.X	This request adds a new requirement to enrollee rights. 42 CFR 438.10 is included in 4.3 Information Requirements for Enrollees and Potential Enrollees.
10.3	NoHLA	Change: 10.3 Advance Directives and Physician Orders for Life Sustaining Treatment (POLST) Add: POLST to entire section whenever it states advance directives.	10.3 ALL	More discussion needed
10.4.6	NoHLA	Change: The Contractor may limit HO enrollees' ability to change PCP's in accord with the Patient Review and Coordination provisions of Exhibit A, Health Options Provision s.????	10.4.7	This language has been removed from the contract. Patient Review and Coordination is not applicable to Medicare enrollees.
10.7	NoHLA	Change: The Contractor must provide female enrollees with direct access to a women's health specialist within the Contractors network for covered care necessary to provide women's routine and preventive health care services in accord with the provisions of WAC 284-43-250, 42 CFR 422.112(a)(3), and 42 CFR 438.206(b)(2).	10.8	42 CFR 422.112(a)(3) is a Medicare Advantage requirement and will be negotiated with CMS.
10.9.3	NoHLA	Add new section: The Contractor shall not deny, limit, or condition the coverage or furnishing of benefits to enrollees offered by the Contractor on the basis of any factor that is related to health status, including but not limited to medical condition, including mental as well as physical illness, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, including conditions arising out of acts of domestic violence, disability. (42 CFR 422.110)	10.10.3	42.CFR 422.110 is a Medicare Advantage requirement and will be negotiated with CMS.
11.1.5	NoHLA	Change: 11.1.5 TUpon request the Contractor shall provide HCA with meeting minutes and a written description of the UMP that includes identification of designated physician and behavioral health practitioners and evidence of the physician and behavioral health practitioner's involvement in program development and implementation. New meeting minutes shall be provided to HCA no later than five (5) working days after the meeting they document, as well as upon HCA's request. The written description of the UMP shall be provided to HCA at a time designated by HCA no earlier than ninety (90) days prior to the effective date of this contract, and on a quarterly basis after the contract goes into effect, as well as upon request by HCA. HCA shall review and document the review of these materials no later than fourteen (14) days after the materials are received by HCA.	11.1.4	Thank you for your comment.
11.1.6.2	NoHLA	Change: The Contractor's Medical Director, in consultation with a health care professional designated by the Contractor's Chief Executive Officer who has substantial current practice experience in the area covered by a recommendation, shall review and follow the recommendations of the Health Technology Assessment (HTA) program promulgated by HCA (Chapter 182-55 WAC). The Contractor shall not provide coverage of services that is less in type, amount, duration or scope than that recommended by the HTA program.	11.1.6.2	Being reviewed
11.1.6.12	NoHLA	Change: Use of board certified consultants to assist in making medical necessity determinations. Such consultants shall be independent contractors who are not employees of the Contractor and who do not have any other conflict of interest that would affect or be reasonably perceived as affecting their recommendations regarding medical necessity.	11.1.6.12	Made this change.
11.1.6.15	NoHLA	Add new section: 11.1.6.15 The methods and procedures to be followed for reviewing and updating the UMP criteria. (WAC 284-43-410(2)).	ADD NEW: 11.1.6.XX	Updated
11.1.7	NoHLA	Change: eEvaluate and update the UMP at least annually.	11.1.7	Updated

11.2	NoHLA	It is unclear how the utilization management requirements would yield a determination of what services are medically necessary to the extent that they are not coextensive with the Contract's/WAC's definition of medically necessary services. At best, this is confusing. At worst, it improperly it denies coverage of medically necessary services in a way that is likely to be misunderstood by enrollees. Medicaid caselaw requires that the authorizing agency give deference to a beneficiary's treating health care professional's exercise of professional judgment that a given service is medically necessary. This doesn't preclude the plan from overruling a client's provider's judgment that a given course of treatment is medically necessary. The provider might have applied medical necessity criteria that are incompatible with the Contract/WAC definition. Or the judgment might clearly be unsupported by the medical evidence. However, this "presumption" in favor of the treating professional not only ensures that the judgment of the individual most familiar with the patient will generally be respected, when exercised properly, but provides a disincentive for plans to use of the UMP to limit care by requiring patients to appeals to obtain relatively uncontroversial but expensive needed treatment. It is unclear what purpose this "finality" provision is meant to serve. In the absence of a clear purpose or meaning, it should be deleted. State should be determining what's medically necessary. Change: The Contractor shall determine which services are medically necessary, according to utilization management requirements and the definition of Medically Necessary Services in this Contract. In determining whether a prescribed covered service is medically necessary, the Contractor shall give deference to the opinion of the enrollee's prescribing provider . The Contractor's determination of medical necessity in specific instances shall be final except as specifically provided in this Contract regarding may be informally reconsidered by the provider or appealed through the process described in Sec. 13 of this Contract. appeals, hearings and independent review .	11.2	Being reviewed
11.3	NoHLA	This language is modeled after Connecticut Public Act 10-3, § 22(b), (2010), codified at Conn. Gen. Stat. § 17b-259b, available at http://www.cga.ct.gov/2011/pub/chap319v.htm#Sec17b-259b.htm. *See also* CT Behavioral Health Partnership – Child Psychiatric Level of Care Guidelines, p. 1, (May 2012), *available at* http://www.ctbhp.com/providers/pdfs/Child_BHP_Level_of_Care_Guidelines.pdf. It is unclear that there is a legal basis for individual MCO's choosing their own assessment tools to us as a basis for covering enrollees' LTSS services in a lesser amount, duration or scope than the enrollees would otherwise be entitled to receive. In any event, this policy seems likely to drive enrollees who require LTSS out of MCO's, if it is actually exercised, although such individuals may well benefit more from the care coordination provided by such health plans. Furnishing an enrollee LTSS more broadly than would otherwise be indicated pursuant to Sec. 11.3 cannot be conditioned on a denial of or an agreement by an enrollee to forgo requesting or receipt of other services or exercising any rights to which the enrollee is entitled. Change: For enrollees receiving LTSS, the contractor shall not deny services for enrollees who have been eligible for services based on their functional impairment in accordance with WAC 388-106-0300 through 388-106-0335. 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 . However, t 11.3.1 The Contractor has the discretion to authorize LTSS more broadly in terms of service eligibility criteriacriteria, type of service, amount, duration and scope, if the Contractor determines that such authorization would provide sufficient value to the Enrollee's care. Value shall be determined in light of the full range of service included in the care plan. 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 .	11.3	Updated
11.4.4.2E	NoHLA	Add new E: The title of the rule, guideline, protocol or other criterion that was used the basis for the decision, as well as the page, section and other appropriate information that identifies the criterion specifically within the document in which it is found.	ADD NEW: 11.4.4.2.2.X	The contractor is already required to provide a copy of the rule, guidline, protocol or other criterion - I added a requirement to give the title of the document.

11.4.4.2H	NoHLA	Change H: The enrollee's right to file an appeal either through the in-plan appeal process, or by proceeding directly to the state administrative and/or Medicare appeals procedures (whichever is or are applicable to the action at issue), including what rights will be given up, if the enrollee elects to forgo an in-plan appeal.	11.4.4.2.2.6	We are not allowing direct access to the state or federal fair hearing process.
11.4.4.2I	NoHLA	(I): The Contract should specify the ombuds service(s) to which this refers, including but not limited to the independent HealthPath ombuds service.	11.4.4.2.2.7	This will be addressed outside of the contract
11.4.4.2N	NoHLA	Change O: In denying services and notices to enrollees, the Contractor will may only deny a service as non-covered if HCA has determined that the service is non-covered under the fee-for-service program. For services that are excluded from this Contract, but are covered by HCA, the Contractor will direct the enrollee to those services and take all reasonable steps required to coordinate and insure the enrollee's receipt of those services.	11.4.4.2.5	Made this change.
11.4.5.5	NoHLA	For example, if a client with LEP has previously requested notices be provided in Spanish, the notice should be translated, except to the extent that an emergent situation might require that initial notice be provided in another manner (e.g., orally through an interpreter) with follow-up notice translated in writing. Change: 11.4.5.5 For all adverse determinations, the Contractor must notify the ordering provider, facility, and the enrollee. The Contractor must inform the parties in advance whether it will provide notification by phone, mail, fax, or other means. The notice provided to the enrollee shall be in a form that complies with state and federal law and that is accessible to and understandable by the enrollee and, when possible, in a format and manner requested by the enrollee. For an adverse authorization decisions involving an expedited authorization request the Contractor may initially provide notice orally, to the extent that this is compatible with the duty to provide notice in a form and manner that is understandable and accessible to the enrollee. For all adverse authorization decisions, the Contractor shall provide written notification within seventy-two (72) hours of the decision. (PBOR, WAC 284-43-410).	11.4.5.5	thank you for your comment
11.5.1	NoHLA	Change: 11.5.1 In determining whether a service that the Contractor considers experimental or investigational is medically necessary for an individual enrollee, the Contractor must have and follow policies and procedures that mirror the process for HCA's medical necessity determinations for its fee-for-service program described in WAC 182-501-0165. Medical necessity decisions are to be made by a qualified healthcare professional and must be made for an individual enrollee based on that enrollee's health condition. The policies and procedures shall identify the persons responsible for such decisions. The policies and procedures and any criteria for making decisions shall be approved by HCA prior to the effective date of this contract, and any proposed changes thereto shall be approved by HCA prior to effective date of the change. The Contractor shall provide this information to prospective enrollees upon request, and to enrollees no later than (5) days after enrollment and at least annually thereafter. The Contractor shall also post such procedures on its website	11.5.1	Thank you for your comment
11.5.2	NoHLA	The meaning and purposes of this section is unclear.	11.5.2	thank you for your comment
11.5.3	NoHLA	Change: 11.5.3 An adverse determination made by the Contractor shall be subject to appeal through the Contractor's appeal process, hearing process and independent review, pursuant to Sec. 13 of this Contract..	11.5.3	HCA is actively review the appeal process with CMS and will make changes as appropriate
11.6	NoHLA	Change: The Contractor shall comply with all Office of the Insurance Commissioner (OIC) regulations regarding utilization management and authorization of services unless those regulations are in direct conflict with Federal regulations. Whenre the Contractor believes that there is a reasonable likelihood of conflict between state and federal legal authority, it shall promptly contact the state agency responsible for promulgating or implementing the state authority in question (e.g., HCA for WAC 182-538; the OIC for WAC 243-53). That agency will direct the Contractor on the proper interpretation of the state authority in questionit is necessary to harmonize Federal and state regulations, HCA will direct such harmonization. If an OIC regulation changes during the Period of Performance of this Contract, the OICHCA will determine whether and when to apply the regulation. If the OIC fails to provide the Contractor direction in this matter after a reasonable period of time has elapsed, which shall be no less than 14 (fourteen) days after the OIC receives the request for direction from the Contractor, except when the direction is sought regarding the application of legal authority to a pending expedited appeal or grievance, then the Contractor shall redirect the inquiry to the HCA, and HCA shall determine whether and when to apply the regulation.	11.6	Imposes a contract requirement on the OIC who is not a part to the contract.

13.1	NoHLA	Change: The Contractor shall have a grievance system which that complies with the requirements of 42 CFR 422 Subpart M and 42 CFR 438 Subpart F, as well as and Chapters 182-538 and 284-43 WAC, insofar as those WACs are not in conflict with 42 CFR 422 Subpart M and 42 CFR 438 Subpart F. The grievance system shall include a blended Medicare and Medicaid grievance process,. NOTE: Provider claim disputes initiated by the provider are not subject to this Section.	13.1	I am not sure what this comment means. What part is being requested to be changed and to what langauge ?
13.1.2.1	NoHLA	Change: A grievance may be called a grievance or complaint and is defined in Sec. 1.__ of this Contract.may be an expression of dissatisfaction with the manner in which the Contractor or delegated entity provides health care services, such as quality of care received or rudeness. In addition, a grievance may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure or item	13.1.3	I am not sure what this comment means. What part is being requested to be changed and to what langauge ?
13.2.3	NoHLA	Change: 13.2.3 The Contractor shall assist the enrollee with all grievance and appeal processes (WAC 284-43-615(2)(e)). HCA, together with the Contractor, HealthPath ombuds staff, staff of the State Protection and Advocacy System, and stakeholder representatives shall develop standard protocols for Contractor staff to follow in providing this assistance in a manner that is accessible and understandable to enrollees and culturally competent. Contractor staff shall receive training in this, including training in enrollee rights, the grievance and appeal process, cultural competency, and disability accommodation. on at least an annual basis in a format approved by HCA together with the Contractor, staff of the State Protection and Advocacy System, HealthPath ombuds staff, and stakeholder representatives.	13.2.3	We cannot comment to this requested change at this time. Please provide us more information about your request.
13.2.7	NoHLA	Change: 13.2.7 The Contractor shall complete the disposition of a grievance and notice to the affected parties as expeditiously as the enrollees health condition requires, but no later than thirty forty-five (3045) calendar days after from receipt of the grievance, although the thirty (30) day deadline may be extended up to fourteen (14) days upon the request of the individual filing the grievance or if the Contractor justifies a need for additional information, documents how the delay is in the interest of the enrollee, and immediately notifies the enrollee in writing of the reasons for the delay . (42 CFR 422.564(e)	13.2.7	Unclear what purpose the requested change seeks to make.
13.3.1	NoHLA	Change: 13.3.1 An enrollee, the enrollee's authorized representative, or a provider acting on behalf of the enrollee and with the enrollee's written consent, may appeal a Contractor action (42 CFR 438.406(b)(1)). In doing so, the individual requesting the appeal should indicate whether he or she wishes to pursue an in-plan appeal to the Contractor or appeal the matter directly to a state fair hearing and/or the Medicare appeal process.	13.3.1	We are not allowing direct access to the state or federal fair hearing process.
13.3.6	NoHLA	The Contract should extend continued benefits to services funded only by Medicare for the entire period of a timely requested beneficiary's appeal, including through the non-plan (federal administrative) appeal process. We understand that continued benefits are not generally required for appeals of terminations or reductions of services authorized by Medicare. However, the Medicare statute does not affirmatively preclude providing continued benefits in this situation. And, even if it did, the broad MMCO/CMMI waiver authority should permit the extension of continued benefits to post-plan Medicare appeals. Moreover, the mandate to provide continued benefits pending appeals flows from the long-standing line of cases beginning with Goldberg v. Kelly holding that recipients of "brutal needs" public benefits are entitled to pre-deprivation hearings to challenge a proposed deprivation of those benefits. When a hearing cannot be scheduled sufficiently in advance of a planned reduction/termination of services, the only way to offer the affected beneficiary a post-deprivation hearing is to offer her or him continued benefits pending the completion of the appeal. One might assert that a program without means testing, such as Medicare, is not such a "brutal needs" benefit and so continued benefits are not generally required pending a hearing challenging a change in Medicare services. . However, it is difficult to argue that health care is any less of a brutal need for a dual eligible (who is necessarily low income), than it is for someone eligible for Medicaid alone, regardless of the specific program paying for that care. Moreover, denying duals medically necessary Medicare-funded care pending the resolution of a successful appeal seems likely to result in the sort of avoidable and costly care disruptions that the duals program is designed to avoid. Thus, as a matter of law and policy, continued benefits should be extended to appellant enrollees who timely request them regardless of the source of funding for the health care services at issue. Change: 13.3.6 Once the beneficiary has exhaustedcompleted the Contractor's internal appeal process and is engaged in the external appeal process, Medicaid only services will continue .	13.3.6	We disagree. For the first time ever, CMS is looking at allowing continuation of services at the plan appeal level only. This will not be extended past the plan level appeal.

13.3.9	NoHLA	Change: The appeal process shall provide the enrollee and the enrollee's representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeal process or that are otherwise relevant to the appeal (42 CFR 438.406(b)(3)).	13.3.9	HCA is actively review the appeal process with CMS and will make changes as appropriate
13.5.2.2	NoHLA	Change: 13.5.2.2 For hearings regarding termination, suspension, or reduction of a previously authorized service, if the enrollee requests continuation of services, within ten (10) calendar days of the date of the	13.5.2.2	Continuation of services for Medicare services will be limited to the plan level appeal. We are working with CMS.
13.5.6	NoHLA	We join with the AARP and NHeLP and the National Senior Citizens' Law Center in the strong recommendation that individuals not be required to exhaust in-plan remedies to avail themselves of the administrative appeal process. This appears to be what is contemplated in the Ohio MOU at p. 67 ("Initial appeals for Medicaid service denials will be made to the ICDS Plan and/or the Bureau of State Hearings). Delete: entire section	13.5.6	We are not allowing direct access to the state or federal fair hearing process.
13.6	NoHLA	Change: After exhausting both the Contractor's appeal process and the state administrative hearing process, an enrollee has a right to independent review in accord with RCW 48.43.535 and WAC 284-43-630.	13.6	We are reviewing the citations and will make modications as appropriate.
13.7.1	NoHLA	Citations to the relevant provisions governing Medicare appeals should be included in the sections of the Contract governing Medicare appeals. Change: If, on internal appeal, the Contractor does not decide fully in the Enrollee's favor within the relevant time frame, tThe Contractor shall automatically forward the enrollee's case file to the CMS Independent Review Entity for a new and impartial review if and when either: a) the enrollee requests a Medicare Appeal of a Contractor's action within the relevant timeframe; or b) if on internal appeal the Contractor does not decide fully in the enrollee's favor within the relevant timeframe.	13.7.1	We agree that the Medicare citations should be added. We are working with CMS on the appeals section and will edit as appropriate.
13.8	NoHLA	Please move to a section before discussing the Medicare process. It was confusing seeing the process so blended. Made it seem like clients come file a Petition for Review with HCA's BOA after a Medicare IR. 42 CFR 438.424 requires the MCO to pay for/authorize/provide services required by a state hearing officer. There is no provision allowing the MCO to appeal further (e.g., to the Board of Appeals, HCA review judge, or IRO). See Sec. 13.11 of the Contract, below. Additionally, "[c]arriers must timely implement the certified independent review organization's determination…" RCW 48.43.535(8). Consequently, health plans are not legally permitted to appeal IRO decisions to a state administrative appellate body, like the BoA or HCA review judge. HCA likely has the right to appeal an adverse OAH decision that dictates that HCA take some action independent of the Contractor's responsibilities to furnish services to the enrollee under the contract (e.g., a decision requiring HCA to authorize or provide Medicaid services to which the enrollee is entitled under a HCBS waiver that are not furnished under the contract). However, it is unclear that HCA would have standing to appeal a determination that the Contractor must provide services to which an enrollee is entitled under the Contract. In any event, even if HCA had standing to appeal, there is little reason for HCA to incur the additional expense of pursuing an appeal and place the additional burden on the client to respond to the agency's appeal, when HCA has little if anything to gain by continuing to press for review. Also, if HCA could appeal an OAH or IRO decision to the BoA, even when it has no interest of its own at stake, that would effectively allow HCA to shield plans from state and federal law requiring the plans to adhere to state hearing officer and IRO decisions, by appealing any such decisions adverse to the plans essentially on the plans' behalf. Change: If an enrollee, the Contractor, or HCA disagrees with the results of the administrative hearing or independent review after a state fair hearing, any party he or she may appeal the decision to HCA Board of Appeals in accord with Chapter 388-526 or 182-526 WAC, whichever is in effect. If HCA disagrees with the results of an administrative hearing that requires to HCA to take some action regarding the determination of the enrollee's eligibility for or entitlement to services, independent of the Contractor's duty under this Contract, HCA may appeal the decision to HCA Board of Appeals in accord with Chapter 388-526 or 182-526, whichever is in effect . Notice of this right will be included in the written decision from the administrative hearing or Independent Review Organization.	13.8	We will reorganize the sections. We disagree that MCOs and the HCA are precluded from appealing to the HCA Board of Appeals. See WAC 182-526-0200, effective Feb 1, 2013. [And previous versions of emergency rules in Chapter 388-526, Chapter 182-538 WAC, and previous versions of Chapter 388-538 WAC and Chapter 388-02 WAC (prior to 7/1/11)]-- All parties to a hearing have always had the right to appeal decisions to the Medicaid agency Board of Appeals. This is not new. Also See 42 CFR Sect. 431.10(e).
13.10	NoHLA	Seems like this section should be moved up to after the state Petition for Review Process before Medicare appeal process. This only applies to Medicaid appeal process.	13.10	We will be reorganizing some of the sections.

13.10.1.4	NoHLA	MCO's should not be permitted to shorten the 10 day window for enrollees to request review with continued benefits by issuing a reduction/termination notice too close to the completion of the authorization period to allow an appeal with continued benefits any time within that 10 day window. Also, as discussed below in comments regarding Sec. 13.10.2.5, cutting off enrollee's continued benefits at the end of a service authorization period that expires in the middle of an appeal for which continued benefits were initially timely requested is generally incompatible with enrollee's rights to due process, pursuant to Goldberg v. Kelly and its progeny. Delete: 13.10.1.4 The original period covered by the original authorization has not expired .	13.10.1.4	We disagree.
13.10.2.5	NoHLA	As discussed above, it is black-letter law flowing from the U.S. Supreme Court case, Goldberg v. Kelly, that public benefits beneficiaries, such as Medicaid recipients are entitled to continued benefits pending their appeal of a termination or reduction of those services. An MCO's preference for imposing what may be arbitrarily short reauthorization periods on particular services cannot trump or allow plans to circumvent the need to comply with patients' constitutional rights to receive continued benefits when they appeal a plan decision to reduce or terminate those needed health care services. This is particularly true when the services are meant to address a chronic condition or an ongoing course of treatment which, if the enrollee succeeds with her or his appeal, will be expected to continue for a significant period of time. Consequently, this requirement should be deleted altogether, or a series of additional requirements instituted to ensure that clients' right to continued care for ongoing health care needs are not squelched by plans' administrative decisions to impose authorization periods the length of which are disconnected from medical concerns. Delete: 13.10.2.5 The time period or service limits of a previously authorized service has been met .	13.10.2.5	We disagree.
13.10.3	NoHLA	At focus group, legal advocates questioned whether this comports with limit of recovery (not sure if there was some past case law?) Needs follow-up. Suggest leaving it as is, but under review. State law limits overpayment recovery to costs incurred in the first 60 days of an unsuccessful appeal. WAC 388-410-0001(3). Moreover, it is my understanding that, in practice, the State has generally not pursued recovery of such overpayments for medical services against this low income Medicaid population. Overpayment recovery policies must be the same for fee for service clients as they are for clients participating in this managed care program. If they will NOT be the same, then this issue must be fully disclosed to prospective enrollees at any point this issue is relevant in a decision to enroll or elect not to disenroll. Change: If the final resolution of the appeal upholds the Contractor's action, the Contractor may recover from the enrollee the amount paid for the services provided to the enrollee, or the premium paid the Contractor by HCA for the enrollee, whichever is lesser, for the first 60 days during which while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services.	13.10.3	We are reviewing this section to determine whether WAC 388-410-0001 applies to service level continuation of services (as opposed to contination of eligibility for which the WAC was written about).
13.12.2	NoHLA	Change: The records shall include actions, grievances and appeals handled by delegated entities, all documents generated or obtained by the Contractor in the course of responding to such actions, grievances and appeals.	13.12.2	Unclear as to what benefit the requested language provides. We believe the reporting section is adequate.
13.12.10	NoHLA	Change: Reporting of grievances shall include, but will not necessarily be limited to all expressions of enrollee dissatisfaction with the Contractor, its agents, their providers, and these entities' activities that are not not related to an actions, as defined herein, and manner in which the grievance was disposed of, regardless of how the grievance was addressed . All grievances are to shall be recorded and counted whether the grievance is remedied by the Contractor immediately or through its grievance and quality of care service procedures.	13.12.10	Unclear as to what benefit the requested language provides. We believe the reporting section is adequate.
14.24.3.3	NoHLA	Thirty days seems likely to be a low and sometimes inadequate period of time to facilitate such a transition. Although the draft language provides for the possibility of extensions, it will likely help to ensure that safe and appropriate transition care choices are made for patients without undue pressure on them to accept inadequate or inappropriate care options by extending the presumptive service continuation period to 90 days. Change: If the Community based residential facility where the enrollee is currently residing is not a contracted provider, the Contractor shall provide continuation of services in such facility for at least ninety (930) days, which shall be extended as necessary to ensure continuity of care pending the facility's contracting with the Contractor or the enrollee's transition to a contracted facility; if the member is transitioned to a contracted facility, the Contractor shall facilitate a seamless transition to the new facility.	16.3.3.3	Updated

14.33	NoHLA	Change: The Contractor shall develop policies and procedures that describe the measures taken by the Contractor to address instances when an enrollee refused to sign the plan of care, including actions taken to resolve any disagreements with the plan of care and shall involve the consumer advocate HealthPath ombuds service in helping to facilitate resolution.	16.2.5	Thank you for your comment.
14.44	NoHLA	We believe this section to be unnecessary, as we strongly recommend that all enrollees be permitted to choose a specialist as their PCP, and that all enrollees with special health care needs be allowed direct access to specialists without referrals, when they require regular specialty care or monitoring. as noted above. If this proposed changes is not adopted. Delete entire section	14.10.4	Thank you for your comment
4.10.5.2	AARP	The information required to be available should be provided to all enrollees without their having to specifically request it and should Include objective quality and credential data on the Contractors. Prior to enrollment the clients should receive a list of all care providers that tehy have used and an indication of wether all such providers are in the network. If there are providers not in the network that the client uses they should be told so and that they will not be able to use that provider. For areas where there are more than 1 MCO the client shuld be enrolled with the MCO that best matches their current medical care providers.	4.3.5.2	This is resource intensive.
4.10.5.7	AARP	The information required to be available should be provided to all enrollees without their having to specifically request it and should include objective quality and credential data on the Contractors.	4.3.5.7	This is resource intensive.
4.10.5.8	AARP	The information required to be available should be provided to all enrollees without their having to specifically request it and should Include objective quality and credential data on the Contractors.	4.3.5.8	This is resource intensive.
7	AARP	LTSS measures are primarily facility focused and should be modified to better reflect HCBS as well. Possibilities: preventable infections, medication errors, use of physical or medication restraints, bed sores; and report assistance and coordiation in access to HCBS services (housing, nutrition services, transportation, home mods.). Suggest measures issued in Strategic Approach to Performance Measurement for Dual Eligible Beneficiaries.	7	Will be discussed with CMS
6.6.4	AARP	Add: an additional measure regarding consumer experience in terms of call "hold" time.	ADD NEW: 6.6.4.X	Updated
6.6.4	AARP	Add: include measures regarding obtaining a timely decision on a request for better services (not just appt. standards)	ADD NEW: 6.6.4.X	Thank you for your comment
5.8	AARP	Add: measures regarding significant reductions in the quantity or cost of care based on Medicare and Medicaid data on curretn plans of care and costs	ADD NEW: 5.X	Will be discussed with CMS
11.1.6.7	AARP	Add: measures regarding significant reductions in the quantity or cost of care based on Medicare and Medicaid data on curretn plans of care and costs	11.1.6.7	Will be addressed with CMS
6.5	AARP	Change: state explicitly that certain LTSS are avaialbe on a 24/7 basis, as in MA contract	6.5	Thank you for your comment.
6.7.12, 7.9	AARP	Add: Require the care coordinator to also work with clients who change LTSS providers to ensure a better transtion, including accompanying them to a follow up appt. if requested beyond this section+C15	ADD NEW: 6.7.12.X & 7.9	See 16.3.2
6.7.12	AARP	Add: appt. time limits for someone who is newly identified as needing LTSS (beyond referral to DSHS within 5 days as noted in this section	ADD NEW: 6.7.12.X	Time limits beyond the referral process are outside of the MCO control
6	AARP	Add: a measure including notification of rights, treatment options and provider choices whenever a client is being asked to make a decision or denied any requested coverage.	ADD NEW: 4.3.5.XX	Thank you for your comment.
1.1	AARP	Change: definition of "action" should expand to include when a person centered plan is unacceptable to the enrollee (language in MA)	1.1	Thank you for your commnet
13.5.6	AARP and W4A	Recommend enrollees not have to exhaust the MCOs appeals process before seeking a administrative hearing.	13.5.6	We are not allowing direct access to the state or federal fair hearing process.
13.12	AARP	Have contractors record and report the portion of appeas in which a denial of coverage is eventually overturend and whether the appeals assistance was provided to enrollees	13.12	HCA is actively review the appeal process with CMS and will make changes as appropriate
4.10.5.19 and 11.4.4.2I	AARP	Suggest an Ombudsman be available to receive and respond to complaints, monitor overall demonstratin activieys and to identify systemic problems.	4.3.5.16.3 & 11.4.4.2.2.7	Will be addressed outside of the contract.
	AARP and W4A	Suggest no passive enrollment with the 90 day retention period.		Thank you for your comment.
6.7.9	Sno.County	Change: Suggest adding a timeline for asssessments and treatment admission for non-IUD similar to required by IUD.	6.7.9	Agree- change made.
6.7.11	Sno.County	Change: Adding detoxification services in addition to crisis services, E&T, Stabilization and Rehab CM. Detox is a key service within the CD crisis system.	6.7.11	Agree- change made.
6.9.6 & 6.9.7	Sno.County	Change: urban/rural distance stadards for MH and CD should be the same	6.9.6 & 6.9.7	Agree- change made.

7.8	Sno.County	Change: Section heading should be expanded to reference MH as well as CD to add clarity.	7.8	Agree- change made.
5.9	WSHA	The states Medicaid contract language is used as the benchmark for hospital payment rates for participating and nonparticipating hospitals. We do not think this is appropriate given Medicare is the primary payer for hosptial services for duals. Medicare hospital rates should be the floor in starting the negotiations between the contractors and hospitals.	5.9	Updated
6.9.8.2	WSHA	Network adequacy provision for skilled nursing care is not sufficient. Hospitals currently have a considerable challenges in placing Medicaid patents in skilled nursing facilities. We would like to see strong standards for network adequacy for skilled nursing care or incentives to assure attention is given to appropriate placements. Ex. it could require the MCOs to pay hospitals fro administratively necessary days while the patient waits in the hospital for a bed. Add: a requirement that skilled nursing care is available within a reasonable time frame	6.9.8.2	Thank you for your comment.
5.1O	WSHA	Change: language referencing "non-participating providers" should be removed. WSHA does not believe it applies to Medicare beneficiaries under Title XVII as referenced by Senate Bill 5927.	5.1	Discuss with CMS
	WSHA	Medicare Advantage plans and Medicare FFS beneficiaries pay Critical Access Hospitals their costs for services and this contract should reflect this practice.	5.9 or ADD NEW: 5.XX	Will be addressed with CMS
6.9 & 6.1O	WSHA	Instead of allowing the plan to establish standards, the contract should require the plans to contraxct with one of each of the ten types of speciialists every 25 mmiles for 90% of enrollees.	6.9 & 6.10	HCA has the ability to monitor specialty contractors with an eye on what area of the state and specialty type the provider is.There are not specialists every 10 miles in some rural areas
	WSHA	Add: A Preamble that clearly states the contractor must meet Medicare Advantage Plan rules. (MA contract)	ADD NEW	Will be addressed with CMS