ENROLLMENT: CONTRACT EXAMPLES

Below are four examples of contract language, which highlight the varying approaches to enrollment in MLTSS programs. The first example is from the Massachusetts' Senior Care Options program, which is a voluntary program that requires the contractor to assist the enrollee in obtaining a primary care physician (PCP) upon enrollment, conduct an initial assessment of the enrollee's selection within 30 days, and conduct an annual evaluation of enrollee orientation activities. The second example is from the New Mexico Coordination of Long-Term Services (CoLTS) contract, which stipulates that the contractor is responsible for all medical conditions of new enrollees, specifying that it may not discriminate on the basis of health status, race, ethnicity, or sexual orientation. The third example comes from Pennsylvania's Adult Community Autism Program (ACAP), which stipulates that all new enrollees must be given a program handbook and develop an enrollment agreement that meet certain specifications. The final example from Texas shows how some states require MLTSS contractors to use existing state assessment instruments.

Massachusetts Senior Care Options

From MassHealth Senior Care Options, Section 2.3, Enrollment Activities.

A. Enrollment

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2. The Contractor may, on behalf of a MassHealth Member, submit enrollments and disenrollments. The Contractor must utilize enrollment forms that are approved by EOHHS and CMS, and must maintain on file such forms that are signed by Enrollees…

B. PCPs

1. *PCP Selection*. Upon enrollment, the Contractor must assist the Enrollee to choose a PCP and to assist in the selection of a new PCP whenever necessary. If the Enrollee has not selected a PCP by the effective date of enrollment, the Contractor must assign a PCP…

C. *Initial Assessment*. The Contractor must complete an Initial Assessment within 30 calendar days of an Enrollee's selection of a PCP. If the Enrollee is in an institution or institutional placement is pending, the Contractor must complete an Initial Assessment within five business days. The Initial Assessment must include:

1. An evaluation of clinical status, Functional Status, nutritional status, and physical well-being;
2. The medical history, including relevant family members and illnesses;
3. Screenings for mental-health status, and tobacco, alcohol and drug use; and

4. An assessment of the need for long term care services, including the availability of informal support.

From MassHealth Senior Care Options, Section 2.14, Required Program Reports.

C. *Enrollee Orientation Performance*. The Contractor must evaluate the effectiveness of Enrollee orientation activities and report the results to EOHHS on each anniversary of the start date of the Contract, specifying the costs and benefits of implementation and the lessons learned. The Contractor must also implement improvements based on the evaluation, including, as appropriate, continuing education programs for Providers and administrative staff…

New Mexico Coordination of Long-Term Services (CoLTS)

From New Mexico Coordination of Long-Term Services program, Section 3.3.

(B) Enrollment Requirements. As required by 42 C.F.R. §434.25, the contractor shall accept eligible individuals, in the order in which they apply and:

1. Without restriction, and pursuant to waiver authority, unless authorized by CMS Regional Administrator;
2. Up to the limits established pursuant to this Agreement;
3. The contractor shall not discriminate against eligible individuals on the basis of health status, need for health services, disability, race, color, national origin, sexual orientation, religion, and gender, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin; and
4. The contractor shall assume responsibility for all covered medical conditions of each Member inclusive of pre-existing conditions as of the effective date of enrollment....

Pennsylvania Adult Community Autism Program (ACAP)

From Pennsylvania ACAP, section 4.2, Participant Handbook and Enrollment Agreement.

A. The Contractor shall use the Participant Handbook specified by the Department and Enrollment Agreement template specified by the Department.

B. The Participant Handbook must include the following:

1. A description of all Capitated Services provided through the Plan, in sufficient detail to enable the Participant or the Participant's representative, if appropriate, to understand the benefits available under the Plan.

2. An explanation of the circumstances under which the Contractor is responsible or Post-Stabilization Care Services.
3. An explanation of the procedure for obtaining Capitated Services, including authorization requirements.
4. Information on the Participant's right to choose his or her PCP and other Providers to the extent possible and appropriate, including information on any restrictions on the Participant's freedom of choice among Network Providers.
5. Locations, telephone numbers, and procedures for obtaining health services in the event of a crisis.
6. The names, locations, telephone numbers, service(s) provided, and identification of non-English languages spoken by Network Providers in the Service Area.
7. Participant rights and responsibilities, as defined in this Section.
8. The disenrollment procedures, as described in Section 4.4 of this Agreement.
9. Information concerning transportation arrangements offered by the Contractor.
10. The extent to which and how Participants may obtain benefits from Non-Network Providers.
11. An explanation of how and where to access any benefits, including family planning services, that are available under the Medical Assistance Program but are not covered under this Agreement, including any cost sharing.
12. The extent to which, and how, after-hours and emergency coverage are provided…

D. Prior to enrollment, the Contractor shall:

1. Review the Participant Handbook and the Enrollment Agreement with each Participant or the Participant's representative, as appropriate;
2. Provide each Participant or the Participant's representative, as appropriate, with a copy of the Participant Handbook and the Enrollment Agreement;
3. Obtain the signature of the Participant or the Participant's representative, as appropriate, on the Enrollment Agreement and on a written statement verifying review and receipt of the Participant Handbook and give the Participant or the Participant's representative, as appropriate, a copy of the Enrollment Agreement and of the signed statement verifying review and receipt of the Participant Handbook.

Texas Star+Plus

From Texas Star+Plus, section 8.3.3, STAR+PLUS Assessment Instruments

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

HMOs must use the DADS Form 2060, as amended or modified, to assess a Member's need for Functionally Necessary Personal Attendant Services. The HMO may adapt the form to reflect the HMO's name or distribution instructions, but the elements must be the same and instructions for completion must be followed without amendment.

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

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

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