Substantive Changes*
2014 Family Care Contract

Article I – Definitions

1. Defines "Financial Abuse" as a practice that is inconsistent with sound fiscal, business, or medical practices and results in unnecessary program costs or an act that constitutes financial abuse as defined under applicable federal and state law. Definition provides further detail on what is included. (Article I.47)

2. Expands definition of "Fraud" to include the defrauding of any health care benefit program or attempting to obtain money or property owned by a health care benefit program. (Article I.51)

3. Combined definitions for Clinical, Functional, Personal Experience and Long Term Care Outcomes as part of the "Outcome" definition:

    - **Clinical Outcome:** Clarifies that clinical outcomes and functional outcomes are referred to as "long term care" outcomes in the Member Care Plan (MCP).

    - **Functional Outcome:** Includes but is not limited to assistance with Activities of Daily Living and Instrumental Activities of Daily Living. In addition, it is included as part of "long term care" outcomes in the MCP.

    - **Personal Experience Outcome**: An outcome that is primarily measured by the member but is not included as part of the "long term care" outcomes in the MCP.

    - **Long Term Care Outcome**: a situation, condition or circumstance that maximizes a member's highest level of independence and is based on the member's identified clinical and functional outcomes.

    (Article I.93)

Article V - Care Management

1. Allows an MCO to make initial contact with the member via telephone or face-to-face; contact must include review of member's stability of current supports. (Article V.D.1.b)

2. Clarifies that IDT must meet face-to-face with member to complete initial risk assessment within 10 calendar days (instead of business days) of enrollment. (Article V.D.1.c.i.)

3. Changes requirement for initial service authorization be signed within 10 calendar (instead of business) days of enrollment. (Article V.D.1.d)

4. Requires comprehensive assessment to be completed within 30 (instead of 90) calendar days. (Article V.D.2.a)

5. Requires the MCP to be completed and signed within 60 (instead of 90) calendar days. (Article V.D.2.b.)

6. Specifies members' rights to file a grievance if an MCO extends the timeframe for making a service authorization decision. (Article V.K.9.a)

7. Requires an MCO to issue a Notification of Non-Covered Benefit when it denies a request for a service or payment of a service outside the benefit package. (Article V.K.11.)

Article VI – Self Directed Supports

Clarifies that case/care management services cannot be self-directed by members. (Article VI.A.)

Article VII - Services

1. Added to allowable use of personal resources the use of unauthorized out-of-network providers that MCOs will not contract with. Requires member to pay full cost (does not apply if services are for emergencies or court ordered). (Article VII.J.2.d.)

2. Clarifies when counseling is necessary in regards to member's use of personal resources. (Article VII.J.3.)

3. Requires MCOs to report when a member uses personal resources to pay for a service/item in the benefit package that the MCO has authorized but for which the member chooses to use an out-of-network provider that the MCO will not contract with. (Article VII.J.9.a.)

Article VIII - Provider Network

Added requirements for provider subcontracts:

a. All amendments to subcontracts must be in writing, signed, and dated by both the provider and MCO; and
b. Subcontract provision that provider must notify MCO of any sanctions imposed by a governmental regulatory agency or any criminal investigation involving the subcontractor.

(Article VIII.D.)

Article XII – Quality Management

1. Clarifies that performance measurement projects be completed annually and must focus on clinical and non-clinical areas. (Article XII.C.8.a.)

2. Requires MCOs to submit an annual report to the Department, regarding the status and results of any approved performance project. (Article XII.C.8.i.)

Article XIII - MCO Administration

1. Requires MCOs to check the federal DHHS OIG List of Excluded Individuals/Entities and the federal General Services Administration Excluded Parties Listing Service at least monthly. (Article XIII.F.)

2. Requires a termination clause in commercial leases due to discontinuation of the MCO/DHS contract. (Article XIII.L.)

Article XIV – Reports and Data

Requires MCOs to test encounter submissions when implementing a new claims processing system or vendor. (Article XIV.B.3)

Article XVI – Contractual Relationship

1. Allows DHS to impose sanctions if an MCO does not provide all necessary services; not just medical services. (Article XVI.D.1.a.i.a)

2. DHS may impose sanctions if an MCO fails to meet financial performance expectations for solvency and financial stability as outlined in Article XVII. (Article XVI.D.1.a.i.c)

3. Allows DHS to impose intensive oversight of an MCO's operations without appointing a temporary manager by placing DHS staff or representatives at the MCO. (Article XVI.D.1.a.ii.c)

4. Specifies that if a change in State or Federal law occurs, DHS will pay the MCO's cost to end operations but not ongoing expenses, such as lease payments. (Article XVI.E.)

***** Technical language changes made to the contract to enhance general understanding or provide clarification are not included in this list.