Substantive Changes*
2016 Family Care Contract
November 20, 2015

Article I – Definitions

- Creates "Medicaid Deductible" to describe the formula and process by which an individual can meet the financial eligibility criteria by deducting medical and remedial costs from monthly income. (Article I.80)

Article III – Eligibility

- Clarifies that, like a member's cost share, a member's patient liability is not pro-rated. (Article III.E.2.c.ii.)

- Requires the Department to notify MCOs of changes to the Wisconsin Administrative Code that relate to functional eligibility. Prior language required the Department to only notify MCOs of changes that directly impacted the functional screen algorithm or logic. (Article III.G.2.)

Article V – Care Management

- Clarifies that the federal restriction against Home and Community Based Services (HCBS) providers also providing case management services or developing member-centered plans only applies to Family Care and Partnership providers, not PACE providers. (Article V.C.3.)

- Clarifies that MCOs are not responsible for processing member disenrollments. (Article V.M.2.c.i. and V.M.2.d.i.)

- Requires MCOs to immediately report certain member incidents to the Department, including certain situations when a member's whereabouts are unknown, death, certain injuries or accidents, or admission to a state IMD or Intensive Treatment Program (ITP). (Article V.O.)

- *Identifying and Responding to Member Incidents* was moved from Article XII.C.6. to create new Article V.J.5. for greater visibility and clarity. The following items have been added to new Article V.J.5.:

    - Specifies where MCO and provider member incident training should be documented. (Article V.J.5.b.iii.)

- Requires MCOs to have policies and procedures for and to report incidents to law enforcement where a member is a victim of or committed a violation of law. (Article V.J.5.b.vi.)

- Requires MCOs to investigate member incidents in a manner consistent with the relative scope, severity, and implications of the incident. (Article V.J.5.b.x.)

Article VIII – Provider Network

- Requires MCOs to have subcontract language that requires the subcontractor to fully cooperate with any member-related investigation conducted by the MCO, the Department, the Federal Department of Health and Human Services, CMS, law enforcement, or any other legally authorized investigative entity. (Article VIII.D.17)

- Requires MCOs to issue service authorizations prior to the start date of designated services. When written authorization is not practicable, verbal authorization should be provided with written authorization following. This is to avoid billing problems or providers unintentionally exceeding authorization limits. Provides direction for service authorizations completed on an emergency basis. (Article VIII.D.22.)

- Clarifies that paying above the Medicaid fee-for-service rate includes paying more than Medicaid fee-for-service would pay when coordinating benefits with other payers. Provides information on where MCOs can find a list of specific fee-for-service Medicaid services that are exempt from the requirements in this section. (Article VIII.N.8.c.)

- Requires MCOs to submit notification to the Department of payment above Medicaid fee for service rate on a form specified by the Department and as part of annual Business Plan submission. Removed cost analysis requirement and specific data criteria for encounter system. Required MCOs to identify expenditures on the services paid for above the Medicaid fee-for-service rate within the encounter data system. (Article VIII.N.8.d.)

Article XI – Grievances and Appeals

- Requires MCOs to provide a written notice to members whose level of care changes from nursing home to non-nursing home. The notice explains the potential impact of the change and appeal rights. (Article XI.E.1.a.)

- Indicates that most members experiencing a complete loss of functional eligibility will receive a CARES notice. References use of the optional MCO Disenrollment notice. (Article XI.E.3.a)

Article XIII – MCO Administration

- Clarifies when an MCO must disclose ownership interests. (Article XIII.E.1.)

- To the extent permitted by law, requires the MCO to fully cooperate with any member-related investigation conducted by the Department, the Federal Department of Health and Human Services, CMS, law enforcement, or any other legally authorized investigative entity. (Article XIII.G.)

- Requires MCOs to have specific insurances (worker's compensation; commercial liability, bodily injury and property; motor vehicle, professional liability; director and officers liability; umbrella; and employee dishonesty or fidelity bond). (Article XIII.M.)

Article XIV – Reports and Data

- Requires that the contents of a member record be retained by five years after a member's most recent date of disenrollment. (Article XIV.F.c.)

Article XVII – Fiscal Components

- Requires an MCO to notify DHS when it applies to CMS to offer a Partnership Dual Eligible SNP and reminds PACE and Partnership MCOs to follow existing guidance at Article XIX to notify DHS about geographical service area changes. (Article XVII.A.3.)

- Requires MCOs, as part of their business plans, to report regional or MCO-wide efforts to control costs. MCOs must then report quarterly on savings. (Article XVII.G.)

Article XVIII – Payment to the Managed Care Organization

- Reference to a primary care rate increase was deleted, as it only applied for one year. (Article XVIII.H.)

- Adds a section regarding the PPACA-imposed annual health insurance fee which applies to the Partnership program. The new section includes

guidelines on MCO reporting, capitation rate amendments, compliance, disputes, and resolution of reporting errors. (Article XVIII.H.)

Article XIX - MCO Specific Contract Terms

- Requires MCOs to notify the Department of a planned service area expansion when it submits a service area expansion application to CMS. The MCO must also notify the Department as soon as it receives approval from CMS for a service area expansion. (Article XIX.B.)

Addendum IV – Data Use Agreement

- Addendum IV is deleted in its entirety, as it is no longer necessary due to the Business Association Agreement. (Addendum IV.)

Addendum X – Benefit Package Service Definitions

- Adds mental health inpatient psychiatric care in a general hospital as a State Plan service, effective July 1, 2016. (Addendum X.B.9.)

Other

- Enrollment Streamlining - Several changes have been made throughout the contract to reflect IT/systems updates in enrollment and disenrollment processing.

- Root Cause Investigation – Throughout the contract, reference to "root cause investigation" was replaced with "investigation." "Root cause" was removed to comply with CMS technical guidance.

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

Prepared by WI DHS
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