{Obtained by LeadingAge Wisconsin from the Department of Health Services on January 2, 2013.}

Substantive Changes*
2013 Family Care Contract
Updated 12-18-12

Article I – Definitions

1. Defined "community supports," "member's home" and "natural supports"

   - **Community Supports:** supports and services that are not authorized or paid for by the MCO and that are readily available to the general population.

   - **Member's Home**: living quarters in which a member resides that is owned or leased by the member or member's family.

   - **Natural Supports**: the social network (family, friends, neighbors, etc.) that may be available to provide assistance to the member.

2. Simplified definitions of long term care and personal experience outcomes to support sustainability initiatives and simplification requested by MCOs.

   - **Long Term Care Outcome:** A situation, condition or circumstance that a member or IDT staff member identifies that maximizes a member's highest level of independence. A long-term care outcome is based on the member's identified clinical and functional needs.

   - **Personal Experience Outcome**: a desirable situation, condition, or circumstance that a member identifies as important to him/her.

Article III – Eligibility

Specified that the same procedures shall be used for collecting cost share and spend down.

Article IV - Enrollment and Disenrollment

1. Clarified cost share due date and 30-day grace period so that all members are treated consistently.

2. Added federally required language specifying circumstances when disenrollment of a member may not occur:
   - Adverse change in member's health;
   - Use of medical services by member changes;
   - Diminished mental capacity exhibited by member; and

- Exhibition of uncooperative or disruptive behavior by members due to their special needs, with certain exceptions.

Article V - Care Management

1. Emphasized sustainability efforts in assessment and member centered planning processes by focusing on long term care outcomes as the focus for MCO authorized/provided services. This includes an evaluation of member strengths, and natural and community supports

2. Allows MCOs to use expedited procedures and reduces documentation requirements for members that are disenrolled and then re-enrolled within 30-days.

3. Allows the most appropriate IDT staff to conduct a reassessment rather than requiring an RN each time. The entire IDT reviews or is updated on this assessment and, if appropriate, the RN will reassess if clinical issues are discovered. The entire IDT must participate in a comprehensive assessment at a minimum of every 12 months.

4. Allows MCOs to develop and obtain Department approval for decision making guidelines that may be used in lieu of documenting evidence in the service authorization process.

5. Clarifies the use of "residential care services" only in the following circumstances:
   - When members long-term care outcomes cannot be cost-effectively supported in the member's home; or
   - When member's health and safety cannot be adequately safe-guarded in the member's home; or
   - When residential care services are a cost-effective option for meeting the member's long term care needs.

Article VII - Services

1. Reworded Member Use of Personal Resources to provide more clarity and also specified that MCOs do not need to report:
   - Use of member resources that amount to less than $100 for a one time purchase or less than $50 per month for a service or item purchased on an on-going basis.

2. Requires MCOs to include in county MOUs regarding Institutes for Mental Disease (IMD) that a discharge crisis plan be established to keep the member in community.

Article VIII - Provider Network

Requires residential rates to be for a period of not less than one year, unless there is mutual agreement to a shorter term. Residential services subcontracts or amendments shall specify a contracted rate, include a fee schedule or reference an acuity-based rate setting model. Rate models may be changed:

1. Anytime, through mutual agreement of the MCO and provider.

2. When a member's change in condition warrants a change in the acuity-based rate setting model.

3. When a rate has been in effect for at least twelve (12) months, and a change is proposed for an individual member or facility:
   a. The MCO must provide a sixty day written notice to the provider prior to implementation of the new rate.
   b. The rate change may apply to the entire contract or to specific rates within the contract, but only on a prospective basis.
   c. Rates which are reduced using sub. 3. are protected from additional decreases during the subsequent twelve (12) month period.

Article IX - Marketing and Member Materials

1. Allows for electronic copies of marketing and outreach materials to be provided to ADRCs and members.

2. MCOs must provide one electronic or one hard copy of marketing/outreach materials to resource centers when they are developed and when there are significant changes to the materials. If a hard copy is provided, additional copies must be furnished to the resource center upon request.

3. Clarifies that MCO's will provide member materials to resource centers for counseling purposes only; MCO is responsible for distributing materials to members.

4. A consumer group review of member/outreach materials is no longer required.

5. MCOs no longer have to provide a copy of the provider network directory to the member upon enrollment, but rather provide information on how to obtain an electronic or paper copy. Removed requirement to offer a provider network directory to the member every three years by March 31.

6. Removed requirement to provide a member handbook to the member annually by January 31.

7. Removes requirement that MCOs have member handbooks available in Spanish, Russian, and Hmong if the MCO has members who are conversant in only those languages. Rather, member materials shall be provided in languages prevalent (5% of the population) in the MCO service area and in accessible formats.

Article XI - Grievance and Appeals

1. Clarifies that the MCO does not need to provide a Notice of Action when it denies a member's request for a service that is outside the benefit package. However, if the MCO reduces or stops providing a service outside the benefit package that the MCO has been providing, it must provide a notice of action.

2. MCOs must provide written notice (DHS will provide a template) to members when a request for a service outside the benefit package is denied.

3. Only these MCOs must only notify the Department of local appeal adverse decisions within 20 days:

    - Any MCO that is in first year of operation, and

    - Any MCO, after the first year of operation, that has been identified by the Department. The Department will make this determination based on the MCO's quality review, quarterly reports, and other factors.

Article XIII - MCO Administration

1. Removed claims processing standards that were different for waiver services versus state plan services. New claims adjudication requirements are:

    - 90% within 30 calendar days of receipt for clean paper claims; 99% within 90 calendar days; and 100% within 180 calendar days.

2. Requires any new contracts, contract renewals, and contract amendments for claims processing systems or software that will be developed into an internal claims processing system to meet Department standards and be approved by the Department. MCOs may request variances for pre-approval of specified types of amendments.

3. All suspected fraud and abuse must be reported to the Department within 10 business days.

4. MCO shall suspend payments to a sub-contracted provider if the Department informs the MCO that the Department has suspended fee-for-service Medicaid payments to the provider because of a credible allegation of fraud,

unless the MCO believes there is good cause for not suspending its payments.

Article XVII - Fiscal Components/Provisions

Added that MCOs must notify DHS and OCI at least thirty (30) calendar days prior to any substantial proposed change in business operations. Defined "substantial." The OCI, consulting with DHS as needed, may disapprove the change prior to the effective date or determine that the proposed change(s) requires submission by the MCO of modifications to its approved business plan or revised financial projections. MCOs are referred to Administrative Code Ins. 57.06 for CMOs and 9.06 for HMOs for guidance and specific requirements.

Article XVIII – Payment to the Managed Care Organization

Added that the Department shall suspend the capitation payment to the MCO if it determines that there is a credible allegation of fraud by the MCO, unless the Department determines there is good cause for not suspending payments or for only suspending them in part. Outlined the procedures to be followed.

Addendum I – Actuarial Basis

Added Money Follows the Person relocation incentive payments to the MCOs. Payments will be $1,000 for each member of an MCO who is relocated from an institution into a community setting consistent with federal guidelines.

Added that DHS will provide an add-on to the capitation rate for members with a nursing home level of care to assist the MCO in the purchase of automated, in-home medication dispensing systems.

Removed acuity/risk adjustment language (Health Status Partnership and PACE Programs/Long Term Care Functional Status/Common Carrier Non-Emergency Medical Transportation).

Addendum XIII - Benefit Package Service Definitions

1. Clarifies that prevocational services may be based on a tiered structure of different levels of service intensity and setting. Lower tiers may require different staffing ratios, less skilled staff, less intensive support and correspondingly lower provider reimbursement rates.

2. Clarifies that residential services and/or nursing home services may only be authorized under the following circumstances:

- A member's long-term care outcomes cannot be cost-effectively supported in a member's home;

- When the member's health and safety cannot be adequately safeguarded in a member's home; or

- When residential care or nursing home services are a cost-effective option for meeting the member's long-term care needs.

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