2024-2025 DHS-MCO Contract Amendment:

Substantive Changes Effective January 1, 2025

Article I: Definitions

- Updating definitions of physical abuse, sexual abuse, Tribal ADRS, and enrollment counseling
- Adding definitions for: Centralized Provider Enrollment System, Competitive Integrated Employment (CIE), HCBS Settings Rule Modification, program integrity abuse, and third-party delegate

Article II: MCO Governance and Consumer and Member Involvement

- Increasing required MCO Member Advisory Committee meetings to at least twice per year (Article II.B.3)

Article IV: Enrollment and Disenrollment

- Clarifying, if an MCO obtains information that *may* result in a member being disenrolled, they are required to inform the member's ADRC (Article IV.B.3.b.iv)

Article V: Care Management

- Clarifying permissible MCO use of text messaging for member contact (Article V.D.1.b, Article V.F.2.c, Article V.H.3.a-b)
- Adding requirement that IDT staff must be trained on person-centered planning requirements contained in the the HCBS settings regulations (Article V.B.4)
- New requirements on identifying risks:
    - Comprehensive Assessments must include all identified risks to the member (Article V.C.1; Article V.C.3)
    - Reassessments must identify member risks and include plans to address, mitigate and reduce those risks – even if the member is not currently willing to address the risk. IDTs must regularly review these risk and mitigation plans with members (Article V.G.1.d; Article V.J.1)
    - Required training and guidance policies for IDT staff regarding identified risks to members; required documentation for said policies (Article V.J.1)
- New Guidance on AIRS:
    - Member Exploitation incidents that must be reported in AIRS include those where a member is a perpetrator of exploitation (Article V.J.6.d.v)
    - MCOs may use a 'proxy member' in AIRS for certain situations (Article V.J.7.iv)
    - MCOS will immediately respond to all 'DHS Notices within one (1) business day and complete all follow-up activities as required (Article V.J.8.a-c)
- Adding requirement that MCOs must authorize and arrange services and supports for members to be discharged from the hospital in a timely manner (Article V.D.1.a-c)
- Adding MCP and comprehensive assessment documentation requirements to ensure compliance with the HCBS Settings Rule (Article V.C.3.c)

Article VII: Services

- Clarifying in lieu of services requirements (Article VII.8)

- Adding requirement that MCOs that offer remote monitoring shall develop, and submit for Departmental review, policies and procedures remote monitoring services.

Article VIII: Provider Network

- Clarifying that MCO provider agreements must include language requiring the provider to follow the MCO's own policies prohibiting all forms of abuse, neglect, exploitation and mistreatment of members (Article VIII.D.37)
- Adding process to enroll providers as a third-party delegate (Article VIII.G.5)
- Adding requirement MCO provider agreements must include provider enrollment document retention requirements. (Article VIII.D)
- Adding requirement that MCOs must verify a Notice of Compliance with HCBS Settings Rule for specified providers. (Article VIII.G.5.a-e)
- Changes to MCO responsibilities to verify provider credentials, enrollment, and background checks (Article VIII.G. and Article XIII.H)
- Update requirements for physician incentive plans (Article VIII.Q)
- Adding requirement that MCOs must pay the fee-for-service rate for complex rehab technology (Article VIII.L.13)

Article IX: Marketing and Member Materials

- Removing requirement that Partnership EOB, SOB and ANOC be developed cooperatively by all Partnership plans and approved by the Department (Article IX.B.10)
- Clarifying that the Department must approve all text messaging communication sent from the MCO to members for marketing/outreach purposes (Article IX.A.2.b; Article IX.4.a-c; Article IX.B.4)
- Adding provider race/ethnicity information to the provider directory (if available and provider does not opt out of publication) (Article IX.D.5.i)

Article X: Member Rights and Responsibilities

- Clarifying member's right to have full and confidential access to an ombudsman or other advocate (Article X.F)

Article XI: Grievances and Appeals

- Clarifying that an MCO-administered long term care functional screen result is appealable only if it results in a change of level of care or loss of functional eligibility (Article XI.B.1.a.1.a-b)
- Clarifying guidelines for MCO release of member's HIPAA information to advocacy agencies (Article XI.C.5.c.i)

Article XII: Quality Management

- Adding that the MCO must analyze incident reporting data from AIRS (Article XII.C.3.h)

Article XIII: MCO Administration

- Adding that the MCO's Program Integrity Plan must be submitted with the required policies and procedures during the MCO annual recertification process and approved prior to the effective date of the new contract year (Article XIII.K.1)

- Updating the requirement for the MCO to submit a preliminary investigation report for any suspected fraud, waste or abuse involving the program within two (2) days of identification (Article XIII.K.2)
- Adding that MCO must submit a Program Integrity report for each contracted LTC program to the Department on a quarterly basis (Article XIII.K.2.e)
- Clarifying that providers, not MCOs, shall request a good cause exception from the Department's Office of Inspector General (OIG) in the event an MCO suspends payment to the provider due to credible allegations of fraud (Article XIII.K.3)

Article XIV: Reports and Data

- Adding that MCOs must submit new or updated SDS worker information to ForwardHealth on a daily basis (Article XIV.C.2)
- Adding requirement that monthly MCO network file is due on the 10th and must include all Medicaid-enrolled providers who are contracted with the MCO (Article XIV.C.3)

Article XVI: Contractual Relationship

- Adding an informal, DHS-level reconsideration process for MCOS that are placed under a corrective action plan (CAP) (Article XVI.E.2.g.i)

Article XVII: Fiscal Components/Provisions

- Adding that MCO financial audit reports must include the number of claims sampled from payments by fiscal management agencies (FMAs) for self-directed supports (SDS) claims and the (Article XVII.E.3.j)
- Updating related party language and relocated to the Risk Corridor Settlement Methodology (Article XVII.N.2.h)
- Updating deadline for MCO's audited financial statements are due (Article XVII.E.1)

Article XVIII: Payment to the Managed Care Organization

- Pay-for-performance (XVIII.E.):
    - Removing Assisted Living Community (ALC) initiative
    - Defining an age range for members in the CIE initiative
    - Distinguishing cohort 1 group 1 from cohort 1 group 2, adding cohort 2, redefining withhold criteria, and redefining incentive criteria for the Community Connections initiative.

Article XIX: MCO Specific Contract Terms

- Clarifying target groups 1 and 3 include persons with irreversible dementia rather than Alzheimer's disease alone (XIX.F.)

Addendum VI: Benefit Package Service Definitions

- Updating Benefit Package Service Definitions in accordance with 2025 1915c waiver renewal