

# **FAMILY CARE**

## **A Review of the Subcontract for Providers**

**Prepared for WAHSA**

**By**

**Reinhart Boerner Van Deuren s.c.  
Long Term Care Practice Group**

## OVERVIEW OF FAMILY CARE

**A. What is Family Care?** Family Care is a managed-care alternative for long-term care services. It is a Medicaid-waiver program that is largely replacing Medicaid fee for service and the traditional Medicaid-waiver programs – Community Options Program (COP) and Community Integration Program (CIP) – which have been in place and managed primarily by counties in Wisconsin for many years.

**B. Cost Control: The Primary Driver Behind Family Care.** Research relied upon by the Department of Health Services revealed that Wisconsin spent 50% more than the national average for each Medicaid-eligible elderly person and used nursing homes at a rate 45% over the national average. Family Care is designed so that the state may use managed care principles, including capitated payments, in an effort to help control costs and transfer risk.

**C. Who is Eligible for Family Care?** The primary enrollees in Family Care are the elderly. However, the Family Care benefit also includes certain target groups who have a long-term condition expected to last for more than 90 days. The groups are:

1. Frail Older Adults
2. People with Physical Disabilities (17 years, 9 months or older)
3. People with Developmental Disabilities (17 years, 9 months or older)

**D. What Items Are Covered by the Family Care Benefit?** Family Care service packages include the traditional Medicaid-waiver services, as well as traditional Medicaid-card services. A list of Family Care covered services is as follows: Note physician services and acute care services are not covered.

- Adaptive Aids (general and vehicle)
- Adult Day Care
- Alcohol and Other Drug Abuse Day Treatment Services (in all settings)

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- Alcohol and Other Drug Abuse Services, except those provided by a physician or on an inpatient basis
- Care/Case Management (including Assessment and Case Planning)
- Communication Aids/Interpreter Services
- Community Support Program
- Consumer-Directed Supports/Self-Directed Supports
- Consumer Education and Training
- Counseling and Therapeutic Resources
- Daily Living Skills Training
- Day Services/Treatment
- Durable Medical Equipment, except for hearing aids and prosthetics (in all settings)
- Home Health
- Home Modifications
- Housing Counseling
- Meals: home delivered
- Medical Supplies
- Mental Health Day Treatment Services (in all settings)
- Mental Health Services, except those provided by a physician or on an inpatient basis
- Nursing Facility (all stays) including Intermediate Care Facility for People with Mental Retardation (ICF/MR) and for people under age 21 or 65 and older Institution for Mental Disease (IMD)
- Nursing Services (including respiratory care, intermittent and private duty nursing)
- Occupational Therapy (in all settings except for inpatient hospital)
- Personal Care
- Personal Emergency Response System Services
- Physical Therapy (in all settings except for inpatient hospital)
- Prevocational Services
- Relocation Services
- Residential Services: Certified Residential Care Apartment Complex (RCAC)
- Community-Based Residential Facility (CBRF)
- Adult Family Home
- Children's Foster Care and Treatment Foster Care

- Respite Care (for care givers and members in non-institutional and institutional settings)
- Specialized Medical Supplies
- Speech and Language Pathology Services (in all settings except for inpatient hospital)
- Supported Employment
- Supportive Home Care
- Transportation: Select Medicaid covered (i.e., Medicaid covered Transportation Services except Ambulance and transportation by common carrier) and non-Medicaid covered
- Vocational Futures Planning

**E. What is the Role of Aging and Disability Resource Centers ("ADRCs")?** Family Care is intended to improve the cost-effective coordination of long-term care services by creating a single flexible benefit that includes a large number of health and long-term care services that otherwise would only be available through separate programs. ADRCs are designed to be a single entry point where older people and people with disabilities and their families can get information and advice about a wide range of resources, including Family Care services, available to them in their local communities.

**F. What is the Role of Care Management Organizations ("CMOs")?** A CMO is basically another name for an HMO. CMOs can be public (county run) or private entities. Whether public or private, a CMO is responsible for contracting with the state Medicaid program and providing Family Care benefits to eligible enrollees. In order to assure access to services, CMOs develop and manage a comprehensive network of long-term care services and support, either through contracts with providers, or directly through CMO employees. CMOs receive a monthly per person payment from the state to manage and purchase care for their members, who may be living in their own homes, group living situations or nursing facilities. Through this capitated payment system, the state is able to reduce costs and transfer risk to the CMOs.

**G. Are Providers Required to Contract with CMOs and Participate in Family Care?** Providers are not required to contract with CMOs nor are they required to participate in Family Care. Long term care providers may choose not to participate in Family Care. However, given that Family Care will largely be replacing traditional Medicaid, it may be necessary for providers to participate in Family Care to survive. That said, it is important to note that CMOs may attempt to shift some of the risk, inherent in their capitated payment scheme, to their

providers. Providers must understand what they are agreeing to before contracting with an CMO and before developing new or expanded services and options to contract with the CMO. Providers subject to federal and state licensure or certification requirements must continue to meet those requirements in addition to the CMO contract obligations.

## OVERVIEW OF WHAT THIS TOOLKIT IS

As discussed above, CMOs contract with the state (specifically, the Department of Health Services, Division of Long Term Care) by entering into a Health and Community Supports Contract (available at <http://www.dhfs.state.wi.us/LTCare/StateFedReqs/FC-RC-CMO-Contracts.htm>). Under the contract, CMOs provide the Family Care benefit and receive a monthly per person payment from the state to manage and purchase care for their members. Through this capitated payment system, the state is able to reduce costs and transfer risk to the CMOs. However, for CMOs to survive, they must transfer some of that risk to the direct care providers. CMOs will attempt to transfer risk to direct care providers when negotiating Family Care provider subcontracts. Each subcontract will be between the CMO and an entity (or group of entities) that will provide direct long term care services within the CMO's network of providers.

The materials in this toolkit are designed to assist long term care providers and their attorneys in reviewing and negotiating Family Care subcontracts with CMOs. The toolkit provides a general overview of the different concepts that must, pursuant to the terms of the Health and Community Supports Contract, be addressed in Family Care subcontracts. Further, it identifies those concepts and terms that are likely negotiable and those that are not. It also provides some general contracting considerations for providers.

This toolkit is not a contract template. It is intended to help long term care providers understand a Family Care subcontract that is presented to them by a CMO. Providers can then decide whether to enter into the subcontract and, if so, what terms may be negotiated to ensure that the contracted rate will cover costs.

**The information in this toolkit is current as of the time it was published. However, long-term care providers should be aware of changes (e.g., changes to the Health and Community Supports Contract) that could affect future CMO subcontracts. Further, it is specifically understood that this publication is not intended to provide technical, legal or other professional services or advice. Readers requiring such services are encouraged to contact appropriate professionals.**

## GENERAL CONTRACTING CONSIDERATIONS

When long term care providers and their attorneys review and negotiate Family Care subcontracts with CMOs, they should always be aware of certain general contracting considerations. **First, these contracts have been developed for all providers and contain provisions that may not be applicable to your specific services and arrangements.** Second, when negotiating any written contract, including a subcontract with a CMO, it is important to ensure that the contract provides the following benefits:

- The contract should provide a tangible statement of the deal.
- The contract should document and protect expectations.
- The contract should provide a safety net for unavoidable or otherwise justified business risk-taking.
- The contract should be the product of up-front negotiations, which are better than back-end disputes or unanticipated liabilities.

As in any negotiation, providers typically will have the most leverage when negotiating their initial subcontract prior to the first term. Thus, the Family Care subcontract should be closely scrutinized on the front end. Organizations that have multiple provider facilities on the same campus will want to consider whether they want to enter into a single subcontract for all facilities or separate subcontracts for each facility.

A critical factor for providers of licensed or certified care such as SNFs, CBRFs and AFHs is that the existing regulatory requirements and obligations continue in place. Therefore, providers should negotiate with the CMO to substitute existing obligations for those proposed by the CMO. For example, provide copies of, or permit access to, policies and procedures related to confidentiality of records, emergency procedures, disaster planning, etc. Similarly, providers are surveyed by the state regularly so the CMO should not need to repeat that effort.

Some of the key issues/concepts that will be covered by a Family Care subcontract may clearly be negotiable and some may not. If an issue/concept is required to be in the Family Care subcontract pursuant to the CMO's contract with

the state (*i.e.*, the Health and Community Supports Contract with the Department of Health Services), then the CMO's hands are probably tied with respect to that particular issue/concept and the CMO will not wish to negotiate. **However, language and specifics can always be negotiated.** Moreover, providers do not need to agree to the entire subcontract as provided by the CMO, there is room to negotiate on most critical issues/concepts. Further, when all is said and done, providers are not required to participate in Family Care and may elect not to enter into a subcontract with a CMO if the terms are not financially viable. **Individuals can opt out of the CMO and make care arrangements on their own.**

For skilled facilities, individuals may opt out of the CMO and return to fee-for-service if they choose. In addition, the IRIS program for self-directed care permits an eligible individual to not work with a CMO and choose their own waiver sources.

**Another critical factor for providers is that the CMO does not run your business. You are responsible for the care provided to your residents and while a CMO may have a right to be informed, it should not have the right to interfere. Similarly, the CMO should not interfere in your employment relations.**

In order to assist long term care providers and their attorneys in identifying key Family Care subcontract issues/concepts that are not negotiable and those that are negotiable, we created the chart located in the next section of this toolkit. The chart describes each issue/concept and identifies whether it is negotiable, and as appropriate, suggests an approach for addressing the issue.

## FAMILY CARE CONTRACTING ISSUES AND CONCEPTS CHART

Issue/Concept	Agreement That Governs	Negotiable	Description
1. Defined Terms	<ul style="list-style-type: none"> <li>·The contract between the CMO and the State (the "State Contract"); and</li> <li>·The contract between the CMO and the provider (the "Subcontract")</li> </ul>	Generally, no	Terms in the Subcontract will typically be defined in accordance with the definitions in the State Contract and the CMO will not be able to change the meaning of such terms in the Subcontract. However, definitions for terms that are not defined in the State Contract should have room for negotiation.
2. Payment of Claims	State Contract	No	A CMO must pay at least 90% of clean claims from providers for services within 30 calendar days of receipt of the bill, and 99% within 90 calendar days, except to the extent providers have agreed to later payment. (See #2 in Attachment A.)
3. Legal Liability Related to CMO Insolvency	State Contract	Generally, no	CMOs must demonstrate the ability to retain operating reserves and minimum risk and solvency reserves as outlined in the State Contract. (See #3 in Attachment A.)
4. Insurance and Indemnification	State Contract and Subcontract	Generally, no	Pursuant to the State Contract, a provider must carry the "appropriate" insurance. The State Contract does not define what specific coverage amounts/minimums are "appropriate" for different provider types. (See #4 in Attachment A.)

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Issue/Concept	Agreement That Governs	Negotiable	Description
5. Notices	State Contract and Subcontract	No	The State Contract requires that the Subcontract specify a means and a contact person for each party for purposes related to the Subcontract. The Subcontract may also set forth more specific notice requirements.
6. Access to Premises	State Contract	No	Provider must agree to provide representatives of the CMO, as well as duly authorized agents or representatives of the DHS and the Federal Department of Health and Human Services, access to its premises, and/or medical records. Although this requirement is not negotiable, providers should require advance notice.
7. Certification and Licensure	State Contract	No	Providers must agree to provide licensure, certification and accreditation status upon request of the CMO. Providers must agree to notify the CMO of changes in licensure.
8. Records/HIPAA	State Contract	Generally, no	Providers must agree to comply with all applicable Federal and State health care record requirements. (See #8 in Attachment A.)
9. Non-Discrimination	State Contract	Unclear	Providers must agree to comply with non-discrimination requirements outlined in the State Contract. (See #9 in Attachment A.) <ul style="list-style-type: none"> <li>▪ Provisions relating to Affirmative Action are</li> </ul>

Issue/Concept	Agreement That Governs	Negotiable	Description
			being discussed with the DHS.
10. Independent Contractor	State Contract	No	The Subcontract must include language establishing that the Subcontract is between two separate parties that are independently and freely entering into the Subcontract.
11. OSHA Requirements	State Contract	No	Providers must attest to meeting applicable OSHA requirements.
12. Provider Appeals for Payment/Denial of Claims	State Contract	No	Providers must agree to abide by the appeal requirements outlined in the State Contract. Providers may appeal on behalf of a member to the CMO. After that, only the member may appeal.
13. Member Appeals and Grievances	State Contract	No	Providers must agree to comply with the CMO's efforts regarding members' appeals and grievances that may involve the provider.
14. Limitations on Endorsement	State Contract	No	The CMO and provider must agree to prohibit communication, activities or written materials that make an assertion or statement that the CMO or provider is endorsed by CMS, the Federal or State government, or any other entity. A provider can say that it participates in the Family Care Program.
15. Parties to the Subcontract	Subcontract	Yes	The State Contract requires that the CMO and the provider(s) entering into the Subcontract be clearly defined.

Issue/Concept	Agreement That Governs	Negotiable	Description
			(See #15 in Attachment A.)
16. Services	Subcontract	Yes	The State Contract <u>only</u> requires the Subcontract to clearly delineate the services being provided, arranged, or coordinated by the provider. Beyond that, the Subcontract controls. (See #16 in Attachment A.)
17. Billing	State Contract and Subcontract	Yes	The State Contract requires providers to agree not to bill a member for services in the LTC benefit package that received advance authorization from the CMO and were provided during the member's period of CMO enrollment. This provision continues in effect even if the CMO becomes insolvent. However, the Subcontract will identify the time period for billing claims (probably will be within 30-60 days of provision of services). (See #17 in Attachment A.)
18. Rates	State Contract & Subcontract	Yes	The State Contract mandates that CMOs may not pay providers more than the Medicaid fee for service rates for Medicaid covered services, unless a higher rate is approved by the DHS. For SNFs, the composite reimbursement rate will not be the same as RUGs rates applied to specific residents. (See #18 in Attachment A.)

Issue/Concept	Agreement That Governs	Negotiable	Description
19. Term	Subcontract	Yes	The State Contract only requires that the Subcontract identify term and renewal periods. The Subcontract term <u>should only</u> be for one year, without automatic renewals. Providers <u>will</u> want to strike automatic renewals to allow for rate negotiation every year.
20. Termination	State Contract and Subcontract	Yes	The State Contract requires the Subcontract to specify the termination date, the CMO's ability to terminate and suspend the Subcontract based on quality deficiencies and a process for providers appealing the termination or suspension decision. (See #20 in Attachment A.)
21. Quality Assurance and Utilization Data	State Contract and Subcontract	Yes	The State Contract subjects CMOs to quality assurance requirements and requires CMOs to gather utilization data. CMOs will expect providers to provide certain data/reports. Providers will want to clearly define what reports/data are expected. (See #21 in Attachment A.)
22. Fees for Records Requests	Subcontract	Yes	Providers may want to include a provision in the Subcontract that requires a fee for multiple or redundant records requests.
23. Access to Services	State Contract and Subcontract	Yes	The State Contract requires that providers agree not to create barriers to access to care by imposing requirements on members that are inconsistent

Issue/Concept	Agreement That Governs	Negotiable	Description
			with the provision of services necessary to achieve outcomes that are in the LTC benefit package, e.g., Third Party Liability recovery procedures that delay or prevent care. However, providers should reserve the right not to admit members that are referred and to charge for items and services that are requested but not covered.
24. Compliance Oversight	State Contract and Subcontract	Yes	The State Contract subjects CMOs to general obligations related to ensuring provider compliance, monitoring provider compliance and taking corrective action. Providers will want to be comfortable with the CMO's monitoring procedure and ensure that it does not interfere with the provider's direct regulatory obligations.
25. Disenrollment and Provider Admission Agreements	Subcontract	Yes	The State Contract does not address how CMOs and providers will handle Family Care disenrollment in light of a long term care provider's discharge planning obligations. (See #25 in Attachment A.
26. CPE Payments	Neither	Yes	Certified Public Expenditure (formerly IGT) payments which apply to county and municipal facilities are to be paid to the facility when the state pays the CMO. The

Issue/Concept	Agreement That Governs	Negotiable	Description
			timing of this payment is negotiable.
27. Audits	Neither	Yes	Providers should make existing audits available to CMO and request funding for any additional requirements.

## ATTACHMENT A

### ADDITIONAL INFORMATION REGARDING KEY CONTRACTING ISSUES/CONCEPTS

#### Issue

- #2. Payment of Claims. The state requirement for payment within 30 days may be significantly longer than many providers now experience. The 30 days is the maximum, you may be able to negotiate a shorter time especially if the CMO has an electronic payment system.

#### Issue

- #3. Legal Liability Related to CMO Insolvency. Providers will want to include language requiring the CMO to immediately notify the provider if the CMO anticipates that it will fall out of compliance with the operating/solvency reserve requirements set forth in the State Contract, allow for termination of the Subcontract in such an event and require indemnification for damages resulting from such an event. In addition, the contract should specify that the CMO is financially responsible for the residents' care in such an event.

#### Issue

- #4. Insurance and Indemnification. Note that certain provisions that may be found in a template Subcontract (e.g., provision requiring participation in the Injured Patient and Family Compensation Fund) may not apply to most long term care providers and should be deleted. Different types of providers have different requirements. Therefore, a template Subcontract may include provisions that would apply to other provider types (e.g., physicians and hospitals) but that are unnecessary for long term care providers. Indemnification or hold harmless provisions should apply to both parties. Further, providers should ensure that their insurance carrier approves of the language used. Note that under the State Contract, CMOs must indemnify, defend if requested and hold harmless the state and all of its officers, agents and employees from all suits, actions, or claims of any character brought for or on account of any injuries or damages received by any persons or property resulting from the operations of the CMO or any of its contractors.

#### Issue

- #8. Records/HIPAA. All providers should have policies regarding health care records and appropriate informed consent policies. Providers must agree to

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make records available to members (i.e., Family Care participants/patients) and their authorized representatives within ten (10) business days of the record request. Providers must forward records to the CMO pursuant to grievances within fifteen (15) business days of the CMO's request. If the provider does not meet the fifteen (15) business day requirement, the provider must explain why and indicate when the records will be provided. Providers must agree to preserve the confidentiality of records. Note the federal nursing home requirements indicate the residents must be given access to their records within 24 hours of making a request. 42 C.F.R. 483.10(b)(2)(i).

The Subcontract will require providers to maintain records and will reference the need to comply with HIPAA. Many assisted living providers are likely not "covered entities" under HIPAA because they do not electronically bill. However, campuses may have designated their facilities as an Organized Health Care Arrangement ("OHCA"), which is an arrangement or relationship, recognized in the HIPAA privacy rules, that allows two or more entities who participate in joint activities to share protected health information about their patients in order to manage and benefit their joint operations. If this is the case, an assisted living provider may need to comply with HIPAA. Alternatively, assisted living facilities on a campus might be able to be carved out of the HIPAA requirements.

Regardless of a provider's circumstances, it should understand its obligations under the law and should ensure that it only contractually obligates itself to comply with those records laws that are applicable to its facility. There is no reason for an entity to agree to HIPAA compliance if it is not covered by HIPAA. Moreover, a provider should not agree to record retention periods that are longer than existing regulatory requirements.

Note that HIPAA-covered providers will already be using an informed consent form for release of information. However, providers not subject to HIPAA may not be using such a form.

#### Issue

- #9. Non-Discrimination. The State Contract refers to a civil rights plan and affirmative action plan requirements for providers. We are seeking clarification on the application of this requirement because it is not clear why an affirmative action plan would be required under federal law and such a requirement would create a significant administrative burden. Since

the state does not require the Subcontract provider to develop its own plan, there has been a suggestion that it should be sufficient for providers to provide a copy of their Medicaid provider agreement, which indicates that the provider shall stay in compliance with all federal and state laws.

Issue

#15. Parties to the Subcontract. Providers are free to negotiate who will be parties to the Subcontract. In the case of a campus community organized under single legal entity, providers may wish to define the specific facilities or services that will be covered by the contract. Given that several CMOs also operate Partnership and Pace programs, it will be important for the contract to define what programs will be covered under the agreement. If multiple programs are covered, this may affect the rates and services.

Issue

#16. Services. Providers should pay close attention to what services they are being asked to provide and what is intended to be included with the service because the rate paid will be attached to the services provided. If there are certain service lines that providers would like to exclude, this should be addressed in the Subcontract. For example, providers may wish to exclude certain types of services for RCAC residents. Providers may also want to limit the services they offer by using language similar to the following: "subject to availability and applicable admission procedures, provider will provide . . ." or "provider reserves the right not to accept a participant." Providers may also want to consider limiting the number of units that will be available for Family Care participants.

Issue

#17 Billing. Although the provider may not bill the participant for services covered in the contract, providers should reserve the right to bill the CMO or participant for "uncovered" services, such as special products and specialized equipment, which may not be covered under the established rate. Providers should discuss how these and other fees like the bed tax and security deposits will be paid for. In addition, any security deposit or "bed tax" may not be included in the MA rate limitation.

Issue

#18. Rates. Assisted living facilities may have more flexibility with respect to negotiating rates because there is no assisted living Medicaid rate.

Nursing homes may also have ability to negotiate rates by identifying service categories and/or acuity levels that indicate a higher rate. Nursing homes should consider the following:

1. Use the RUGs rate for individual clients and not the facility composite rate.
2. For short term stays without an ability to define the RUGs rate, consider using the composite rate.
3. For potential residents who have higher needs, *e.g.*, behavioral residents who need 1:1 supervision, or who have bariatric needs, request a higher rate and DHS approval.
4. Since RUGs rates are adjusted quarterly, seek similar adjustments to the contracts.

Providers should also ensure that the Subcontract addresses how any rate increases are determined and reviewed, especially in the event of any Medicaid rate increases in which case the Subcontract should allow for retroactive payments. If the provider requires a security deposit or entrance fee, the Subcontract should address how they will be handled. Providers should also be clear on who will be collecting the participant's personal liability amount.

#### Issue

#20. Termination. The Subcontract will likely say that if the Subcontract terminates, the provider agrees to ensure continuity of care. Providers should make sure that compensation is provided during these periods. For example, the following language could be used: "CMO shall continue to compensate provider for services provided during such transition in accordance with the rates set forth in this agreement."

Providers will want to ensure that the Subcontract requires the parties to negotiate in good faith on rate changes prior to a renewal and that if they can't agree the Subcontract should allow for termination by either party upon thirty days notice.

Ideally, providers would like the ability to terminate without cause.

#### Issue

#21. Quality Assurance and Utilization Data. Providers already gather and report certain quality indicator information. It may be possible to submit

some/all of that information rather than create new information for the CMO. Further, providers may want to include language which states that the disclosure of such reports/data does not constitute a waiver of the provider's quality assurance privilege and that the CMO must maintain the confidentiality of such information. Moreover, some QA information is protected and is not disclosed to any outside organization.

#### Issue

#25. Disenrollment and Provider Admission Agreements. With respect to discharging residents, the Subcontract should have language indicating that the provider's admission agreement controls and that payment continues until federal and state discharge processes have been followed. If a resident is discharged by the facility or disenrolled by the CMO, providers may want to specify the CMO's role in finding an alternative placement for the individual.

## ADDENDUM B

### UPDATES (DRAFT JUNE 23, 2009)

#### OVERVIEW OF FAMILY CARE

##### Page 1

- A. **What is Family Care?** The term "Family Care" is the name given to the program in the Wisconsin Statutes for the managed-care alternative funding program for long-term care services. It includes ADRCs (Aging and Disability Resource Centers) and MCOs (Managed Care Organizations).

##### Page 3

- E. **What is the Role of Aging and Disability Resource Centers ("ADRCs")?** ADRCs complete the functional screen for persons to determine eligibility for services, including Family Care. If a person is functionally and financially eligible, the person may choose to enroll in an MCO or can elect to participate in straight MA or IRIS programs.

#### OVERVIEW OF WHAT THIS TOOLKIT IS

- Page 5, paragraph 3:** The intent of the toolkit is to assist long-term care providers to understand a subcontract, identify areas for discussion and clarification with an MCO, provide ideas about terms which may be negotiated to best meet the business needs of the provider and the service needs of the MCO member under the terms of the subcontract and as required by law.

#### GENERAL CONTRACTING CONSIDERATIONS

- Page 6, paragraph 1:** MCO subcontracts are evolving through experience with network providers and subcontracts may be tailored to fit the purchaser of services of a particular provider type, *e.g.*, CBRF, nursing home.

- Page 6, paragraph 2:** A provider should ensure that it has the capacity to manage separate contracts. Providers should discuss with an MCO

how to tailor contracts to reflect the range of services provided and the costs of various services provided to members.

**Page 7, paragraph 1:** If members decide to withdraw from participation in an MCO, they will lose MA waiver benefits, but will retain MA card services. Members should be fully informed of risks and benefits when considering such choices.

## **FAMILY CARE CONTRACTING ISSUES AND CONCEPTS CHART**

**Item 9: Non-Discrimination:** Providers must not discriminate; must implement programs to ensure compliance with state and federal requirements. Can make statement affirming compliance.

**Item 12: Provider Appeals for Payment/Denial of Claims:** Providers have the right to appeal payment and denial of claims by an MCO. See pp. 90-91 of the Family Care contract. Providers may appeal the denial of service on behalf of a member of an MCO

**Item 13: Member Appeals and Grievances:** Members have the right to appeal a denial of service by an MCO.

**Item 17: Billing:** Providers need to fully understand MA requirements for billing (*e.g.*, format, timeline) and preauthorization for services. It is recommended to separate provider claims from service that provider can bill member for (*e.g.*, private room rate).

**Item 25: Disenrollment and Provider Admission Agreements:** "Disenrollment" refers to loss of eligibility. Providers are encouraged to ask to be notified as soon as a member is at risk for loss of eligibility so it can be discussed with the member and make alternate arrangements for payment or placement, as appropriate.