

**SUMMARY OF PROPOSED MODEL CONTRACT CHANGES
SINCE JANUARY 19, 2011 BOARD MEETING**

Section		Page	Type of Change	Comments
I. Introduction	C.2. Geographic Areas Covered	1-2	Substantive	<ul style="list-style-type: none"> <u>Plan can not make changes to its coverage areas within the first ninety (90) days of the benefit year. Adds language that if the change in geographic coverage area is to withdraw due to a plan initiated change, the Contractor shall request such approval at least 90 days prior to the date the change will take place.</u>
I. Introduction	E. Term of Agreement	3	Non-Substantive	<ul style="list-style-type: none"> Changes the Term of Agreement from 2011 to 2012.
II. Enrollment	K.5. Network Information Services	10	<u>No Change</u> Substantive	<ul style="list-style-type: none"> Adds language requiring the Contractor to promptly notify the State of any providers that have been debarred, suspended, proposed for debarment, or declared ineligible or voluntarily excluded from participation in any federally-funded health care program.
II. Enrollment	M.5. Public Awareness	12	Non-Substantive	<ul style="list-style-type: none"> Clarifies the reason the state provides the AER file, so the Contractor may assist subscribers in retaining coverage.
III. Customer Service	B.2. Grievance Procedure for Department of Managed Health Care Licensees and Department of Insurance Licensees	12-13	Substantive	<ul style="list-style-type: none"> Adds grievances related to mental health services, substance abuse treatment services, and prescription drugs as specific reporting categories.

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IV. Covered Services and Benefits	B.1. California Children's Services (CCS)	18	Substantive	<ul style="list-style-type: none"> Clarifies that medically necessary services authorized and provided under CCS are not covered services under this Agreement. Changes the reference in Title 22.
IV. Covered Services and Benefits	B.3. California Children's Services (CCS)	18	Substantive	<ul style="list-style-type: none"> Requires Contractor to provide its CCS referral policies and procedures to the State upon request.
IV. Covered Services and Benefits	B.8. California Children's Services (CCS)	19	Substantive	<ul style="list-style-type: none"> Clarifies the Contractor's responsibility once the CCS program is providing services. Changes the reference in Title 22.
IV. Covered Services and Benefits	B.9. California Children's Services (CCS)	19	No Change Substantive	<ul style="list-style-type: none"> This provision is covered by Section IV.B.7. Clarifies the Contractor's responsibility to provide all medically necessary covered services to treat the CCS condition in the event the CCS Program does not provide the services needed.

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IV. Covered Services and Benefits	C.2. Mental Health and Substance Abuse Services	20	Substantive	<ul style="list-style-type: none"> • Adds a new section requiring the Contractor to develop and submit a plan and timeframe as to how Contractor will educate support parents of children with mental health and substance abuse conditions and outlines the possible elements of the plan should include. the Contractor will submit to the State.
IV. Covered Services and Benefits	C.3. Mental Health and Substance Abuse Services	20	Substantive	<ul style="list-style-type: none"> • Requires Contractor to track and report the length of time from the date a subscriber was referred for plan-provided mental health services to the actual date mental health services were provided to the subscriber.
IV. Covered Services and Benefits	D.3.b. and 3.d. Mental Health: Services for Subscriber Children with Serious Emotional Disturbance or Serious Mental Disorder	22	<u>No Change</u> Non-Substantive	<ul style="list-style-type: none"> • MRMIB is not making changes to the MOU at this time. Clarifies that referral protocols and continuity of care procedures will be consistent with the MOU between the Contractor and the counties.
IV. Covered Services and Benefits	D.4. Mental Health: Services for Subscriber Children with Serious Emotional Disturbance or Serious Mental Disorder	22	<u>Non-Substantive</u> Substantive	<ul style="list-style-type: none"> • No changes to reporting requirements. Requires the Contractor to notify the State of the mental health screening tools used and report on the number of subscribers screened for mental health conditions. • Changes the timeframe for reporting from October to February.
IV. Covered Services and Benefits	D.6.a. Mental Health: Services for Subscriber Children with Serious	23	Non-Substantive	<ul style="list-style-type: none"> • Clarifies the counties' responsibility to notify the Contractor of the serious emotional disturbance

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	Emotional Disturbance or Serious Mental Disorder			determination.
IV. Covered Services and Benefits	D.6.b. Mental Health: Services for Subscriber Children with Serious Emotional Disturbance or Serious Mental Disorder	23	Substantive	<ul style="list-style-type: none"> Deletes language regarding the conversion of an inpatient day for other less intensive treatment services which is not needed due to the new mental health parity law.
IV. Covered Services and Benefits	D.6.e. Mental Health: Services for Subscriber Children with Serious Emotional Disturbance or Serious Mental Disorder	23	<u>No Change</u> <u>Substantive</u>	<ul style="list-style-type: none"> <u>MRMIB is not making changes to the MOU at this time. Requires the Contractor to coordinate inpatient care with county mental health departments.</u>
<u>IV. Covered Services and Benefits</u>	<u>D.7. Mental Health: Services for Subscriber Children with Serious Emotional Disturbance or Serious Mental Disorder</u>	<u>23</u>	<u>Substantive</u>	<ul style="list-style-type: none"> <u>Clarifies that the plan is not responsible for providing services that are authorized and provided by the County Mental Health Department.</u>
IV. Covered Services and Benefits	E. Other Public Linkages	24	Non-Substantive	<ul style="list-style-type: none"> Clarifies that local education agencies include schools.
IV. Covered Services and Benefits	H.3. Copayments	24-25	<u>No Change</u> <u>Substantive</u>	<ul style="list-style-type: none"> <u>No changes to reporting requirements. Deletes provision regarding the reporting of subscribers who meet the annual copayment maximum and replaces it with a requirement that the Contractor report all copayments paid by</u>

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				subscriber households for covered services in the previous benefit year.
IV. Covered Services and Benefits	H.5. Copayments	25	<u>No Change</u> <u>Substantive</u>	<ul style="list-style-type: none"> <u>No change to monitoring requirements.</u> Requires the Contractor to monitor subscriber household copayments on a quarterly basis.
<u>IV. Covered Services and Benefits</u>	<u>H.6. Copayments</u>	25	<u>Substantive</u>	<ul style="list-style-type: none"> <u>Requires the Plan to provide two (2) notices to families about the annual copayment maximum and the process for notifying the Plan when the family reaches the maximum.</u> <u>Requires the second (2nd) notice to be provided in the third (3rd) quarter of the benefit year.</u>
IV. Covered Services and Benefits	H.7. Copayments	25	Substantive	<ul style="list-style-type: none"> Requires the Contractor to inform its providers to stop collecting copayments when a subscriber household reaches the two-hundred and fifty dollars (\$250) family copayment maximum in a benefit year. Requires the Contractor to reimburse <u>the subscriber households that have notified the Contractor when the family has reached the annual copayment maximum of</u> the amount exceeding two-hundred and fifty dollar (\$250) within ninety (90) days of Contractor's determination that an overpayment occurred. Requires Contractor not to rely solely on the subscriber household to notify Contractor when the subscriber household reaches the \$250 copayment maximum.

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IV. Covered Services and Benefits	I.2. Coordination of Benefits	26	Substantive	<ul style="list-style-type: none"> Requires the Contractor to designate at least one of the Contractor's employees as a Dental Plan Liaison to coordinate benefits and services and resolve issues with a subscriber's dental plan. <u>Deletes reference to this being a "primary" function of the liaison.</u>
V. Clinical Quality Measures and Management Practices	A.1. Measuring Clinical Quality	27	<u>No Change</u> Substantive	<ul style="list-style-type: none"> <u>No change to current language. Notifies Contractor that the HEDIS measures may be modified to include core quality measures as required by CMS.</u>
V. Clinical Quality Measures and Management Practices	C.3.a. Health Care Services	29	<u>No Change</u> Substantive	<ul style="list-style-type: none"> <u>No change to current language. Requires Contractor to report information on overweight and obese children's Body Mass Index.</u>
V. Clinical Quality Measures and Management Practices	C.3.b. Health Care Services	29	Substantive	<ul style="list-style-type: none"> Requires Contractor to <u>inform increase awareness among</u> its providers <u>the availability of screening tools at a discounted rate. MRMIB will provide information on how to order the tools.</u> of the importance of screening for behavioral health and developmental issues in subscriber children ages 0-5. <u>Requires Contractor to report on its activities to increase screening of young children.</u> <u>Requires Contractor to make available to its providers standardized screening tools and lists examples of such tools.</u>
V. Clinical Quality Measures and Management	C.3.c. Health Care Services	29	Substantive	<ul style="list-style-type: none"> Requires Contractor to increase awareness among providers of the importance of routine pediatric dental care and encourage

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Practices				pediatricians to educate parents about oral health and the need to visit a dentist for check-ups during well-baby visits.
V. Clinical Quality Measures and Management Practices	D.2. Encounter and Claims Data	30	Substantive	<ul style="list-style-type: none"> Requires the Contractor to provide encounter and claims data no later than sixty (60) 30 days after requested by the State. Requires submission of encounter and claims data no later than one hundred and eighty (180) days after the end of the month in which a service was rendered.
V. Clinical Quality Measures and Management Practices	D.3. Encounter and Claims Data	30	Substantive	<ul style="list-style-type: none"> Requires the Contractor to provide encounter and claims data retroactively to January 1, 2008 2006
V. Clinical Quality Measures and Management Practices	E.1.b. Quality Performance	31	Non-Substantive	<ul style="list-style-type: none"> Moves provisions regarding the External Quality Review Organization (EQRO) to the next section.
V. Clinical Quality Measures and Management Practices	E.1.c. Quality Performance	31-32	Substantive	<ul style="list-style-type: none"> Requires Contractor to cooperate with the State and the EQRO and provide all information requested by the EQRO. Contractor may be required to submit a corrective action plan if the State determines

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				that the Contractor's performance does not meet established standards.
V. Clinical Quality Measures and Management Practices	E.3. Quality Performance	32	Substantive	<ul style="list-style-type: none"> Notifies Contractor that the State will track Contractor's performance and Contractor agrees to submit a quality improvement plan when requested by the State.
V. Clinical Quality Measures and Management Practices	F. Group Needs Assessment	32	Substantive	<ul style="list-style-type: none"> Requires Contractor to submit an update to the 2011 Group Needs Assessment by September 30, 2012.
Exhibit B	I.B.1	2	Non -Substantive	<ul style="list-style-type: none"> Changes the timeframe for the State to pay fees to the Contractor from fifteen (15) days to forty-five (45) days after completion of the month of coverage.
Exhibit B	II.A.2	3	Non-Substantive	<ul style="list-style-type: none"> Changes the timeframe for reporting the Minimum Loss Ratio (MLR) to reflect the October 1 benefit year.