Cardinal Care Managed Care Contract FY 2027 Amendments
Effective July 1, 2026

Affected Contract Sections	Description of Changes	Reason for Change
1.3.3 Juvenile Justice Reentry Program	Added language to require MCOs to integrate all program requirements into its policies and procedures, and to include participation of Care Managers in Reentry Transitional Meetings for eligible youth enrolled with the MCO when requested by Re-Entry Targeted Case Managers.	Clarification of program requirements
3.9.1 Required Outreach to Certain Members to Assist with Medicaid Eligibility Redeterminations	Added new sections to describe MCO responsibilities with assisting members with redeterminations. These changes are needed to assist members impacted by HR1 redetermination requirements.	Federal Requirement
4.4.3 Permitted Marketing and Outreach Activities	Added new language describing MCOs ability to outreach to members to assist with redeterminations. This applies to the non HR1 impacted members. MCOs always had the option to do this but requested this language be added to clarify that ability.	Clarification of program requirements
5.12.1.1 LTSS Screening Documentation Requirements	Added language to clarify DMAS expectations for MCO outreach methods to contact members to screen for LTSS. MCOs were confused about previous requirements.	Clarification of contract language
5.12.2.5 Individual Experience Survey for ADHC Members	Updated IES requirements for Adult Day Health Care members	Clarification of contract language
5.12.2.20 LTSS Documentation Requirements	Updated reporting and documentation requirements for Adult Day Health Care providers.	Clarification of contract language
5.12.4.2 DMAS 225 Notification Circumstances	Removed outdated language to reflect that we no longer use the DMAS 225 to be notified of members' incarceration.	Removed Outdated Language
5.12.5 Consumer Direction and Contract with the Fiscal/Employer Agent and various subsections	In 5.12.5.1, 5.12.5.2, 5.12.5.3, 5.12.5.5, 5.12.5.6, 5.12.5.7, 5.12.5.10, 5.12.5.11, 5.12.5.12, 5.12.5.14, 5.12.5.17, 5.12.5.18, 5.12.5.22, 5.12.5.23 were amended to make various language updates to requirements for Fiscal/Employer Agents in recording personal care attendant hours, sick leave, overtime and other activities. Also updates language to include performance standards for F/EA call center operations, web portal, and processing of new employee onboarding. Performance standards added to this amendment are actually already in place but had not been included in the contract language, so those were added for clarity. The current DMAS F/EA contract also includes performance standards and mirroring a similar	Clarification of contract language

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	structure helps maintain consistency in oversight and expectations across the Consumer Direction program.	
5.12.8.1 Nursing Facility (Including Specialized Care and Long-Stay Hospital)	Updated language to explain forms of notification that triggers the MCO's entry of facility admissions or discharges into the DMAS Web portal to ensure DMAS is notified timely.	Clarification of contract language
5.12.9 Reporting of LTSS Service Reductions and Denials	Updated language to clarify DMAS review of LTSS service reductions and denials in accordance with the CMS 2024 Interoperability Final Rule.	Federal regulatory change per Interoperability Final Rule
5.14 Non-Emergency Medical Transportation Services	Added language to revise MCO NEMT Broker reporting requirements in accordance with General Assembly action.	GA action
5.15 Pharmacy Services and various subsections	5.15, 5.15.1, 5.5.1.1, 5.15.1.3, 5.15.4, 5.15.4.1, 5.15.4.3, 5.15.5, 5.15.6, 5.15.10, 5.15.11, Updated language to reflect GA changes, clarify requirements for MCO PBMs in accordance with GA action; update and correct regulatory references, and correct typos.	GA action, federal regulatory changes, clarification of contract language
5.16 Telehealth and Telemedicine	Removed reference to State Plan Amendment as DMAS will not be seeking a State Plan Amendment for telehealth at this time.	Language correction
7.1.2 Provider Choice Standards	Clarified the types of Behavioral Health providers to which member choice standards apply.	Clarification of contract language
7.3.4 Provider Credentialing Standards	Added the requirement that Contractors conduct in-person site reviews at freestanding psychiatric facilities and ASAM Level 3.1, 3.3, 3.5 and 3.7 facilities in accordance with NCQA policy. Language was added to point out this is an NCQA requirement for accredited health plans.	Clarification of contract language
7.3.5.2 ARTS Provider Qualifications and Annual Review	Removed outdated language requiring Contractors to recredential certain ARTS providers in accordance with current practice.	Language correction
8.4.2.1 Mandatory High Priority Populations, and 8.4.6, Restratification	Clarified that members receiving Private Duty Nursing services through third parties such as commercial insurance are a Mandatory High Priority Population. Also clarified in 8.4.6 that members receiving PDN through third party coverage must be restratified as well. Changes are being made to ensure this high-need population is addressed appropriately when being served by third parties.	Clarification of contract language

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8.4.2.2 Mandatory Priority Populations	Added members who are inpatients at state facilities such as state hospitals to Mandatory Priority Populations to ensure MCOs provide care coordination as appropriate.	Clarification of contract language
8.4.4 Case Manager Staffing Ratios	Updated requirements for care manager ratios for members receiving Private Duty Nursing services and excludes these members from blended care manager caseloads. Also added language including members receiving PDN from third parties (such as private insurance) to this exclusion. PDN members are highly complex and MCOs must ensure appropriate staff availability to address their needs.	Clarification of contract language
8.9.1.2 Coordination of Member Services and Providers Across the Continuum	Clarifies that MCO must support members under age 21 experience a denial of or reduction in services to ensure they are meeting the needs of this vulnerable population.	Clarification of contract language
8.18 Assistance for Members Required to Participate in Community Engagement Activities	Added a new Section, 8.18, to describe requirements related to HR1 Community Engagement (Work Requirements) activities. Also renamed Section 8.17 which previously included "Community Engagement" in the section title.	Federal Requirement
9.1 Grievances	Moved an existing requirement from section 2.12.3 to 9.1. We require MCOs to track member and provider complaints. Because the language was in the Call Center section (2.12.3) MCOs interpreted the to requirement to mean they only had to track the complaints made to the call center, which is not our intent since MCOs have several other methods a complaint can be filed. By moving the language we hope to resolve this issue.	Clarification of contract language
9.5, Coverage Decision Letter for Certain Dual Eligible Members	Beginning January 1, 2025 and in accordance with both Federal and State requirements, all of our Health Plans must provide an integrated Appeals and Grievance process for members that have elected to enroll in the Health Plans Dual Eligible Special Needs Plan (DSNP). Health Plans have failed to properly integrate their process which has negatively impacted members ability to appeal. We have revised the language to clarify the requirements.	Clarification of Federal Requirement
9.7 State Fair Hearing Process	Updated requirements for documentation the MCO must submit to DMAS in advance of State Fair Hearings. Currently, DMAS requires MCOs to notify the Appeals Division when an appellant failed to exhaust the internal appeal process. Content of these notices varies, which can cause confusion between parties. Requiring the additional information prevents erroneous appeal dismissals and helps the Appeals Division ensure the MCO used the correct information when searching for an internal appeal.	Internal process change
9.8.2 Provider Appeals to the Department	Clarified requirements in 9.8.2 and 9.8.3 for MCO submission of provider appeal documentation in formal and informal appeals.	Clarification of contract language

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9.8.3 Informal Appeals	Clarified requirements for MCO submission of informal provider appeals case summary	Internal process change
9.8.4 Formal Appeals	Clarifies that a DMAS staff attorney is required to provide appeal representation during formal appeals to serve as the counsel of record. Change is being made at this time because DMAS has been requiring MCOs to provide their own attorneys for appeal actions since July 2025 but was recently informed by OAG that we cannot do this so we are reverting back to prior policy.	Internal process change
12.1.10 Value Based Payments, and subsequent subsections	Updated language in 12.1.10,12.1.10.1, 12.1.10.3, 12.1.10.4, 12.1.10.5,12.1.10.6, to clarify VBP reporting requirements.	Clarification of contract language
12.1.10.7 and 12.1.10.8, Nursing Facility Value-Based Payment Incentive Initiative	Updated NF VBP reporting and payment processes requirements. MCOs expressed confusion	Clarification of contract language
12.1.11 Physician Incentive Plans	Updated requirements for contracts between MCOs and physicians governing PIPs in accordance with new federal regulations implemented as part of the 2025 Managed Care Final Rule.	Federal regulatory change
12.2.5.1 Obstetric and Gynecologic Services	Moved OB/GYN payment requirements from section 5.13.2, Maternity Care, into new section 12.2.5.1, a subsection of Section 12, Provider Payment, for language congruence.	Contract clean-up
15.2.6 Performance Withhold Program, and subsequent subsections	Updated language in 15.2.6, 15.2.6.1, 15.2.6.2 and 15.6.2.3 to clarify requirements for PWP reporting and quality measurement. Also removed outdated language relating to prior FY suspension of withholds.	General Assembly action and language clarifications
15.2.7 Clinical Efficiencies and subsections	Updated language in 15.2.7, 15.2.7.1, 15.2.7.2 and 15.2.7.3 to reflect General Assembly budget action and to update requirements for MCO measurement of clinical efficiencies to prevent Emergency Department visits and hospital readmissions.	General Assembly action, clarification of contract requirements
15.2.8 Discrete Incentive Transition Program	Edited language to include applicable CFR section to assist MCO understanding of program requirements.	Clarification of contract language
19.3.1 Monthly Reporting of Identified Overpayments and Recoveries	Inserted new section 19.3.1 with language requiring MCO to report monthly to DMAS on provider overpayments and recoveries in accordance with provisions of the 2025 Managed Care Final Rule. Also added a section requiring the MCO to seek DMAS approval on recovery actions exceeding $100,000 due to provider abrasion over ongoing recovery efforts.	Federal regulatory change, clarification of contract language
19.3.2 Treatment of Recoveries	Inserted new section 19.3.2 with language requiring MCO to notify DMAS of provider claims recovery efforts over $100,000. DMAS has received many provider complaints about lack of transparency around the MCOs' recovery of provider claims payments.	Internal process change

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Definitions	Added definitions related to changes at Section 3.9.1 related to HR1 requirements.	Federal Requirement
Attachment C, Network Provider Agreement Requirements	Revised language regarding providers ability to place liens against members. Some providers have been charging members for services improperly. DMAS worked with OAG and the Trail Lawyers Association to draft new language.	Clarification of contract language
Attachment E, Covered Services Chart	Update language in the Mammograms entry to match changes made to the language in 5.13.2.1 to replace American Cancer Society with USPSTF A and B recommendations. This is a correction from the mid-year amendment.	Policy Update