2011 MSHO/MSC+ Contract

(MCO)

MINNESOTA DEPARTMENT OF HUMAN SERVICES CONTRACT FOR MINNESOTA SENIOR HEALTH OPTIONS AND MINNESOTA SENIOR CARE PLUS SERVICES

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MINNESOTA DEPARTMENT OF HUMAN SERVICES CONTRACT FOR MINNESOTA SENIOR HEALTH OPTIONS AND MINNESOTA SENIOR CARE PLUS SERVICES

THIS CONTRACT, which shall be interpreted pursuant to the laws of the State of Minnesota, is made and entered into by the State of Minnesota, acting through its Department of Human Services (hereinafter STATE), and **MCO**, Managed Care Organization (hereinafter MCO);

The MCO has entered into a contract with the Centers for Medicare and Medicaid Services (CMS) to provide Medicare Parts A, B, and D services pursuant to the Medicare Modernization Act (MMA); MCO is participating in Medicare Advantage as a Dual Eligible Special Needs Plan (SNP) and meets or will meet CMS qualifications to participate as a low income benchmark plan for Medicare; and

The STATE has authority to implement voluntary Medicaid managed care under § 1915(a) of the Social Security Act, 42 U.S.C. § 1315 et. seq., and

Accordingly, the STATE and the MCO agree to comply with the laws, regulations, and general instructions of CMS regarding the coordination of Medicare and Medicaid benefits; and

The STATE may enter into agreements in furtherance of the Minnesota Medical Assistance Program for the provision of prepaid medical and remedial services pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., 42 CFR, Parts 434 and 438, Minnesota Statutes, § 256B.69 and § 256B.692, and may request waivers for the Medical Assistance program pursuant to § 1115 of the Social Security Act, 42 U.S.C. § 1315 et seq., and pursuant to § 1915 of the Social Security Act for Home and Community-based waiver services; and,

The STATE and the MCO agree to continue to coordinate and share Medicare and Medicaid information about Minnesota Senior Health Options Enrollees enrolled in the MCO's approved MSHO SNP, and Minnesota Senior Care Plus Enrollees; and

The STATE has received a § 1915(b) waiver for managed care for all individuals sixty-five (65) and over, and a § 1915(c) waiver amendment for Home and Community-Based Services in certain counties; and

Through this renewal contract, **Byyyyy**, the STATE and the MCO have agreed to renew the 2010 Contract, numbered Bxxxxx, for the next Contract Year, January 1, 2011 through December 31, 2011;

NOW, THEREFORE, in consideration of the mutual undertakings and agreements hereinafter set forth, the parties agree as follows:

Article. 1 Overview. This Contract implements: 1) Minnesota Senior Health Options (MSHO), that creates an alternative delivery system for acute and long-term care services integrating Medicare and Medicaid funding for persons age sixty-five and over who are Dually Eligible for

Medicare and Medicaid; and 2) Minnesota Senior Care Plus (MSC+), that outlines the health benefits the MCO shall provide through the Prepaid Medical Assistance Medical Care program to eligible Enrollees, including Home and Community-Based Waiver Services (HCBS). The Medical Assistance Medical Care program is a public health benefits program intended to provide Enrollees with access to cost-effective health care options.

All articles of this Contract apply to all programs, unless otherwise noted. All references to "days" in the Contract mean calendar days unless otherwise specified in the Contract (e.g. "business days"). All references to Special Needs Plan or SNP in the Contract pertain only to MCO's MSHO product.

Article. 2 Definitions. Whenever used in this Contract, the following terms have the respective meaning set forth below, unless the context clearly requires otherwise, and when the defined meaning is intended, the term is capitalized.

2.1 638 Facility means facilities funded by Title I or V of the Indian Self-Determination and Education Assistance Act (Public Law 93-638), as amended.

2.2 Abuse means the definition as set out in Minnesota Rules, Part 9505.2165, subpart 2. Abuse shall also include substantial failure to provide Medically Necessary items and services that are required to be provided to an Enrollee under this Contract if the failure has adversely affected or has a substantial likelihood of adversely affecting the health of the Enrollee.

2.3 Action means 1) the denial or limited authorization of a requested service, including the type or level of service; 2) the reduction, suspension, or termination of a previously authorized service; 3) the denial, in whole or in part of payment for a service; 4) the failure to provide services in a timely manner; 5) the failure of the MCO to act within the timeframes defined in sections 8.3 and 8.4; or, 6) for a resident of a Rural Area with only one MCO, the denial of an Enrollee's request to exercise his or her right to obtain services outside the network.

2.4 Adjudicated means that a claim has reached its final disposition of paid or denied.

2.5 Adult Guardianship means

(A) Private Guardian refers to a person or party who has been appointed and ordered by the court to execute the powers, authority, duties and responsibilities involved in the protective arrangement of a guardianship, whereby the agent manages the personal life affairs, as needed, for a ward, who has been deemed or determined to be an incapacitated person by the court in accordance with Minnesota Statutes, §§ 524.5-101 through 524.5 502.

(B) Public Guardian refers to a situation where the Commissioner is ordered and appointed by the court to act as public guardian for an adult with a mental disability who lacks resources to employ a guardian, but needs this level of supervision and protection, and has no other private party willing and able to act as private guardian, in accordance with Minnesota Chapter Law 252A and Public Guardianship Rule #175, Minnesota Rules, parts 9525.3010 through 9525.3100.

2.6 Advance Directive means "advance directive" as defined in 42 CFR § 489.100.

2.7 Aged means a category of MSC+ Enrollees used as a factor to determine the Rate Cell status of an individual Enrollee. The Aged category includes those MSC+ Enrollees who are age sixty five (65) and older.

2.8 American Indian means those persons for whom services may be provided pursuant to 42 CFR § 136.12.

2.9 Appeal means an oral or written request from the Enrollee, or the Provider acting on behalf of the Enrollee with the Enrollee's written consent, to the MCO for review of an Action.

2.10 Atypical Services or Atypical Provider means those non-healthcare services or Providers of those services for whom CMS does not issue a National Provider Identifier (NPI). Examples include non-emergency transportation Providers and carpenters building a home modification.

2.11 Authorized Representative means a person who has assumed the responsibilities outlined in and pursuant to Minnesota Rules, Part 9505.0085, Subpart 2.

2.12 Basic Care Rate means the rate for provision and administration of State Plan services covered in the MCO's contract, excluding Nursing Facility Services.

2.13 Benefit Period means, under Medicare, the period of consecutive days that begins with the first day on which an Enrollee is furnished Inpatient Hospitalization or extended care services by the MCO, and ends at the close of a period of sixty (60) consecutive days during which the Enrollee was neither an inpatient in a hospital nor met the criteria for payment for a Skilled Nursing Facility.

2.14 Business Continuity Plan means a comprehensive written set of procedures and information intended to maintain or resume critical functions in the event of an Emergency Performance Interruption (EPI).

2.15 Capitation Payment means a payment the STATE makes periodically to the MCO for each Enrollee covered under the Contract for the provision of services as defined in Article 6, regardless of whether the Enrollee receives these services during the period covered by the payment.

2.16 Care Coordination for MSHO Enrollees means the assignment of an individual who coordinates the provision of all Medicare and Medicaid health and long-term care services for MSHO Enrollees, and who coordinates services to an MSHO Enrollee among different health and social service professionals and across settings of care. This individual must be a social worker, public health nurse, registered nurse, physician assistant, nurse practitioner, or physician.

2.17 Care Management for All Enrollees means the overall method of providing ongoing health care in which the MCO manages the provision of primary health services with additional appropriate services provided to an Enrollee. See section 6.1.

2.18 Care Plan means the document developed in consultation with the Enrollee, the Enrollee's treating physician, health care or support professional, or other appropriate individuals, and where appropriate, the Enrollee's family, caregiver, or representative that, taking into account the extent of and need for any family or other supports for the Enrollee, identifies the necessary health and Home and Community-Based services to be furnished to the Enrollee.

2.19 Care System means any entity that an MCO contracts with and delegates some portion of its Care Management and/or Primary Care responsibilities.

2.20 Case Management for MSC+ Enrollees means the assignment of an individual who coordinates Medicaid health and long-term care services for an MSC+ Enrollee receiving Elderly Waiver Services among different health and social service professionals and across settings of care.

2.21 Clean Claim means, pursuant to 42 CFR § 447.45 and 447.46, and Minnesota Statutes, § 62Q.75, subd. 1(b), a claim that has no defect or impropriety, including any lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

2.22 Clinical Trials means those trials that have been subjected to independent peer-review of the rationale and methodology; are sponsored by an entity with a recognized program in clinical research that conducts its activities according to all appropriate federal and state regulations and generally accepted standard operating procedures governing the conduct of participating investigators; and whose results will be reported upon completion of the trial regardless of their positive or negative nature.

2.23 CMS means the Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services.

2.24 Commissioner means the Commissioner of the Minnesota Department of Human Services or the Commissioner's designee.

2.25 Common Carrier Transportation means the transport of an Enrollee by a bus, taxicab, or other commercial carrier or by private automobile.

2.26 Community Health Service Agency means a "local health agency" or a public or private nonprofit organization that enters into a contract with the Commissioner of Health pursuant to Minnesota Statutes, § 145.891 through § 145.897.

2.27 Community Non-Elderly Waiver (Community Non-EW) means Enrollees who, at capitation for MSHO or MSC+, coded in MMIS to be in a community living arrangement and are not enrolled in the Elderly Waiver for the first of the following month.

2.28 Community Elderly Waiver (Community EW) means Enrollees who, at capitation for MSHO or MSC+ are coded in MMIS to be in a community living arrangement and are enrolled in the Elderly Waiver for the first of the following month.

2.29 Community Health Worker means a person who meets the certification or experience qualifications listed in Minnesota Statutes § 256B.0625, subd. 49, to provide coordination of care and patient education services under the supervision of a Medical Assistance enrolled physician, advanced practice registered nurse, Mental Health Professional, dentist, or a certified public health nurse operating under the direct authority of an enrolled unit of government.

2.30 Community Health Worker Services means patient education and care coordination provided by a Community Health Worker in clinics and community settings for the purpose of disease prevention, promoting health, and increasing access to health care for individuals and their communities.

2.31 Contract Year means the calendar year for which the term of this Contract is effective, as described in section 5.1.

2.32 Cost Avoidance Procedure means the process by which a Provider obtains payment from the identified third party resource before billing the MCO.

2.33 County Care Coordination System means a county or multi-county entity with which the MCO contracts for care coordination and related functions for MSHO Enrollees.

2.34 County Case Management System means a county or multi-county entity with which the MCO contracts for case management and related functions for MSC+ Enrollees.

2.35 Covered Service means a health care service as defined in Minnesota Statutes, § 256B.0625, and Minnesota Rules, Parts 9505.0170 through 9505.0475, and as applicable, Minnesota Statutes, § 256B.0915, and that was provided in accordance with the MCO's Service Delivery Plan and the MCO Certificate of Coverage, as approved by the STATE.

2.36 Customized Living means services delivered by a class A or class F home care Provider, and provided in a building that is registered as a housing with services establishment under Minnesota Statutes Chapter 144D.

2.37 Cut-Off Date means the last day on which new enrollment information may be entered in the STATE's Medicaid Management Information system (MMIS) in order to be effective the first day of the following month.

2.38 Disease Management Program means a multi-disciplinary, continuum-based approach to improve the health of Enrollees that proactively identifies populations with, or at risk for, certain medical conditions, and this program: 1) supports the physician/patient relationship and place of care, 2) emphasizes prevention of exacerbation and complications utilizing cost-effective evidence-based practice guidelines and patient empowerment strategies such as self-management, and 3) continuously evaluates clinical, humanistic, and economic outcomes with the goal of improving overall health.

2.39 Dual Eligible or Dual Eligibility or Dual means an individual who has established eligibility for Medicare as their primary coverage and Medicaid as their secondary coverage.

2.40 Education Begin Date means the date on which the MCO will be presented by the Local Agency as an initial enrollment option to Recipients.

2.41 Elderly See Aged.

2.42 Elderly Waiver means the Home and Community Based Services waiver program authorized by a federal waiver under § 1915(c) of the Social Security Act, 42 U.S.C. § 1396, and pursuant to Minnesota Statutes, § 256B.0915.

2.43 Emergency Care means the provision of Covered Services that are required to treat an immediate Medical Emergency as defined at section 2.78.

2.44 Emergency Performance Interruption (EPI) means any event, including, but not limited to: wars, terrorist activities, natural disasters, pandemic or health emergency, that the occurrence and effect of which is unavoidable and beyond the reasonable control of the MCO and/or the STATE, and which makes normal performance under this contract impossible or impracticable.

2.45 Enrollee means a Medical Assistance eligible person age sixty-five (65) or older whose enrollment in the MCO has been entered on MMIS. Where this contract confers certain rights or obligations that the individual (or a court of law acting on the individual's behalf) has conferred to a guardian, conservator, legal or Authorized Representative, the use of the terms "Recipient" or "Enrollee" does not preclude the legal or Authorized Representative from meeting those obligations or exercising those rights, to the extent of the legal or Authorized Representative's authority.

2.46 End Stage Renal Disease (ESRD) means chronic kidney failure, or a stage of renal impairment requiring either a regular course of dialysis or kidney transplantation to maintain life.

2.47 Experimental or Investigative Service means a drug, device, medical treatment, diagnostic procedure, technology, or procedure for which reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes, pursuant to Minnesota Rules, Parts 4685.0100, subpart 6a and 4685.0700, subpart 4, item F.

2.48 Family Planning Service means a family planning supply (related drug or contraceptive device) or health service, including screening, testing, and counseling for sexually transmitted diseases, such as HIV, when provided in conjunction with the voluntary planning of the conception and bearing of children and related to an Enrollee's condition of fertility.

2.49 Fraud means the definition set out in Minnesota Rules, Part 9505.2165, subpart 4.

2.50 Generally Accepted Community Standards means that access to services is equal to or greater than that currently existing in the Medical Assistance fee-for-service system in the Metro or Non-Metro area.

2.51 Grievance means an expression of dissatisfaction about any matter other than an Action; including but not limited to, the quality of care or services provided or failure to respect the Enrollee's rights.

2.52 Grievance System means the overall system that includes Grievances and Appeals handled at the MCO and access to the State Fair Hearing process.

2.53 Health Care Home means a clinic, personal clinician, or local trade area clinician that is certified under Minnesota Rules, parts 4764.0010 to 4764.0070.

2.54 Health Care Professional means a physician, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife, licensed independent clinical social worker, and registered respiratory therapy technician.

2.55 Home and Community Based Services (HCBS) means services provided under a federal waiver under § 1915(c) of the Social Security Act, 42 U.S.C § 1396n, and pursuant to Minnesota Statutes, § 256B.092 subd. 4, and § 256B.0915. These services are for Enrollees who meet specific eligibility criteria including being at risk of institutional care if not for the provision of HCBS services. The services are intended to prevent or delay Nursing Facility placements. See also Elderly Waiver Services as described in section 6.1.11.

2.56 Home Care Services means a Medicare health service as listed in § 1861 of the Social Security Act (42 U.S.C. § 1395x(m)); and for Medicaid, meets the criteria for Medical Necessity, is ordered by a physician and documented in a service plan that is reviewed by the physician at least once every sixty (60) days for the provision of home health services, or private duty nursing, or at least once every three hundred and sixty-five (365) days for personal care; and the services are provided to the recipient at the recipient's residence that is a place other than a hospital or long-term care facility or as specified in Minnesota Statutes, § 256B.0625, subd. 6(a). These services include the following:

(A) Home health aide services as listed in Minnesota Statutes, § 256B.0625 subd. 6(a), § 256B.0651, and 256B.0653, subd. 3;

(B) Skilled nursing visits including telehomecare visits, provided by a certified Home Health Care Agency as authorized by Minnesota Statutes, § 256B.0625, subd.6a, and § 256B.0653, subd. 4;

(C) Home care therapies as listed in Minnesota Statutes, § 256B.0625 subd. 8, and § 256B.0651, subd. 1(a);

(D) Durable medical equipment, and associated supplies when accompanied by a home care service as described in Minnesota Statutes § 144A.43 subd.3 (10); and

(E) Personal Care Assistance (PCA) services as authorized by Minnesota Statutes, § 256B.0659, subd. 2.

2.57 Hospice means a public agency or private organization or subdivision of either of these that is primarily engaged in providing hospice care for individuals with terminal illnesses authorized under § 1861(dd) of the Social Security Act and defined in 42 CFR § 418.100 et seq.

2.58 Hospice Care means palliative and supportive care and other services provided by an interdisciplinary team under the direction of an identifiable hospice administration to terminally ill hospice patients and their families to meet the physical, nutritional, emotional, social, spiritual, and special needs experienced during the final stages of illness, dying, and bereavement, as defined in Minnesota Statutes, § 144A.75, subd. 8, and includes the set of services as determined by the Medicare program under §1861(dd) of the Social Security Act and defined in 42 CFR § 418.3.

2.59 Improper Payment means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This includes, but is not limited to: 1) any payment for an ineligible Recipient; 2) any duplicate payment; 3) any payment for services not received; 4) any payment incorrectly denied; and 5) any payment that does not account for credits or applicable discounts.

2.60 Indian Health Care Provider means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). Indian Health Care Provider includes a 638 Facility and provision of Indian Health Service Contract Health Services (IHS CHS).

2.61 Indian Health Service (IHS) means the federal agency charged with administering the health programs for American Indians and Alaska Natives (AI/AN) who are enrolled members of federally recognized Indian tribes.

2.62 IHS Contract Health Services (IHS CHS) means health services covered by this contract that would otherwise be provided at the expense of the Indian Health Service, from public or private medical or hospital facilities other than those of the Indian Health Service, to American Indian Enrollees.

2.63 Indian Health Services Facility (IHS Facility) means a facility administered by the Indian Health Service that is providing health programs for American Indians and Alaska Natives (AI/AN) who are enrolled members of federally recognized Indian tribes.

2.64 Informed Choice means a voluntary decision made by the Enrollee or the Enrollee's legal representative, after becoming familiar with the alternatives, and having been provided sufficient relevant written and oral information at an appropriate comprehension level and in a manner consistent with the Enrollee's or the Enrollee's legal representative's primary mode of communication.

2.65 Inpatient Hospitalization means inpatient medical, mental health and chemical dependency services provided in an acute care facility licensed under Minnesota Statutes, §§ 144.50 through 144.56.

2.66 Institutionalized means Recipients who are coded as being in an Institutionalized living arrangement in MMIS at the time of enrollment. For changes in MSHO Rate Cell Categories after initial enrollment, Institutionalized Recipients are those MSHO Enrollees who have been Institutionalized for thirty (30) consecutive days. For MSC+ Enrollees, Institutionalized means a

category of Enrollees used as a factor to determine the Rate Cell of an Enrollee who resides in a Nursing Facility or intermediate care facility for the developmentally disabled (ICF/DD, formerly known as ICF/MR).

2.67 Lead Agency means a county, tribal health entity, or a participating MCO who is responsible to put into effect appropriate Home and Community Based Services waiver functions as delegated by the STATE, for any Enrollee who meets waiver program eligibility criteria under Medicaid HCBS Waivers, § 1915(c).

2.68 Level of Care Criteria means classifications and questions developed by the Minnesota Departments of Health and Human Services used to determine an Enrollee's Nursing Facility care needs.

2.69 Local Agency means a county or multi-county agency that is authorized under Minnesota Statutes, § 393.01, subd. 7, and § 393.07, subd. 2, as the agency responsible for determining Recipient eligibility for the Medical Assistance. Local Agency also means a federally recognized American Indian tribe's social service, human service, and/or health services agency.

2.70 Long Term Care Consultation (LTCC) means the assessment of Enrollees, pursuant to Minnesota Statutes, § 256B.0911, for the purpose of preventing or delaying Nursing Facility placements to offer cost-effective alternatives appropriate for the Enrollee's needs, and to assure appropriate admissions to a Nursing Facility. LTCC assessments shall be completed by a qualified professional, defined for the purposes of the LTCC as a social worker, public health nurse, registered nurse, physician assistant, nurse practitioner or physician. The qualified professional shall use the form designated by the STATE to determine eligibility for Nursing Facility placement or HCBS services.

2.71 Managed Care Organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract, and that is: (1) a Federally Qualified HMO that meets the advance directives requirements of 42 CFR § 489.100-104; or (2) any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: a) makes the services it provides to its Medicaid Enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid Recipients within the area served by the entity, and b) meets the solvency standards of 42 CFR § 438.116.

2.72 Managing Employee means an individual, (including a general manager, business manager, administrator, or director), who exercises operational or managerial control over the entity or part thereof, or who directly or indirectly conducts the day-to-day operation of the entity or part thereof as defined in 42 CFR § 455.1001.1001(a)(ii)(A)(6).

2.73 Marketing means any communication from the MCO, or any of its agents or independent contractors, with an Enrollee or Recipient that can reasonably be interpreted as intended to influence that individual to enroll or remain enrolled in that particular MCO's product, or to disenroll from or not enroll in another MCO's product.

2.74 Marketing Materials means materials that are produced in any medium by or on behalf of an MCO and can reasonably be interpreted as intended to market to potential or current

Enrollees. Marketing Materials include any informational materials targeted to potential or current Enrollees that: 1) promote the MCO or any product offered by the MCO; 2) inform potential or current Enrollees that they may enroll or remain enrolled in a plan offered by the MCO; 3) explain the benefits of enrollment in an MCO or rules that apply to Enrollees; or 4) explain how Medicare services are covered under the MSHO product, including conditions that apply to such coverage.

2.75 Material Modification of Provider Network means 1) a change that would result in an Enrollee having only three remaining choices of a Primary Care Provider within thirty (30) miles or thirty (30) minutes; or 2) a change which results in the discontinuation of a Primary Care Provider who is responsible for Primary Care for one third (1/3) or more of the Enrollees in the applicable area (the same area from which the affected Enrollee chose their Primary Care Provider or sole source Provider, prior to the Material Modification); or 3) a change which involves a termination of a sole source Provider where the termination is for cause. Such changes include both Medicare and Medicaid Providers and pharmacy benefit managers (PBM). For purposes of this section, termination of a Provider for cause does not include the inability to reach agreement on contract terms.

2.76 Medical Assistance means the federal/state Medicaid program authorized under Title XIX of the federal Social Security Act and Minnesota Statutes, Chapter 256B.

2.77 Medical Assistance Drug Formulary means prescription or over-the-counter drugs covered under the Medical Assistance program as determined by the Commissioner pursuant to Minnesota Statutes, § 256B.0625, subd. 13.

2.78 Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) placing the physical or mental health of the Enrollee (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) continuation of severe pain; 3) serious impairment to bodily functions; 4) serious dysfunction of any bodily organ or part; or 5) death. Labor and delivery is a Medical Emergency if it meets this definition. The condition of needing a preventive health service is not a Medical Emergency.

2.79 Medical Emergency Services means Inpatient and outpatient services covered under this Contract that are furnished by a Provider qualified to furnish emergency services and are needed to evaluate or stabilize an Enrollee's Medical Emergency.

2.80 Medically Necessary or Medical Necessity means, with the exception of Elderly Waiver services, pursuant to Minnesota Rules, Part 9505.0175, subpart 25, a health service that is consistent with the Enrollee's diagnosis or condition and:

(A) Is recognized as the prevailing standard or current practice by the Provider's peer group; and

(B) Is rendered:

(C) In response to a life threatening condition or pain; or

(D) To treat an injury, illness or infection; or

(E) To treat a condition that could result in physical or mental disability; or

(F) To care for the mother and unborn child through the maternity period; or

(G) To achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition; or

(H) Is a preventive health service defined under Minnesota Rules, Part 9505.0355.

2.81 Medicare means the federal insurance program for Aged and disabled people as defined under 42 U.S.C. § 1395 et. seq.

2.82 Medicare Advantage (MA) means the managed care program established for beneficiaries of Medicare Part A and enrolled under Part B, pursuant to the Medicare Modernization Act of 2003.

2.83 Medicare Advantage Organization (MAO) means a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of Provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements, pursuant to 42 CFR § 422.2.

2.84 Medicare Advantage Plan (MA Plan) means health benefits coverage offered under a policy or contract by an MA organization that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the Service Area of the MA plan (or in individual segments of a Service Area, pursuant to 42 CFR § 422.304(b)(2)), pursuant to 42 CFR § 422.2.

2.85 Medicare Advantage Special Needs Plan (MA SNP) means an MA Plan that exclusively enrolls, or enrolls a disproportionate percentage of, special needs Enrollees as set forth in 42 CFR § 422.4(a)(1)(iv) and provides Part D benefits under 42 CFR Part 423 to all Enrollees; and has been designated by CMS as meeting the requirements of a MA SNP as determined on a case-by-case basis using criteria that include the appropriateness of the target population, the existence of clinical programs or special expertise to serve the target population, and whether the proposal discriminates against sicker members of the target population, pursuant to 42 CFR § 422.2.

2.86 Medicare Prescription Drug Program (Part D Drug Benefit) means the prescription drug benefit for Medicare beneficiaries, pursuant to Title I of the Medicare Modernization Act of 2003.

2.87 Mental Health Professional means a person providing clinical services in the treatment of mental illness who meets the qualifications required in Minnesota Statutes, § 245.462, subd. 18(1) through (6), for adults; and Minnesota Statutes § 245.4871, subd. 27(1) through (6), for children.

2.88 Mental Illness means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that: 1) is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0 or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition, Axis I, II, or III; and 2) seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation as defined under Minnesota Statutes, § 245.462 subd. 20.

2.89 Metro Area means the following seven Minnesota counties: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington.

2.90 Minnesota Senior Care Plus (MSC+) means the mandatory PMAP program for Enrollees age sixty five (65) and over. MSC+ uses § 1915(b) waiver authority for State Plan services, and § 1915(c) waiver authority for Home and Community-Based Services. MSC+ includes Elderly Waiver services for Enrollees who qualify, and one hundred and eighty (180) days of Nursing Facility care.

2.91 Minnesota Senior Health Options (MSHO) means the Minnesota prepaid managed care program, pursuant to Minnesota Statutes, § 256B.69, subd. 23, that provides integrated Medicare and Medicaid services for Medicaid eligible seniors, age sixty-five (65) and over. MSHO includes Elderly Waiver services for Enrollees who qualify, and one hundred and eighty (180) days of Nursing Facility care.

2.92 MMIS means the Medicaid Management Information System.

2.93 MSHO Rate Cell Categories means the rate setting model for MSHO that includes Rate Cell Categories (RCCs) that are based on Enrollee living arrangement and Elderly Waiver status. Payment to the MCO will be based on which of these categories to which the MSHO Enrollee is assigned:

Living Arrangement	Rate Cell Category
Community Non-EW	A
Community EW	B
Institutionalized	D
Community Non-EW/Hospice	E
Community EW/Hospice	F

2.94 National Provider Identifier (NPI) means the ten (10) digit number issued by CMS which is the standard unique identifier for health care Providers, and which replaces the use of all legacy Provider identifiers (e.g., UPIN, Medicaid Provider Number, Medicare Provider Number, Blue Cross and Blue Shield Numbers) in standard transactions.

2.95 Non-Institutionalized means a category of MSHO and MSC+ Enrollees used as a factor to determine the Rate Cell of an Enrollee not permanently residing in a NF or ICF/DD (formerly known as ICF/MR).

2.96 Notice of Action means a Denial, Termination, or Reduction of Service Notice (DTR) or other Action as defined in 42 CFR § 438.400(b).

2.97 Nursing Facility (NF) means a long term care facility certified by the Minnesota Department of Health for services provided and reimbursed under Medicaid. Also known as Nursing Home.

2.98 Nursing Facility (NF) Add-On means the monthly per capita value of Nursing Facility services that are expected to be utilized within the Contract Year by those Recipients who are eligible for Medical Assistance and in the community prior to being Institutionalized within the same period.

2.99 Nursing Home Certifiable (NHC) means a designation indicating that an Enrollee is in need of Nursing Facility level of care as defined by the Level of Care Criteria. NHC status must be determined through face-to-face assessment using the STATE Long Term Care Consultation (LTCC) tool and Level of Care Criteria according to procedures in section 6.1.11(B).

2.100 Out of Service Area Care means health care provided to an Enrollee by non-Participating Providers outside of the geographical area served by the MCO.

2.101 Out-of-Plan Care means health care provided to an Enrollee by non-Participating Providers within the geographic area served by the MCO.

2.102 Participating Provider means a Provider who is employed by or under contract with the MCO to provide health services to Enrollees.

2.103 Person Master Index (PMI) means the STATE identification number assigned to an individual Recipient.

2.104 Person with an Ownership or Control Interest means a person or corporation that: A) has an ownership interest, directly or indirectly, totaling five percent (5%) or more in the MCO or a disclosing entity; B) has a combination of direct and indirect ownership interest equal to five percent (5%) or more in the MCO or the disclosing entity; C) owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by the MCO or the disclosing entity, if that interest equals at least five percent (5%) of the value of the property or assets of the MCO or the disclosing entity; or D) is an officer or director of the MCO or the disclosing entity (if it is organized as a corporation) or is a partner in the MCO or the disclosing entity (if it is organized as a partnership).

2.105 Personal Care Assistance Provider Agency (PCPA) means a Medical Assistance enrolled provider that provides or assists with providing personal care assistance (PCA) services and includes a personal care assistance provider organization (PCPO), personal care assistance choice agency (PCPA), class A licensed nursing agency, and Medicare-certified home health agency.

2.106 Physician Incentive Plan means any compensation arrangement between an organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided to Enrollees of the MCO, as defined in 42 CFR § 422.208(a).

2.107 Post Payment Recovery means seeking reimbursement from third parties whenever claims have been paid, for which there are third parties that are liable for payment of the claims. This is also referred to as the "pay and chase" method.

2.108 Post-Stabilization Care Services means Medically Necessary Covered Services, related to an Emergency medical condition, that are provided after an Enrollee is stabilized, in order to maintain the stabilized condition, and for which the MCO is responsible when: 1) the services are Service Authorized; 2) the services are provided to maintain the Enrollee's stabilized condition within one hour of a request to the MCO for Service Authorization of further Post-Stabilization Care Services; 3) the MCO could not be contacted; 4) the MCO did not respond to a Service Authorization within an hour; or 5) the MCO and treating Provider are unable to reach agreement regarding the Enrollee's care.

2.109 Potential Enrollee means a Medical Assistance Recipient who may voluntarily elect to enroll in a given managed care program, but is not yet an Enrollee of an MSHO MCO.

2.110 Prepaid Medical Assistance Program, or PMAP means the program authorized under Minnesota Statutes, § 256B.69 and Minnesota Rules, Parts 9500.1450 through 9500.1464.

2.111 Primary Care means all health care services and laboratory services customarily furnished by or through a general practitioner, family practice physician, internal medicine physician, obstetrician/gynecologist, or geriatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

2.112 Primary Care Provider means a Provider or licensed practitioner, pursuant to Minnesota Rules, Part 4685.0100, subpart 12a, or a nurse practitioner or physician assistant, pursuant to Minnesota Rules, Part 4685.0100, subpart 12b, under contract with or employed by the MCO.**Priority Services** means:

(A) Those services that must remain uninterrupted to ensure the life, health and/or safety of the Enrollee;

(B) Medical Emergency Services, Post-Stabilization Care Services and Urgent Care;

(C) Other Medically Necessary services that may not be interrupted or delayed for more than fourteen (14) days;

(D) A process to authorize the services described in paragraphs (A) through (C);

(E) A process to pay Providers who provide the services described in paragraphs (A) through (C).

2.114 Privacy Incident means violation of the Minnesota Government Data Practices Act (MGDPA) and/or the HIPAA Privacy Rule (45 CFR Part 164, subpart E), including, but not limited to, improper and/or unauthorized use or disclosure of Protected Information, and incidents in which the confidentiality of the information maintained by the parties has been breached.

2.115 Protected Information means private information concerning individual STATE clients that the MCO may handle in the performance of its duties under this Agreement, including any or all of the following:

(A) Private data (as defined in Minnesota Statutes, § 13.02, subd. 12), confidential data (as defined in Minnesota Statutes, § 13.02, subd. 3), welfare data (as governed by Minnesota Statutes, § 13.46), medical data (as governed by Minnesota Statutes, § 13.384), and other non-public data governed elsewhere in Minnesota Government Data Practices Act (MGDPA), Minnesota Statutes, Chapter 13;

(B) Medical records (as governed by the Minnesota Health Records Act [Minnesota Statutes, § 144.291 through 144-298]);

(C) Health records (as governed by the Minnesota Health Records Act [Minn. Stat. §§144.291-144.298]);

(D) Chemical health records (as governed by 42 U.S.C. § 290dd-2 and 42 CFR § 2.1. to § 2.67);

(E) Protected health information ("PHI") (as defined in and governed by the Health Insurance Portability Accountability Act ["HIPAA"], 45 CFR § 164.501); and

(F) Electronic Health Records (as governed by Health Information Technology for Economic and Clinical Health Act (HITECH), 42 USC § 201 note, 42 USC § 17931); and

(G) Information protected by other applicable state and federal statutes, rules, and regulations governing or affecting the collection, storage, use, disclosure, or dissemination of private or confidential individually identifiable information.

2.116 Provider is an individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services.

2.117 Provider Manual means the current Internet online version of the official STATE publication, entitled "*Minnesota Health Care Programs Provider Manual*" available to enrolled Providers for policy clarification, procedures, or definitions of Covered Services under the Medical Assistance program.

2.118 Qualified Professional (QP) means a Qualified Professional for supervision of Personal Care Assistance services as defined in Minnesota Statutes, § 256B.0625, subd. 19c.

2.119 Rate Cell means the pricing data attributed to an Enrollee to determine the monthly prepaid Capitation Payment that will be paid by the STATE and CMS to the MCO for health coverage of that Enrollee. A Rate Cell is determined based on Rate Cell determinants, which may consist of all, or a part of the following, consistent with MMIS requirements: age, sex, county of residence, major program, eligibility type, living arrangement, Medicare status, rate cell category and Product ID.

2.120 Recipient means a person who has been determined by the Local Agency to be eligible for the Medical Assistance program.

2.121 Restricted Recipient Program means a program for Recipients and Enrollees who have failed to comply with the requirements of the program. Placement in the Restricted Recipient Program does not apply to services in long term care facilities and/or covered by Medicare. Placement in the Restricted Recipient program means:

(A) Requiring that for a period of twenty four (24) or thirty six (36) months of eligibility the Enrollee or Recipient must obtain health services from a designated Primary Care Provider located in the Enrollee's or Recipient's local trade area, a hospital used by the primary care provider, a pharmacy, or any other designated health service Provider, including a Minnesota Health Care Program (MHCP) enrolled Personal Care Provider Agency (PCPA) or Medicare certified Provider;

(B) Prohibiting the Enrollee or Recipient from using the personal care assistance choice, flexible use option, or consumer directed community services for a period of twenty-four (24) or thirty-six (36) months of eligibility.

2.122 Rural Area means any area other than an urban area as an urban area is defined in 42 CFR § 412.62(f)(1)(iii).

2.123 Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

2.124 Serious and Persistent Mental Illness (SPMI) means a condition that meets the criteria defined in Minnesota Statutes, § 245.462 subd. 20(c).

2.125 Service Area means the counties of Minnesota in which the MCO agrees to offer coverage under this Contract.

2.126 Service Authorization means a managed care Enrollee's request, or a Provider's request, on behalf of an Enrollee, for the provision of services, and the MCO's determination of the Medical Necessity for the medical service and authorization of Home and Community Based Services prior to the delivery or payment of the service. Home and Community Based Services are not subject to the Medical Necessity definition in this section.

2.127 Service Delivery Plan means the plan submitted by the MCO as part of the response to the Request for Proposals, and approved by the STATE.

2.128 Skilled Nursing Facility (SNF) means a facility certified by Medicare to provide inpatient skilled nursing care, rehabilitation services or other related health services. Such services can only be performed by, or under the supervision of, licensed nursing personnel.

2.129 Spenddown means the process by which a person who has income in excess of the Medical Assistance income standard allowed in Minnesota Statutes, § 256B.056, subd. 5, becomes eligible for Medical Assistance by incurring medical expenses that are not covered by a liable third party, except where specifically excluded by state or federal law, and that reduce the excess income to zero.

2.130 Spenddown, Medical (Medical Spenddown) means a type of spenddown for Enrollees who live in the community and are eligible for Medical Assistance with a medical spenddown.

2.131 STATE means the Minnesota Department of Human Services or its agents, and the Commissioner.

2.132 State Fair Hearing means a hearing filed according to an Enrollee's written request with the STATE pursuant to Minnesota Statutes, § 256.045, related to the delivery of health services or participation in the MCO, denial (full or partial) of a claim or service, failure to make an initial determination in thirty (30) days, or any other Action.

2.133 Substitute Health Services means those services an MCO has used as a replacement for or in lieu of a service covered under this Contract because the MCO has determined: (1) the MCO reimbursement for the Substitute Health Service is less than the MCO reimbursement for the Covered Service would have been, had the Covered Service been provided; and (2) that the health status of and quality of life for the Enrollee is expected to be the same or better using the Substitute Health Service as it would be using the Covered Service.

2.134 Telemedicine Consultation means physician services made via two-way interactive video or store-and-forward technology, and for mental health services that are otherwise covered by Medical Assistance as direct face-to-face services. The Enrollee record must include a written opinion from the consulting physician providing the Telemedicine Consultation. A communication between two physicians that consists solely of a telephone conversation is not a Telemedicine Consultation.

2.135 Tribal Community Member means individuals identified as enrolled members of the tribe and any other individuals identified by the tribe as a member of the tribal community. This definition is used only in the Tribal Assessments sections 6.1.11(F) below and 6.1.14(E).

2.136 Unique Minnesota Provider Identifier (UMPI) means the unique identifier assigned by the STATE for atypical Providers that are not eligible for a NPI.

2.137 Urgent Care means acute, episodic medical services available on a twenty-four (24)-hour basis that are required in order to prevent a serious deterioration of the health of an Enrollee.

2.138 Volunteer Driver means an individual working with a program or organization recognized by the Local Agency or its representative that provides rides to health care appointments for eligible MHCP enrollees in the community.

2.139 Waiver Obligation means the amount that an Enrollee must contribute to the cost of services received under the Elderly Waiver as determined by the process authorized by Minnesota Statutes, § 256B.0915.

Article. 3 Duties. MCO agrees to provide the following services to the STATE during the term of this Contract.

3.1 Eligibility and Enrollment Duties.

3.1.1 Eligibility

(A) Service Area. Only those eligible persons who are enrolled in Medical Assistance residing within the Counties of the State of Minnesota identified in Appendix I (Service Areas) shall be eligible for enrollment.

(B) Eligible Persons. Any Recipient who resides within the Service Area may enroll in the MCO at any time during the duration of this Contract, subject to the limitations contained in this Contract.

(C) Eligibility Determination. Eligibility for Medical Assistance will be determined by the Local Agency. Eligibility for Medicare will be determined by CMS. All persons who receive Medical Assistance and reside in the Service Area will participate in MSC+, except for residents described in the Enrollment Exclusions section below. Persons eligible for MSC+ may voluntarily enroll in MSHO, subject to the limitations contained in this Contract.

(D) Enrollment Exclusions. The following Recipients are excluded from enrollment in the MCO's program:

(1) Both programs: The following exclusions apply to MSC+ and MSHO:

(a) Recipients eligible for the Refugee Assistance Program pursuant to 8 U.S.C. § 1522(e).

(b) Residents of State Regional Treatment Centers, unless the MCO approves placement. For purposes of this Contract, approval by the MCO would include a placement that is court-ordered within the terms described in section 6.1.23(Y). For purposes of this section, Woodhaven Senior Community is not considered a State Regional Treatment Center.

(c) Individuals who are Qualified Medicare Beneficiaries (QMB), as defined in § 1905(p) of the Social Security Act, 42 U.S.C. § 1396d(p), and who are not otherwise eligible for Medical Assistance.

(d) Individuals who are Specified Low-Income Medicare Beneficiaries (SLMB) as defined in § 1905(p) of the Social Security Act, 42 U.S.C. § 1396a(a)(10)(E)(iii) and § 1396d(p), and who are not otherwise eligible for Medical Assistance.

(e) Recipients, who at the time of notification of mandatory enrollment in MSC+ or voluntary enrollment in MSHO have a communicable disease whose prognosis is terminal and whose primary physician is not a Participating Provider in the

MCO, and that physician certifies that disruption of the existing physician-patient relationship is likely to result in the patient becoming noncompliant with medication or other health services.

(f) Recipients who are eligible while receiving care and services from a non-profit center established to serve victims of torture.

(g) Recipients eligible for the emergency Medical Assistance program.

(2) The following exclusions apply to MSHO only:

(a) Individuals who have Medicare coverage through United Mine Workers.

(b) Individuals with a diagnosis of End Stage Renal Disease (ESRD) prior to enrollment in the MCO. See also 3.1(10) below.

(3) The following exclusions apply to MSC+ only:

(a) Medical Assistance Recipients who are terminally ill as defined in Minnesota Rules, Part 9505.0297, subpart 2, item N. and who, at the time enrollment in MSC+ would occur, have an established relationship with a primary physician who is not part of an MSC+ MCO.

(b) For MSC+, non-citizen Recipients who only receive emergency Medical Assistance under Minnesota Statutes, § 256B.06, subd. 4.

(c) For MSC+, Recipients receiving Medical Assistance on a Medical Spenddown basis.

(d) Medical Assistance Recipients with private health care coverage through a HMO certified under Minnesota Statutes, Chapter 62D. Such Recipients may enroll in MSC+ on a voluntary basis if the private HMO is the same as the MCO the person will select under MSC+.

(e) For MSC+, Medical Assistance Recipients with cost-effective employer-sponsored private health care coverage or who are enrolled in a non-Medicare individual health plan determined to be cost-effective, pursuant to Minnesota Statutes. § 256B.69, subd. 4(b)(9).

(E) Voluntary Enrollment populations for MSHO and MSC+. The following population is excluded from mandatory enrollment, but may elect to enroll in MSHO and MSC+ on a voluntary basis: Adults age sixty five (65) and over who are determined to have a Serious and Persistent Mental Illness and are eligible to receive Medical Assistance targeted case management services pursuant to Minnesota Statutes, §245.4711.

(F) Eligibility Determinations for MSHO. In order to be eligible to enroll in the MCO for MSHO, the individual must be:

(1) Sixty-five (65) years of age or older; or

(2) Turning sixty-five (65) years of age within the month they are requesting enrollment; and

(3) Eligible for Medical Assistance and Medicare Parts A and B; and

(4) Eligible to enroll in MSC+ within the MCO's Service Area as defined in Appendix I of this Contract.

(G) Additional Eligibility Parameters for MSHO.

(1) Nursing Facility and Community Residents. Nursing Facility residents and persons living in the community are eligible to enroll in the MCO for MSHO.

(a) Hospice. Enrollees who elect to enroll in the Medicare Hospice program while enrolled in MSHO are not required to disenroll from the MCO's MSHO product.

(b) End Stage Renal Disease (ESRD). Enrollees who are identified by CMS as having ESRD after enrollment in MSHO are not required to disenroll from the MCO's MSHO product. Individuals who develop ESRD while enrolled in a health plan (e.g., a commercial or group health plan, or a Medicaid plan) offered by the MA organization are eligible to elect an MA plan offered by that organization. In order to be eligible, there must be no break in coverage between enrollment in the health plan offered by an MA organization, and the start of coverage in the MA plan offered by the same organization. An individual who elects the MSHO SNP plan and who is medically determined to first have ESRD after the date on which the enrollment form is signed (or receipt date stamp if no date is on the form), but before the effective date of coverage under the MSHO SNP plan is still eligible to elect the MSHO SNP plan.

(c) Spenddown. Non-Institutionalized Recipients who are eligible for MSHO but are not required to enroll in MSC+ due to a Spenddown may enroll in the MCO for MSHO. Until further notice, the STATE is not currently enrolling new Enrollees who have Medical Spenddowns into MSHO. The only exception is for Recipients residing in a nursing facility and coded with a Medical Spenddown because they have elected Hospice. Enrollees who are enrolled into MSHO prior to acquiring a Medical Spenddown are not required to disenroll from MSHO provided the Enrollee agrees to pay the Medical Spenddown to the STATE on a monthly basis.

3.1.2 Enrollment

(A) Nondiscrimination. The MCO will accept all eligible Recipients who select the MCO for MSHO or who select or are assigned to the MCO for MSC+. The MCO will

enroll all eligible Recipients who select or are assigned to the MCO without regard to physical or mental condition, health status, need for health services, claims experience, medical history, genetic information, disability, marital status, age, sex, sexual orientation, national origin, race, color, religion, or political beliefs, and shall not use any policy or practice that has the effect of such discrimination.

(B) Order of Enrollment. The MCO shall enroll Recipients in the order in which they apply.

(C) Timing of Enrollment. Recipients may enroll with the MCO at any time during the duration of this Contract, subject to the limitations of this Article.

(D) Period of Enrollment.

(1) Each MSC+ Recipient enrolled in the MCO pursuant to this Contract shall be enrolled for twelve (12) months following the effective date of coverage, subject to the exceptions in this section.

(2) For MSHO, the MCO agrees to retain Medicare eligible Enrollees for three months after losing their Medicaid eligibility in the MCO, including Enrollees who no longer meet the requirements for managed care enrollment, as part of the MCO's Medicare Special Needs Plan enrollment.

(E) STATE Enrollment Limitation. The STATE may limit the number of Enrollees in the MCO if in the STATE or CMS's judgment, the MCO is unable to demonstrate a capacity to serve additional Enrollees. Enrollees already enrolled in the MCO shall be given priority to continue that enrollment if the STATE and CMS determine that the MCO does not have the capacity to accept all those seeking enrollment in the MCO's product.

(F) Open Enrollment. The MCO shall enroll any eligible Recipients during any open enrollment period required by the STATE or CMS.

(G) Voluntary Enrollment for MSHO. Enrollment in the MCO for the MSHO program shall be voluntary.

(H) Enrollee Change of MCO. Enrollees may change to a different MSHO MCO every thirty (30) days, and for MSC+ and MSHO, upon request to the MCO during the open enrollment period, or as allowed under Minnesota Rules, Part 9500.1453, subparts 5, 7, and 8, and 42 CFR Part 438.

(I) No Random Assignment of Provider. In no circumstance shall the MCO randomly assign an Enrollee to a Primary Care Provider upon reenrollment.

(J) Choice of Health Care Professional. The MCO must allow an Enrollee to choose his or her Health Care Professional to the extent possible and appropriate. "To the extent possible and appropriate" includes limiting the selection of a Primary Care Provider to participants in the MCO's network, unless the Primary Care Provider was already at

capacity, and other instances discussed in the "Provisions of the Proposed Rule and Analysis of and Response to Public Comments" to 42 CFR § 438.6(m), Volume 67, Number 115, column 3 of page 41,006 and column 1 of page 41,007 of the Federal Register, June 14, 2002.

(K) Health Care Home. The MCO Provider network must include Providers that include clinics, personal clinicians, or local trade area clinicians designated as Health Care Homes that meet the certification criteria listed in Minnesota Rules, parts 4764.0010 to 4764.0070. In addition, the MCO must:

(1) Track Enrollees with complex or chronic health conditions who are Enrolled in a certified Health Care Home; and

(2) Attribute enrollment in the Health Care Home to the clinic site, and the Enrollee specific care provided, pursuant to the Health Care Home Standards listed in Minnesota Rules, Part 4764.0040.

(L) Enrollee Change of Primary Care Provider. The Enrollee may change to a different Primary Care Provider within the MCO's network or Care System every thirty (30) days upon request to the MCO. This section does not apply to Enrollees who are under administrative sanctions pursuant to section 8.11.

3.1.3 MCO Enrollment Responsibilities. The MCO shall:

(A) Submission/and Data Entry of Enrollment Forms. Prior to submitting an enrollment form to the STATE, or entering enrollment information on MMIS, the MCO must verify (or must contractually arrange for verification of) Medicare status of the Potential Enrollee via the Medicare Advantage and Prescription Drug user Interface (MARx) or other system as directed by the STATE and CMS. A copy of the CMS eligibility screen print must be included with any enrollment form submitted to the STATE.

(B) The MCO must ensure that appropriate MCO staff have access to the MN-ITS and appropriate Medicare eligibility and managed care systems as directed by the STATE and CMS, including MARx.

(C) Agreement Not to Limit Enrollment. The MCO agrees not to set any enrollment limits on the number of Medical Assistance Recipients that it will serve, except as provided under Minnesota Statutes, § 62D.04, subd. 5, and Minnesota Statutes, § 256B.0644.

(D) LTCC Screening Document Entry. The MCO will be responsible to enter all screening documents into MMIS for all LTCC screenings performed, for the purpose of determining Rate Cell and payment. The MCO may enter the screening documents or may contract with a Local Agency or Care System to enter screening documents. The MCO shall submit to the STATE's security liaison a signed data privacy statement for all MCO employees and subcontractors who will be responsible for entering screening documents into MMIS.

(1) The STATE shall offer training to MCOs and its subcontractors on this process.

(2) The MCO shall download and install the required internet access software "Blue Zone" onto workstations for those staff that will be responsible for entering Screening Documents.

(3) The MCO shall be responsible for entering initial LTCC screenings, reassessments, telephone screenings for Nursing Facility placements, and other forms required by this contract.

(4) The MCO shall be responsible for entering screenings for Non-EW community Enrollees.

(E) STATE and CMS MSHO Enrollment; Enrollment TPA Services.

(1) Enrollment in MSHO for Medicaid in MMIS will be performed by the STATE or MCO.

(a) The STATE and MCO agree that coordination of enrollment processes for Medicare SNP and Medicaid benefits will be consistent with the requirements of 42 CFR § 422.107 (c) (6), regarding verification of the Enrollee's eligibility for both Medicare and Medicaid.

(b) MCO agrees to use the real-time data exchange and enrollment processes further described in sections 3.1.2 (Enrollment), 3.1.3(F) (Capability to Receive Enrollment Data Electronically), 3.1.3(D)(3), and the timeframes in 3.2.6,

(2) Assignment of Rate Cell Categories will be done by the STATE, based on information in MMIS at the time of capitation.

(3) The STATE will continue to be available to provide enrollment TPA services to the MSHO MCOs. The charge and scope of duties for this service will be negotiated between the MCO and the State in an additional contract. These duties will include, but not be limited to the submission of Medicare SNP enrollment to CMS on a monthly basis.

(F) Capability to Receive Enrollment Data Electronically. The MCO shall have the capability to receive enrollment data electronically via a medium prescribed by the STATE.

(1) If there is a disruption of the STATE's electronic capabilities, the MCO has fifteen (15) days to disseminate enrollment information to its Enrollees, pursuant to section 3.2.6 of this Contract.

(2) The MCO shall provide valid enrollment data to Providers for Enrollee coverage verification by the first day of the month and within two working days of availability of enrollment data at the time of reinstatement, pursuant to section 3.4.7. This shall include all subcontractors. The MCO may require its Providers to use the STATE's

Electronic Verification System (EVS) or MN-ITS system to meet the requirement. Additional enrollment parameters for MCOs who contract with the STATE for enrollment TPA services are subject to the terms and conditions of the separate TPA contract.

(3) The STATE shall provide to the MCO an annual MMIS schedule of enrollment and reinstatement deadlines. If the STATE changes this schedule, other than electronic disruptions as indicated in this subsection, the STATE shall provide the MCO with reasonable written notice of the new timelines.

3.1.4 Effective Date of Coverage.

(A) MCO coverage of Enrollees shall commence as follows:

(1) For MSHO, when enrollment has been approved on or before the last day of the month, medical coverage shall commence at midnight, Minnesota time, on the first day of the month following the month in which enrollment was approved. Enrollments received after capitation must be submitted directly to the STATE.

(2) For MSC+, when enrollment occurs and has been entered on the STATE MMIS after the Cut-Off Date, medical coverage shall commence at midnight, Minnesota time, on the first day of the second month following the month in which enrollment was entered on the STATE MMIS.

(B) Inpatient Hospitalization and Enrollment:

(1) For MSHO Enrollees receiving Inpatient Hospitalization, services will be enrolled in accordance with section 3.1.4(A)(1) above. All charges related to Inpatient Hospitalization for any MSHO Enrollee who is receiving Inpatient Hospitalization services on the effective date of coverage will not be the responsibility of the MCO.

(2) For MSC+ Enrollees receiving Inpatient Hospitalization services, enrollment will be delayed until the first day of the month following the month of discharge.

(3) MCO coverage under MSC+ for Medical Assistance Recipients who disenroll from MSHO and are required to remain enrolled in MSC+ but who are hospitalized on the first effective date of re-enrollment in MSC+ shall commence according to 3.1.4(B)(2) above.

(C) CD Services and Enrollment.

(1) For MSHO Enrollees receiving inpatient hospital based CD services, or who are in a Residential Treatment Facility at the time of enrollment in the MCO, enrollment will not be delayed. For the Contract Year, the MCO will be financially responsible for inpatient hospital based CD services unless these services are covered by Medicare.

(2) For MSC+ Recipients who are receiving inpatient hospital-based Chemical Dependency (CD) services, at the time the Recipient is scheduled to be enrolled in the MCO, the effective date of the enrollment will be delayed until the first day of the month following the Recipient's discharge from the hospital from which they are receiving inpatient hospital-based CD services.

(3) The MCO will be financially responsible for CD room and board services that were authorized in combination with CD treatment pursuant to the Rule 25 assessment criteria.

(D) (F) Maintenance of Enrollment Forms. Original enrollment forms will be maintained by the STATE, MCO or the Local Agency, whichever enrolled the Enrollee, and may be imaged in accordance with Minnesota Statutes, § 15.17.

3.1.5 Enrollee Rights. The MCO shall have written policies regarding the rights of Enrollees and shall comply with any applicable Federal and State laws that pertain to Enrollee rights. When providing services to Enrollees, the MCO must ensure that its staff and affiliated Providers consider the Enrollee's right to the following:

(A) Receive information pursuant to 42 CFR § 438.10.

(B) Be treated with respect and with due consideration for the Enrollee's dignity and privacy.

(C) Receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand.

(D) Participate in decisions regarding his or her health care, including the right to refuse treatment.

(E) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

(F) Request and receive a copy of his or her medical records pursuant to 45 CFR §§ 160 and 164, subparts A and E, and request to amend or correct the record as specified in 45 CFR § 164.524 and § 164.526.

(G) Be provided with health care services and, as applicable, Home and Community-Based Services, in accordance with 42 CFR § 438.206 through § 438.210, and to be provided with the information contained in the pamphlet, DHS-4134, “Know Your Rights About Services For Older Minnesotans.”

(H) The freedom to exercise his or her rights and that the exercise of these rights will not adversely affect the way the Enrollee is treated.

(I) Assistance, in identifying services needed to maintain the Enrollees who receive LTCCs in the most inclusive environment, pursuant to M.S. § 256B.0911, subd. 1a(1).

(J) To be offered choices in types of Home and Community Based services wherever possible within a system of identified Providers.

3.2 MCO and Potential Enrollee/ Enrollee Communication The MSHO MCO agrees to integrate all Medicare (including Part D) and Medicaid materials provided to Enrollees and Potential Enrollees to the extent allowed by CMS and the STATE. The STATE and the MCO will develop model materials for this purpose using guides provided by CMS. The MCO will work with the STATE to assure that where CMS language misrepresents, or does not cover information about all Medicare and Medicaid benefits available to Duals, clarifying language is included.

3.2.1 Compliance with Title VI of the Civil Rights Act. Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et. seq. and 45 CFR Part 80 provide that no person shall be subjected to discrimination on the basis of race, color or national origin under any program or activity that receives Federal financial assistance and that in order to avoid discrimination against persons with limited English proficiency (LEP) and for LEP persons to have meaningful access to programs and services, the MCO must take adequate steps to ensure that such persons receive the language assistance necessary, free of charge. The MCO shall comply with the recommendations of the revised Policy Guidelines published on August 8, 2003 by the Office for Civil Rights of the Department of Health and Human Services, titled "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (hereinafter "Guidance" and "LEP") and take reasonable steps to ensure meaningful access to the MCO's programs and services by LEP persons. The MCO shall apply, and require its Providers and subcontractors to apply, the four factors described in the Guidance to the various kinds of contacts they have with the public to assess language needs, and decide what reasonable steps, if any, they should take to ensure meaningful access for LEP persons. The MCO shall document its application of the factors described in the Guidance to the services and programs it provides.

3.2.2 Americans with Disability Act Compliance. (Americans with Disabilities Act of 1990, 42 U.S.C., § 1210, et seq.; hereafter "ADA")

(A) All communications with Enrollees must be consistent with the Americans with Disabilities Act's prohibition on unnecessary inquiries into the existence of a disability.

(B) The MCO shall have information available in alternative formats and in a manner that takes into consideration the Enrollee's special needs, including those who are visually impaired or have limited reading proficiency.

(C) All written materials, including all membership materials, must be updated with the following statement: "This information is available in other forms to people with disabilities by calling 000-000-0000 (voice), or 1-800-000-0000 (toll free), or 000-000-0000 (TDD), or 7-1-1, or through the Minnesota Relay direct access numbers at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (Speech-to-Speech)," or similar language approved by the STATE pursuant to section 3.2.

3.2.3 Requirements for all Enrollee and Potential Enrollee Communication.

(A) Written Information.

(1) The MCO shall submit to the STATE for review and approval written information intended for Enrollees or Potential Enrollees. Information requiring approval is listed in the Materials Guide posted on the DHS managed care website. The list of materials identifies information that is submitted for purposes of file and use, information only, STATE review and approval, or information not to be submitted. The STATE will notify the MCO of any changes or updates to the Materials Guide. Written material for MSHO will include both Medicare and Medicaid information.

(2) The MCO shall determine and translate vital documents and provide them to households speaking a prevalent non-English language, whenever the MCO determines that five percent (5%) or one thousand (1,000) persons, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered in the MCO's Service Area speak a non-English language. For purposes of this section, "prevalent" means a significant number or percentage of Enrollees and Potential Enrollees speak a non-English language. If a Potential Enrollee or Enrollee speaks any non-English language, regardless of whether it meets the threshold, the MCO must provide that the Potential Enrollee or Enrollee receives free of charge information in his/her primary language, by providing oral interpretation or through other means determined by the MCO.

(B) Language Block. All material sent by the MCO to Enrollees or Recipients, that targets Recipients or Enrollees under this Contract, shall include the STATE's language block. The MCO may request a waiver from this requirement if special circumstances apply.

(C) Readability Test. All written materials, including Marketing, new Enrollee information, member handbooks, Grievance, Appeal and State Fair Hearing information and other written information, which target Recipients or Enrollees under this Contract and are disseminated to Recipients or Enrollees by the MCO in the English language must be understandable to a person who reads at the seventh grade level, using the Flesch scale analysis readability score as determined under Minnesota Statutes, § 72C.09. The results of the Flesch score must be submitted at the time all documents specified in this subsection are submitted to the STATE for approval. All materials sent to Recipients or Enrollees must be in at least a 10-point type size, with the exception of the membership card, which may have non-essential items in a smaller type size.

(D) Compliance with State Laws. The MCO's Marketing and education practices will conform to the provisions of Minnesota Statutes, § 62D.22, subd. 8, and applicable rules and regulations promulgated by the Commissioners of Commerce and Health.

(E) American Indians. All Enrollee and Recipient Marketing and enrollment materials that reference access to covered benefits or the MCO's network shall explain the right of American Indians to access out-of-network services at IHS or 638 facilities, including Elderly Waiver services managed by a tribe, where available.

(F) Prior Notice of STATE Materials. The STATE shall provide the MCO with text of notices it sends to all Enrollees. To the extent possible, the STATE shall provide the notices to the MCO prior to distribution to Enrollees.

3.2.4 Marketing Materials.

(A) General Marketing. The MCO shall participate with the STATE in the development of general Marketing Materials and enrollment materials.

(B) Prior Approval of Materials.

(1) CMS and STATE Review Process for MSHO. The MCO shall present to the STATE for approval all Marketing materials for MSHO that the MCO or its subcontractors plan to use during the contract period prior to the MCO's use of such Marketing Materials. All client education and Marketing Materials for MSHO, including, but not limited to Marketing scripts for such activities as presentations or radio advertisements, posters, brochures, Internet web sites, any materials which contain statements regarding the benefit package, and Provider network-related materials, must be prior approved by the STATE and CMS. Internet web sites that merely link to the DHS web site for information do not need prior approval. If the Marketing Materials target American Indian Recipients, the STATE shall consult with tribal governments within a reasonable period of time before approval. Such approval by the STATE shall not be unreasonably withheld or delayed.

(2) The MCO must submit all materials for review in a final format to the STATE prior to receiving an approval from the STATE, including Medicare and Part D materials. When the MCO submits the material for review, the MCO shall include information on the purpose, the intended audience and the timeline for use of the material being reviewed. The STATE and CMS shall review all Medicare related materials. The STATE shall review Medicaid only materials. Upon receiving STATE approval of MSHO material, the MCO is responsible for submitting material subject to CMS review directly to CMS for review. If CMS requires changes to the STATE approved material, the MCO shall submit a copy of the final document to the STATE.

(3) STATE Review Process for MSC+. The MCO shall present to the STATE for approval all Marketing Materials for MSC+ that the MCO, or its subcontractors, plan to use during the contract period, including but not limited to posters, brochures, Internet web sites, any materials which contain statements regarding the benefit package, and Provider network-related materials, prior to the MCO's use of such Marketing Materials. Internet web sites that merely link to the DHS web site for information do not need prior approval. If the Marketing Materials target American Indian Recipients, the STATE shall consult with tribal governments within a reasonable period of time before approval. Such approval by the STATE shall not be unreasonably withheld or delayed. When the MCO submits the material for review, the MCO shall include information on the purpose, the intended audience and the timeline for use of the material being reviewed.

(C) Direct Marketing.

(1) Direct Marketing for MSHO. The MCO may do direct Marketing of its MSHO product to MSHO-eligible individuals and current MCO Enrollees who will become eligible for Medicare within the next six (6) months. Direct Marketing includes, but is not limited to, telephone contacts, mailings, face-to-face Marketing, promotions and individual and group meetings. If the MCO directly markets to MSHO-eligible individuals within a given Service Area, it must market to both Institutional and community MSHO-eligible individuals. All Marketing activities and materials for MSHO must be Prior Approved in writing by the STATE and CMS before use or implementation as stated in section 3.2.4(B).

(a) Notices to Recipients for MSHO. The MCO may provide notices to all MSHO-eligible Recipients who reside in the Service Area, at MCO expense, using a list provided by the STATE. The STATE will provide the MCO with lists no more than twice per Contract Year and in a format to be determined by the STATE. The MCO's notices must not contain false or materially misleading information.

(b) Use of Subcontractors for Marketing. The MCO may not use subcontractors to market MSHO to MSHO-eligible individuals not currently enrolled in the MCO.

(2) Direct Marketing for MSC+. Direct Marketing for MSC+ is not allowed, except for mailing and publications set forth in section 3.2.4(F).

(D) For MSHO: The MCO, its agents and Marketing representatives, shall not:

(1) Offer or grant any reward, favor, compensation or provide for cash or any other monetary rebate, as an inducement to a Recipient or an MSHO Enrollee to enroll in the MCO. This restriction does not prohibit the MCO from explaining any legitimate benefits a Recipient might obtain as an Enrollee of the MCO. The MCO shall not seek to influence a Recipient's enrollment with the MCO in conjunction with the sale of any private insurance.

(2) Offer or grant any reward, favor or compensation to a person, county or organization that is not directly hired or contracted by the MCO to conduct marketing, who in the process of informing potential Enrollees about Medical Assistance or other Medicare Programs, steers or attempts to steer the potential Enrollee toward a specific plan or limited number of plans.

(3) Engage in any discriminatory activities.

(4) Engage in any activities that could mislead or confuse Recipients, or misrepresent the MCO.

(5) Make any written or oral assertions or statements that a Recipient or Enrollee must enroll in the MCO in order to obtain or maintain Medical Assistance and

covered Medicare benefits, or that the MCO is endorsed by CMS, Medicare, the STATE, or federal government. The MCO may explain that it is approved for participation in Medicare.

(6) Conduct door-to-door solicitation to current or potential MSHO Enrollees. In addition, the MCO must comply with Medicaid regulations that do not allow direct or indirect telephone or other cold-call marketing activities to potential MSHO Enrollees.

(7) Distribute Marketing Materials for which the MCO has not received STATE and CMS approval.

(E) Enrollment Requirements. In its Marketing for MSHO, the MCO must establish and maintain a system for confirming that enrolled Dual Eligible Recipients have in fact enrolled in the MCO and understand the rules applicable under the plan. The enrollment form must include a statement indicating to Recipients that upon voluntary disenrollment from MSHO, they will remain enrolled in the MCO's MSC+ product, unless they request the STATE to return them to the MSC+ product in which they were enrolled immediately prior to enrollment in MSHO. If the MCO does not comply with the requirements of this section, the STATE may seek remedies including, but not limited to, the partial breach remedy specified in section 5.3 of this contract.

(F) Marketing Restrictions for MSC+. Except through mailings and publications as set forth below, the MCO, which includes any of its subcontractors, agents, independent contractors, employees and Providers, is restricted from Marketing and promotion to Recipients who are not enrolled in the MCO, including, but not limited to: telephone Marketing, face-to-face Marketing, promotion, cold-calling, or direct mail Marketing. Such mailings shall not contain false or materially misleading information. The MCO shall not make any written or oral assertions or statements that a Recipient or Enrollee must enroll in the MCO in order to obtain or maintain covered benefits, or that the MCO is endorsed by CMS, the STATE, or federal government.

(G) Mailings to Recipients for MSHO and MSC+. The MCO may make no more than two mailings per calendar year to Enrollees of the MCO, or potential Enrollees who reside in the MCO's Service Area. Two mailings per calendar year means the MCO may request no more than two mailing lists from the STATE per Contract. Additional mailings will only be allowed upon approval by the STATE, and limited to Service Area expansion, new programs, or other changes initiated by the STATE.

(H) Other Publications. The MCO, acting indirectly through the publications and other material distributed by the Local Agency or the STATE, or through mass media advertising (including the Internet), may inform Recipients who reside in the Service Area as defined in Appendix I of this Contract of the availability of medical coverage through the MCO, the location and hours of service and other plan characteristics, subject to section 3.2.5.

(1) The MCO may also distribute brochures and display posters at physician offices and clinics, informing patients that the clinic or physician is part of the MCO's Provider network.

(2) The MCO may provide health education materials for Enrollees in Providers' offices.

(3) All posters, brochures and Provider network-related materials must be Prior Approved by the STATE and/or CMS as required in accordance with this Article.

3.2.5 Enrollee and Potential Enrollee Information.

(A) Prior Approval Required:

(1) For MSHO Materials. The MCO agrees that the integrated Medicare, Medicare Part D and Medicaid Certificate of Coverage (COC)/Evidence of Coverage (EOC) sent to each MCO Enrollee and all Marketing Materials, plans, procedures, mailings, enrollment forms and their revisions that are designed for Recipients shall be used only after receiving approval in accordance with section 3.2.4(B). The MCO must revise its COC for all substantial changes in its Grievance and Appeals procedures, and its health care delivery systems, including changes in procedures to obtain access to or approval for health care services. All revisions to the Certificate of Coverage must be approved in writing by the STATE and CMS in accordance with section 3.2.4(B), and issued to Enrollees prior to implementation of the change.

(2) For MSC+ Materials. The STATE must approve all enrollment materials including the Certificate of Coverage (COC) sent to Enrollees prior to their use. The MCO must revise its Certificate of Coverage for all substantial changes in its Grievance and Appeals procedures, and its health care delivery systems, including changes in procedures to obtain access to or approval for health care services. All revisions to the Certificate of Coverage must be approved in writing by the STATE in accordance with this section and issued to Enrollees prior to implementation of the change. Approvals by the STATE for these materials shall not be unreasonably withheld. The MCO must submit its documents in a final format prior to receiving an approval from the STATE. The STATE agrees to inform the MCO of its approval or denial of these documents within thirty (30) days of receipt of these documents from the MCO.

3.2.6 Enrollment Information. The MCO shall present to all new Enrollees the following information within fifteen (15) calendar days of availability of readable enrollment data from the STATE:

(A) A Certificate of Coverage (COC) that has been Prior Approved by the STATE and CMS (for MSHO).

(1) For MSHO, the MCO will cooperate with the D-SNP Integrated Member Materials work group to adjust the CMS Medicare model EOC to incorporate STATE requirements. The MCO will use the model developed by the D-SNP

Materials work group to develop its own COC, which is then submitted to the STATE and includes information as below in section 3.2.6(A)(2)(a) through (u).

(2) For MSC+, the STATE will provide annually to the MCO a model Certificate of Coverage (COC) or COC Addendum as the base document. After the MCO has incorporated its specific information, the completed COC or COC Addendum will be submitted to the STATE for prior approval. The COC must include the following:

(a) A description of the MCO's medical and remedial care program, including specific information on benefits, limitations, and exclusions;

(b) A description of the Enrollee's rights and protections as specified in 42 CFR § 438.100;

(c) Cost sharing, if applicable;

(d) Notification of the open access of Family Planning Services and services prescribed by Minnesota Statutes, § 62Q.14;

(e) Information about providing coverage for prescriptions that are dispensed as written (DAW);

(f) A statement informing Enrollees that the MCO shall provide language assistance to Enrollees that ensures meaningful access to its programs and services according to title VI of the Civil Rights Act and federal regulations adapted under that law, or any guidance from the United States Department of Health and Human Services;

(g) A description of how American Indian Enrollees may directly access Indian Health Service and certain tribal Providers and how such Enrollees shall obtain referral services. In prior approving this portion of the COC, the STATE shall consult with tribal governments;

(h) A description of how Enrollees may access services to which they are entitled under Medical Assistance, but are not provided under this Contract;

(i) A description of Medical Necessity for mental health services under Minnesota Statutes, § 62Q.53;

(j) A description of how transportation is provided;

(k) A description of how the Enrollee may obtain services, including hours of service, appointment procedures, Service Authorization requirements and procedures, what constitutes Medical Emergency and Post Stabilization care the process and procedures for obtaining Medical Emergency and Post Stabilization care, including a twenty-four (24) hour telephone number for Medical Emergency Services, procedures for Urgent Care, and Out of Plan care, and how Enrollees may access Home and Community-Based Services. The MCO must indicate that

Service Authorization is not required for Medical Emergencies and that the Enrollee has a right to use any hospital or other setting for Emergency Care. If the MCO does not allow direct access to specialty care, the MCO must inform Enrollees the circumstances under which a referral may be made to such Providers;

(l) A toll-free telephone number that the Enrollee may contact regarding MCO coverage or procedures;

(m) A description of all Grievance, Appeal and State Fair Hearing rights and procedures available to Enrollees, including the MCO's Grievance System procedures, the availability of an expert medical opinion from an external organization pursuant to Article 8, the ability of Grievances, Appeals and State Fair Hearings to run concurrently, and the availability of a second opinion within the MCO. This includes but is not limited to:

(n) For State Fair Hearing: the right to a hearing; the method for obtaining a hearing; and the rules that govern representation at the hearing.

i) The right to file Grievances and Appeals.

ii) The requirements and timeframes for filing a Grievance or Appeal.

iii) The availability of assistance in the filing process.

iv) The toll-free numbers that the Enrollee can use to file a Grievance or an Appeal by phone.

(o) An explanation that, when an Appeal is requested by the Enrollee,

i) Benefits will continue if the Enrollee files an Appeal or a request for State Fair Hearing within the timeframes specified for filing, and requests continuation of benefits within the time allowed; and

ii) the Enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is not wholly favorable to the Enrollee.

(p) Any Appeal rights available to Providers to challenge the failure of the MCO to cover a service.

(q) Appeal rights for denial of prescription drug coverage.

(r) A description of the MCO's obligation to assume financial responsibility and provide reimbursement for Medical Emergency Services, Post-Stabilization Care Services, and Out of Service Area Urgent Services;

(s) General descriptions of the coverage for durable medical equipment, including additional equipment and home modifications available to eligible members

through home and community based services, level of coverage available, and criteria and procedures for any Service Authorizations, and also the address and telephone number of a MCO representative whom an Enrollee can contact to obtain (either orally or in writing upon request) specific information about coverage and Service Authorization. The MCO shall provide information that is more specific to a prospective Enrollee upon request;

(t) A description of the Enrollee's right to request information about Physician Incentive Plans from the MCO, including whether the prepaid plan uses a Physician Incentive Plan that affects the use of referral services, the type of incentive arrangements, whether stop-loss protection is provided, and a summary of survey results; and

(u) A description of the Enrollee's right to request the results of an external quality review study and a description of the MCO's Quality Assurance System, pursuant to 42 CFR §438.364.

(B) For MSHO, an integrated Medicare and Medicaid pharmacy directory.

(C) A Provider Directory.

(1) For MSHO, an integrated Medicare and Medicaid Provider directory; and for MSC+ a Medicaid Provider directory that lists the contracted Providers within the MCO's network, including Primary Care Providers,, specialty and subspecialty Providers, hospitals, and Nursing Facilities including Provider names, locations, and telephone numbers, and other requirements as specified in the "*Provider Directory Guidelines*" posted on the State's managed care website. The MCO must include a statement on how an Enrollee can request a listing of home care agencies and PCPAs.

(2) The directory shall also indicate those current Participating Providers who speak a non-English language. For hospitals, the MCO should list only the languages spoken by the on-site interpreter staff. The MCO must identify any Participating Provider that is not accepting new patients.

(3) The Provider directory shall be updated annually and shall include a phone number where an Enrollee may call to verify or receive current information.

(4) The Provider directory document may be listed on the MCO's web site. The document must meet all of the *Provider Directory Guidelines* and may not differ from the State-approved paper copy. Enrollees may choose to access this document electronically instead of receiving a paper copy. The MCO must retain documentation of the Enrollee's affirmative choice to receive the Provider Directory electronically in the form of written direction from the Enrollee or a documented phone call followed by an MCO confirmation letter to the Enrollee that explains that the Enrollee may change to the other method at any time. Upon a request from CMS or the STATE, within ten (10) business days the MCO must provide a copy of the documentation of the Enrollee's choice.

(5) The MCO must provide a list of EW service Providers who are available to eligible Enrollees based on the Enrollee's place of residence. This EW list shall be updated annually and shall include a phone number where an Enrollee may call to verify or receive current information. The MCO may choose to include EW service providers in the Provider Directory.

(6) If the MCO limits access to Providers by use of a Care System model, the MCO must describe which Providers are available to Enrollees based on Care System enrollment.

(D) Membership Card.

(1) For MSHO, an integrated Medicare and Medicaid membership card, and

(2) for MSC+, a membership card that conforms to the requirements in Minnesota Statutes, § 62J.60, subd. 3.

(3) MSHO and MSC+ cards must be approved by the STATE prior to printing, The card must identify the Recipient as an MCO Enrollee and contain an MCO telephone number to call regarding coverage, procedures, and Grievances and Appeals. The membership card shall demonstrate that the Enrollee is a Recipient of Minnesota Health Care Programs, either by printing the Enrollee's STATE PMI number on the card, or by other reasonable means. The card may include data elements required by CMS for Medicare eligible Enrollees.

(E) A website accessible to Enrollees and Potential Enrollees, Local Agency staff, and other outreach partners, that provides information regarding Provider (clinic) locations, phone numbers, hours of availability, Provider (clinic) specialty, whether the Provider (clinic) is accepting new patients, and whether a non-English language is spoken. The website must provide enough information to allow an Enrollee to select a Primary Care Provider, and other Providers if the MCO requires them to be selected.

(F) Primary Care Network List (PCNL).

(1) The MCO must supply all Local Agencies within its Service Area with copies of a standardized document (known as a Primary Care Network List, or PCNL) that provides information about the MCO's Medicare and Medicaid Provider network and that includes a description of the essential components of the MCO, to be used by the Local Agencies to educate consumers. This document must follow the STATE specification as indicated in the STATE document "*PCNL Guidelines*" posted on the STATE's managed care website and must be Prior Approved by the STATE in accordance with section 3.2.5(A). The document must be printed on a grade of paper that is equivalent to bond paper that is not less than nineteen (19) pound bond but not greater than twenty (20) pound bond. If the PCNL has a cover, the grade of paper may be on un-coated offset paper or on glossy paper. The paper must be 8 ½" x 11" or 17" x 11". A 17" x 11" document must fold to 8 ½" x 11". The document must contain the following information:

(2) A list of contracted Providers with summary information, which shall include but is not limited to addresses and phone numbers including clinics, Primary Care physicians, specialists, hospitals, Nursing Facilities, and Care Systems. The MCO may satisfy or partially satisfy the requirement to list specialists by listing multi-specialty clinics. The PCNL must indicate Providers who speak a non-English language and identify Providers that are not accepting new patients within the Service Area at the time the list is prepared. The MCO must also provide information upon request regarding a specific Provider, including specialists, if the Provider is not listed in the PCNL. The MCO may list other affiliated Providers and their addresses or provide a toll-free phone number where a Potential Enrollee may call to obtain the specific information. The information required by this section may be posted on the MCO's web site but the MCO must continue to provide paper copies to the STATE and the counties.

(3) A toll-free telephone number that the Recipient may contact regarding MCO coverage or procedures, and updated information regarding Providers, language spoken, and open and closed panels of Providers.

(4) Information that oral interpretation is available for any language and written information will be available in prevalent non-English languages.

(5) Information about how to access mental health, chemical dependency, Elderly Waiver, Home Care, dental, and Medical Emergency and Urgent Care services.

(6) A description of the MCO's MSC+ and MSHO Care Systems, Care Coordination systems, Case Management systems, and any other distinguishing information that will assist the Enrollee in making a decision to enroll in the MCO's MSC+ and/or MSHO product. If the MCO limits access to Providers by use of a Care System model, the MCO must describe which Providers are available to Enrollees based on the Care System chosen.

(7) Information concerning the selection process, including a statement that the Enrollee must select a MCO in which their Primary Care Provider or specialist participates if they wish to continue to obtain services from him/her.

(8) Any restrictions on the Enrollee's freedom of choice among network Providers.

(9) Information regarding open access of Family Planning Services and services prescribed by Minnesota Statutes, §62Q.14, and the availability of transitional services.

(10) Any language required by the Minnesota Department of Health (MDH) in order to provide protection and additional information for consumers of health care. Currently this language includes the following:

"Enrolling in this health plan does not guarantee you can see a particular Provider on this list. If you want to make sure, you should call that Provider to ask whether he or she is still part of this health plan. You should also ask if they are accepting new patients. This health plan may not

cover all your health care costs. Read your contract, or 'Certificate of Coverage,' carefully to find out what is covered."

If MDH determines that new language needs to be included, the MCO will incorporate it into the next available printing of the PCNL.

(11) A misrepresentation of Providers on the MCO's PCNLs or Provider Directory may be determined by the STATE to be an intentional misrepresentation in order to induce Recipients to select the MCO.

(12) When the MCO is new to a Service Area, the MCO must supply the STATE, or in certain cases, the Local Agency, with the final, printed and approved PCNL pursuant to the STATE's specifications, in quantities sufficient to meet the STATE's need. This time period may be waived by the STATE for the initial enrollment of current MCO MSC+ Enrollees into the MCO's MSHO product. The MCO must update the PCNL as necessary to maintain accuracy, particularly with regard to the list of Participating Providers, but not less than twice per year. The PCNL and all revisions to it must be submitted to the STATE along with a cover letter detailing all changes in the PCNL. The PCNL must be approved in writing by the STATE pursuant to 0. Such approval by the STATE shall not be unreasonably withheld. The MCO shall distribute the PCNLs to the Local Agencies and the STATE in a timely manner. The STATE shall respond to inquiries by the Local Agencies in a timely manner and shall communicate any issues or problems regarding distribution of the PCNLs to the MCO.

(G) Local Agency Training and Orientation. When the MCO or a MCO product is new to a Service Area, the MCO must provide training and orientation to the Local Agency, regarding the MCO or the MCO product. Such training and orientation shall be provided to the Local Agency by the MCO prior to the Education Begin Date and as necessary upon request by the STATE thereafter. The MCO must supply the Local Agency with training and orientation materials to be used by the Local Agency in educating new Enrollees in the Service Area about the MCO. Such materials shall be provided by the MCO to the Local Agency twenty (20) working days in advance of the Education Begin Date. Training and orientation materials are: lists of contacts and their phone numbers at the MCO, Complete Network Listings or additional Provider directories, if any, and organization charts.

(H) Tribal Training and Orientation. The MCO shall provide training and orientation materials to tribal governments upon request, and shall make available training and orientation for any interested tribal governments.

(I) Additional Information. The MCO shall furnish the following information to Recipients and Enrollees upon request:

(1) The licensure, certification and accreditation status of the MCO, or the health care facilities in its network.

(2) Information regarding the education, licensure, and Board certification and recertification of the Health Care Professionals in the MCO's network. For purposes of this section, health care professionals mean professionals with whom the Recipient or Enrollee has or may have an appointment for services under this Contract.

(3) Other information that is available to the MCO within reasonable means, on requirements for accessing services to which an Enrollee is entitled under the contract, including factors such as physical accessibility.

3.2.7 Enrollee/ Potential Enrollee Education.

(A) The STATE or the Local Agency, will inform Medical Assistance Recipients who reside in the Service Area of the options available in health care coverage. The STATE or Local Agency shall describe through presentations and/or written materials the various MCOs available to Enrollees in a particular geographic area. The STATE or Local Agency shall complete enrollment by obtaining the signature of Enrollees or their Authorized Representatives on the enrollment form. For MSHO, the MCO also may complete enrollment. For Enrollees in MSC+ who are assigned to an MCO, a signature will not be obtained. Tribal governments may assist the STATE or Local Agency in presenting or developing materials describing the various MCO options for their members. If the tribal government revises any MCO materials, the MCO may review them prior to distribution. If the MCO deems the revisions to be substantial, the MCO shall have thirty (30) days to respond to the tribal government and no MCO materials will be distributed until there is mutual agreement on the revisions.

(B) Neither the STATE nor the Local Agency will distribute to Enrollees written educational materials which describe the MCO or its health care plan without providing reasonable notice and opportunity for review by the MCO. Any inaccuracies will be corrected prior to dissemination, but final approval by the MCO is not required.

(1) This section does not prohibit the MCO or its subcontractors from providing information:

(a) For MSHO, to Recipients eligible for MSHO for the purposes of educating Recipients about Provider choices available through the MCO, subject to the limitations in the Marketing Restrictions section.

(b) For MSC+, to Recipients who are enrolled in the MCO for the purpose of educating Enrollees about Provider choices available through the MCO, subject to the limitations in the Marketing Restrictions section.

(C) Local Agency staff and MCO staff shall make available to Recipients the information about Providers as specified in section 3.2.6(F).

3.2.8 Significant Events. The MCO must notify the STATE as soon as possible of significant events affecting the level of service either by the MCO or its Medicare and Medicaid Providers or subcontractors. Such events include:

(A) Material Modification of Provider Network.

(1) Notice to STATE. The MCO must notify the STATE of a possible Material Modification in its Provider network within ten (10) working days from the date the MCO has been notified of the possibility that a Material Modification is likely to occur. A Material Modification shall be reported in writing to the STATE no less than one hundred and twenty (120) days prior to the effective date or within two (2) working days of becoming aware of it, whichever occurs first. A MCO may terminate a subcontract without one hundred and twenty (120) days notice in those situations where the termination is for cause. For purposes of this section, termination of a Provider for cause does not include the inability to reach agreement on contract terms.

(2) Notice to Enrollees. The MCO shall provide prior written notification to Enrollees that will be affected by such a Material Modification. The MCO shall submit such notice to STATE for prior approval. The notice must inform each affected Enrollee that:

(a) One of the Primary Care Providers they have used in the past is no longer available and they must choose a new Primary Care Provider from the MCO's remaining choices, or that the Enrollee has been reassigned from a terminated sole source Provider; and

(b) In either case, the Enrollee has the opportunity to disenroll or change MCOs up to one hundred and twenty (120) days from the date of notification, unless open enrollment occurs within one hundred and twenty (120) days of the date of notification. The MCO shall fully cooperate with the STATE and Local Agency to facilitate a change of MCO for Enrollees affected by the Provider termination.

(B) Provider Access Changes. The MCO shall not make any substantive changes in its method of Provider access during the term of this Contract, unless approved in advance by the STATE. For the purposes of this section, a substantive change in the method of Provider access means a change in the way in which an Enrollee must choose his/her Primary Care Provider clinic Provider and his/her physician specialists. Examples of methods of Provider access include but are not limited to: 1) Enrollee has open access to all Primary Care Provider clinic Providers; 2) Enrollee may self-refer to a physician specialist; 3) Enrollee must choose one Primary Care Provider clinic Provider; and 4) Enrollee must receive a referral to a physician specialist from his/her Primary Care Provider clinic Provider. For the purposes of this section, a substantive change in the method of Provider access shall not include the addition or deletion of Service Authorization requirements for services.

(C) County-Based Purchasing Notice. For County-Based MCOs, the STATE must review for approval any proposed change involving the movement of counties or eligibles within a county under this Contract, or from this Contract to another county-based purchasing project. The MCO shall submit any such proposed changes to the

STATE at least one hundred and eighty (180) days prior to the proposed implementation date.

3.2.9 Enrollee Notification of Terminated Primary Care Provider. The MCO, or if applicable its subcontractor, shall make a good faith effort to provide written notice of the termination of a Participating Provider, within fifteen (15) days after the MCO's, or if applicable its subcontractor's, receipt or issuance of the Participating Provider termination notice, to an Enrollee who receives his or her Primary Care from, or was seen on a regular basis by, that Participating Provider. A sample Enrollee notice must be prior approved by the STATE. The MCO must provide the following information to the STATE:

(A) Date the contracted Provider will no longer be available to Enrollees;

(B) Number of Enrollees affected in each Minnesota Health Care Program;

(C) Impact on the MCO's Provider network; and

(D) Remedy offered by MCO to alleviate the situation

3.2.10 Enrollee Notification of Terminated Residential Provider. If the MCO is providing residential services such as residential care, Customized Living, foster care or 24-Hour Customized Living services to any Enrollee and terminates that Enrollee's residential Provider without cause, the MCO must give written notice to the Enrollee at least sixty (60) days prior to the termination, and, in any case, must assist with emergency placement of the Enrollee when necessary.

3.3 Termination of Enrollee Coverage.

3.3.1 Disenrollment from MSHO But Not From MSC+. The Enrollee may disenroll from the MCO's MSHO product at the end of any thirty (30) day period of consecutive enrollment. Disenrollment will be effective according to the termination of coverage schedules outlined in section 3.3.5. Additional conditions for disenrollment from MSHO include:

(A) If the Enrollee disenrolls from the MCO's MSHO product, the Enrollee shall remain enrolled in the MCO's MSC+ product, subject to the MCO's participation requirement in section 3.5, unless the Enrollee requests the STATE to return them to the MSC+ product in which they were enrolled immediately prior to enrollment in MSHO.

(B) If the Enrollee has a Medical Spenddown, the Enrollee shall not be re-enrolled in MSC+ as this is an excluded population group under that program.

(C) An Enrollee who disenrolls from the MCO's MSHO product and remains enrolled in the MCO's MSC+ product shall be enrolled in the MCO's MSC+ product for a period of twelve (12) months, subject to the exceptions in sections 3.1.2(D) and 3.3.3 (as applicable), and 5.1.2 of this Contract.

(D) If the MSHO MCO does not offer an MSC+ product because they are not the single plan operating in that Service Area, the Enrollee will be automatically assigned to the MSC+ plan serving that area.

3.3.2 Voluntary Disenrollment from MSHO The Enrollee may voluntarily disenroll and thereby terminate from the MCO's MSHO product at the end of a thirty (30) day period of consecutive enrollment. Except as provided in this section, the MCO may not orally or in writing, or by any action or inaction encourage an MSHO Enrollee to disenroll. If Enrollee's request for disenrollment is not acted on in a timely fashion, the disenrollment is considered effective as of the first day of the month following the disenrollment request.

3.3.3 Termination by STATE. An Enrollee's coverage in the MCO may be terminated by the STATE for one of the following reasons:

(A) Required termination includes:

(1) The Enrollee becomes ineligible for Medical Assistance;

(2) The Enrollee no longer meets the eligibility criteria in section 3.1.1.;

(3) For MSHO, the Enrollee becomes ineligible for Medicare Part A or Part B;

(4) The Enrollee's MA Plan application is rejected by CMS. For MSHO enrollment rejected by CMS, the Recipient will be re-enrolled in MSC+ retroactively, and the capitation will be re-processed;

(5) The Enrollee moves out of the MCO's Service Area and the MMIS county of residence is updated per eligibility policy, except in the case where the Enrollee is receiving Inpatient Hospitalization services overnight on the last day of the month;

(6) For MSHO, for non-payment of Medical Spenddown if the enrollee does not pay the Medical Spenddown in full for three (3) months directly to the State as described in section 3.1.1(G)(1)(c). The enrollee will not be allowed to re-enroll in MSHO after termination for non-payment unless all past due Medical Spenddowns are paid in full and the enrollee no longer has a Medical Spenddown at the time of application.

(7) The Enrollee changes MCOs without cause pursuant to 42 CFR §438.56(c) within ninety (90) days following the Enrollee's initial enrollment with the MCO. For counties where the MCO is the only choice, the Enrollee cannot disenroll, but may change Primary Care Providers pursuant to section 3.1.2(J). The enrollee may change MCOs pursuant to Minnesota Rules, Part 9500.1453 because of problems with access, service delivery, or other good cause;

(8) For MSC+, pursuant to Minnesota Rules, Part 9500.1453, subpart 5, the Enrollee elects to change MCOs once during the first year of initial enrollment in the MCO or during the first sixty (60) days after a change in enrollment from an MCO that is no longer participating;

(9) The Enrollee elects to change MCOs due to substantial travel time or Local Agency error, pursuant to Minnesota Rules, Part 9500.1453, subparts 7 and 8;

(10) The Enrollee elects to change MCOs during an annual open enrollment period, pursuant to Minnesota Rules, Part 9500.1453, subpart 5; or the Enrollee misses the opportunity to change during open enrollment due to disenrollment; or for MSHO, monthly, pursuant to section 3.1.2(D);

(11) The Enrollee elects to change MCOs within one hundred twenty (120) days following notice of a Material Modification of the MCO's Provider network under section 3.2.8(A);

(B) Optional termination includes the circumstances listed in 42 CFR § 422.74(b)(1) as follows:

(1) The MSHO Enrollee has engaged in disruptive behavior, and the request for disenrollment meets the requirements listed in 42 CFR § 422.74(d)(2). Disenrollment will be allowed only upon review and approval by CMS.

(2) The Enrollee provided fraudulent information on his or her enrollment form or permits abuse of his or her enrollment card.

3.3.4 Termination by MCO. The MCO may not request disenrollment of an Enrollee for any reason except as described in section 3.3.3(B) above.

3.3.5 Notification and Termination of Coverage. Notification and termination of coverage shall become effective at the following times:

(A) For MSHO, when a disenrollment request has been received by the STATE on or before the last day of the month, medical coverage shall cease at midnight, Minnesota time, on the first day of the month following the month in which termination was approved.

(B) For MSC+, when termination has been entered on the STATE MMIS after the Cut-Off Date, medical coverage shall cease at midnight, Minnesota time, on the first day of the second month following the month in which termination was entered on the STATE MMIS.

(C) When termination takes place due to ineligibility for Medical Assistance, or Enrollee becomes ineligible for participation in the MSC+ or MSHO program, and the Enrollee is receiving Inpatient Hospitalization services, on the effective date of ineligibility, coverage shall cease at midnight, Minnesota time, on the first day following discharge from the hospital. The STATE will not pay to the MCO a Capitation Payment for any month after the month in which the Enrollee's eligibility for Medical Assistance was terminated.

(D) When termination takes place for any reason other than those set forth in this section, including the termination or expiration of this Contract, while the Enrollee is

receiving Inpatient Hospitalization services, excluding chemical dependency services provided in freestanding residential centers that are not inpatient hospital-based services, MCO coverage shall cease at midnight, Minnesota time, on the first day of the month following discharge from the hospital.

3.3.6 Reinstatement. An Enrollee terminated from the MCO at first capitation may be reinstated for the following month with no lapse in coverage if the Enrollee re-establishes his or her Medical Assistance eligibility and such eligibility is entered into MMIS by the last business day of the month.

3.3.7 Re-enrollment.

(A) An MSHO or MSC+ Enrollee who loses Medical Assistance eligibility for not more than three months, or for any break of time within a three month period, may be re-enrolled for the month following disenrollment and subsequent months in the same MCO without completing a new enrollment form. Upon re-enrollment, the STATE may update the Enrollee's Rate Cell Category using information from the MCO, Care System, or MMIS/MAXIS. The status of the one hundred and eighty (180) day SNF/NF benefit at disenrollment will resume upon re-enrollment. The STATE shall pay the Medical Assistance portion of the Capitation Payment for the month of coverage in which the Enrollee was reinstated.

(B) For MSC+, if an Enrollee is disenrolled for any reason and subsequently becomes eligible to enroll, the STATE shall reenroll the Enrollee in the same MCO, unless the Enrollee requests a change in MCOs in accordance with section 3.3.1.

(C) In no circumstance shall the MCO randomly assign an Enrollee to a Primary Care Provider upon reenrollment.

3.4 Reporting Requirements.

3.4.1 Encounter Data

(A) The MCO must maintain patient encounter data to identify the physician who delivers services or supervises services delivered to Enrollees, as required by §1903(m)(2)(A)(xi) of the Social Security Act, 42 U.S.C. §1396b(m)(2)(A)(xi).

(B) The MCO agrees to furnish information from its records to the STATE, or the STATE's agents that the STATE may reasonably require to administer this Contract. The MCO shall provide the STATE upon the STATE's request in the format determined by the STATE and for the time frame indicated by the STATE, the following information:

(1) Individual Enrollee specific, claim-level encounter data for services provided by the MCO to Enrollees detailing all Medicare and Medicaid medical and dental diagnostic and treatment encounters, all pharmaceuticals (including Medicare Part D items), supplies and medical equipment dispensed to Enrollees, Home and Community-Based Services, Nursing Facility services, and Home Care Services for

which the MCO is financially responsible. Encounter data shall include all paid lines associated with a claim, and include in its encounter submission those denied claims or lines, for which Medicare or a third party has paid in full or F-codes associated with CPT code 99387 or 99397 related to the CEHE incentive in section 7.14.5.

(2) Claim-level data must be reported to the STATE using the following claim transaction formats: a) the X12 837 standard format for physician and professional services and specified Elderly Waiver Services (837P), inpatient and outpatient hospital services, Nursing Facility services (837I), and dental services that are the responsibility of the MCO (837D); and b) the 5.1 NCPDP for 1.1 batch pharmacy, and for physician-dispensed pharmaceuticals. The MCO may submit the 5.1 NCPDP for non-durable medical supplies which have an NDC code.

(3) All encounter claims must be submitted electronically. The MCO must comply with STATE and federal requirements, including the federal Implementation Guide, and the STATE's *837 Encounter Companion Guide for Professional, Institutional and Dental Claims*, and the *Pharmacy Encounter Claims Guide* posted on the STATE's managed care website. The MCO must submit charge data using HIPAA standard transaction formats. Charge data shall be the lesser of the usual and customary charge (or appropriate amount from a Relative Value Scale for missing or unavailable charges) or submitted charge. Claims submitted must include, but are not limited to the paid units of service, valid procedure codes, bill type, place of service, dates of services and accurate applicable Provider numbers.

(4) The MCO shall submit on the encounter claim the Provider allowed and paid amounts effective January 1, 2011 for the NCPDP 1.1 pharmacy claim format, and effective April 1, 2011 for the 837P, 837D and 837I professional, dental and institutional claim formats respectively.

(a) For MSHO, this requirement applies to both Medicaid and Medicare services, excluding Part D. For MSC+ this includes MCO payment for Medicare crossover claims.

(b) For the purposes of this section "paid amount" is defined as the amount paid to the Provider excluding third party liability, Provider withhold and incentives, and Medical Assistance co-payments. For the purposes of this section "allowed amount" is defined as the Provider contracted rate prior to any exclusions or add-ons.

(c) In accordance with Minnesota Statutes, §256B.69, subd. 9b(b), the data reported herein is non-public and is defined in Minnesota Statutes, §13.02.

(d) For allocation of Medicare and Medicaid data for the purpose of reporting Medicaid data, see also section 3.4.2(V)(3).

(5) The MCO will submit Medicaid drug information, effective for paid dates occurring on or after January 1, 2011 on pharmacy (NCPDP 1.1), and effective for paid dates occurring on or after April 1, on professional (837P) and institutional

(837I) encounter claims in accordance with STATE data element specifications related to the collection of drug rebates. These specifications will be outlined in the Companion Guides for the NCPDP Batch 1.1 Pharmacy, 837 Professional and 837 Institutional encounter claims. The MCO and its subcontractor, if applicable, must comply with these specifications and submit encounter data no less than monthly and no later than 30 days after the MCO (or its subcontractor) adjudicates these outpatient pharmacy and physician-administered drug claims in order for the STATE to comply with 1927(b), 1903m(2)(A) and 1927(j)(1) of the Social Security Act as amended by Section 2501 (c) of the Patient Protection and Affordable Care Act.

(6) Third party liability payments, including Medicare reimbursement, shall be reported on the encounter claim. The MCO may choose to report personal injury settlements on a separate monthly report. The monthly report shall include all data elements required on the encounter claim and is due on the 10th of the month for all settlements paid to the MCO for the previous month. The MCO shall indicate to the STATE which method it chooses for reporting personal injury settlements.

(7) The STATE shall provide the MCO with an electronic listing of all Medical Assistance Providers and their Provider numbers. The MCO must update the Provider identification numbers by submitting, for Providers who are new to the MCO and do not already have a STATE Provider number (UMPI) or NPI, demographic information about the Provider that is current and complete, on a form approved by the STATE. The MCO shall not require Providers to enroll as an MHCP fee-for-service Provider. If a Provider will only be serving MCO Enrollees, the MCO shall follow the process established by the STATE for MCO-only Providers.

(8) The MCO shall comply with the applicable provisions of Subtitle F (Administrative Simplification) of the Health Insurance Portability and Accountability Act of 1996 and any regulations promulgated pursuant to its authority, including the new 5010 transaction standards that are required to be operational no later than January 1, 2012. The MCO also shall cooperate with the STATE as necessary to ensure compliance.

(9) All encounter data for Nursing Facility and Skilled Nursing Facility services must be submitted according to procedures as prescribed by the STATE in the current EDI specifications document available on the STATE website at http://www.dhs.state.mn.us/provider/mco .

(10) The MCO shall be responsible for submitting claim-level encounter data that distinguishes between the Skilled Nursing Facility (SNF) and the Nursing Facility (NF) days used by the Enrollee.

(11) The MCO shall submit Home and Community-Based Services encounter data pursuant to the 837 national standard. This includes type of service, units of service, and dates of service, sufficient to provide CMS with the required audit trail.

(12) The MCO agrees to participate in a workgroup with the STATE to ensure that all units of service, HCPCS codes and modifiers are being submitted correctly for encounter data for home care and Home and Community-Based Services.

(13) The MCO shall submit encounter data on all Personal Care Assistance (PCA) services using the X12 837 standard transaction format, and report PCAs as treating Providers. The MCO shall submit complete encounter data on PCA services, including the date of service, the amount of service by date, and the treating PCA provider. The STATE will monitor PCAs as treating Providers.

(14) The MCO shall notify the STATE sixty (60) days prior to any change in the submitter process, including but not limited to the use of a new submitter.

(C) The MCO shall submit encounter claims at least monthly with all of the required data elements to the STATE no later than ninety (90) days after the date the MCO adjudicated the claim, except for outpatient pharmacy and physician-administered drug encounter claims, which must be submitted no later than thirty (30) days after adjudication. The MCO shall make submissions for each transaction at least monthly. If the MCO is unable to make a submission during a certain month, the MCO shall contact the STATE to notify it of the reason for the delay and the estimated date when the STATE can expect the submission.

(D) For all encounter claims, when the STATE returns or rejects a file of claims, the MCO shall have thirty (30) days from the date the MCO receives the file to resubmit the file with all of the required data elements in the correct file format.

(E) If the MCO chooses to resubmit a claim previously paid or denied on the MCO's remittance advice, the MCO must resubmit the claim as a replacement claim.

(F) The STATE will provide a remittance advice on a schedule specified by the STATE, for all submitted encounter claims, including void and replacement claims. The Remittance Advice will be provided in X12 835 standard transaction format and in accordance with the *Remittance Advice Companion Guide* on the STATE's managed care website..

(G) The MCO shall collect and report to the STATE individual Enrollee specific, claim level encounter data that identifies the Enrollee's treating Provider (the Provider that actually provided the service within the groups below), when the Provider is part of a group practice that bills on the CMS 837P format or 837D format. The treating Provider is not required when there is an individual practice office (i.e., a sole treating Provider), because in those cases it will be identical to the pay-to Provider. Group practice Provider categories that bill on the 837P format or 837D format and will require a treating Provider are:

(1) Community Mental Health Clinics;

(2) Physician Clinics;

(3) Dental Clinics;

(4) County Contracted Mental Health Providers;

(5) Indian Health Care Providers, where applicable;

(6) Federally Qualified Health Centers;

(7) Rural Health Clinics;

(8) Chiropractic Clinics;

(9) Personal Care Provider Agencies (PCPAs) and other organizations that employ PCAs, for PCA services.

No treating provider is required for any other claim type.

(H) The MCO shall submit interpreter services on encounter claims, if the interpreter service was a separate, billable service.

(I) The MCO must require any subcontractor to include the MCO when contacting the STATE regarding any issue with encounter data. The MCO will work with the STATE and subcontractor or agent to resolve any issue with encounter data.

(J) Coding Requirements.

(1) The MCO must use the most current version of the following coding sources:

(a) Diagnosis codes obtained from the International Classification of Diseases, Clinical Modification (ICD-9-CM).

(b) Procedure codes obtained from Physician's Current Procedural Terminology (CPT) and from CMS' Health Care Common Procedure Coding System (HCPCS Level 2).

(c) Procedure codes obtained from the International Classification of Diseases, Clinical Modification (ICD-9-CM) for inpatient claims.

(d) American Dental Association (ADA) current dental terminology codes as specified in Minnesota Statutes, §62Q.78.

(e) National Drug Codes.

(f) Current local home care and waiver codes, including units of service. The EW codes must be HIPAA compliant according to the most current published instructional Minnesota Department of Human Services (DHS) bulletin 09-69-02, or as required in subsequent bulletins.

(2) The MCO and its subcontractors must utilize the coding sources as defined in this section and follow the instructions and guidelines set forth in the most current versions of ICD-9-CM, HCPCS and CPT.

(3) Neither the MCO nor its subcontractors may redefine or substitute these required codes.

(4) HIPAA compliant codes must be submitted on encounter data.

(K) National Provider Identifier (NPI) and Atypical Provider Types. The MCO shall use the NPI for all Providers for whom CMS issues NPIs. For Providers of Atypical Services, the MCO shall use the STATE-issued UMPI.

3.4.2 Other Reporting Requirements. The MCO must provide the STATE and CMS with the following information in a format and time frame determined by the STATE and CMS. The MCO shall submit information to the effect that no change has occurred since the prior year for reports which require an annual update and where no change has occurred since the prior year.

(A) Enrollment and Marketing Materials. Enrollment and Marketing Materials and plans as outlined in this Agreement.

(B) Service Delivery Plan. Any substantive changes in the Service Delivery Plan previously submitted shall be provided by the MCO to the STATE within thirty (30) days of the effective date of this Contract and prior to any subsequent changes made by the MCO. The STATE must approve all changes to the MCO's Service Delivery Plan.

(C) Care Coordination and Case Management Systems: By September 15th of the Contract Year, the MCO must provide an updated description of the Case Management System for MSC+ and Care Coordination system for MSHO. This description shall include, but will not be limited to:

(1) A document describing how MSHO care coordination and MSC+ case management is being provided for community, EW and nursing home members by county and population group including whether it is provided through contracts with local agencies or tribes, clinic or provider care systems, community agencies, health plan staff or other arrangements or through a combination of such arrangements;

(2) The most recent SNP Model of Care as submitted to CMS, unless already submitted to DHS and there has been no change since the submission;

(3) Lists and descriptions of entities providing Care Coordination and Case Management contractors, duties of such entities or subcontractors, contracting and delegation arrangements;

(4) A description of Care Coordination and/or Case Management screening and assessment tools, timelines and follow up processes;

(5) A description of use of protocols for management of chronic conditions including procedures for communication with clinics and physicians;

(6) A description of use of Nurse Practitioners in the care of Nursing Facility residents if applicable; and

(7) A description of the MCO's oversight and training of subcontractors and Care Coordinators/Case Managers, qualifications and case loads/ratios of Care Coordinators/Case Managers.

(8) Changes and updated descriptions, if any, must be included in Care system, County Care Coordination system and County Case Management system audit reports provided annually by September 15th as provided in sections 0 and 0. If there are no changes in each of the reports, the MCO will provide notice of the lack of change.

(D) Provider Information.

(1) The MCO must submit annually by April 15th of the Contract Year a complete list of Participating Providers, including name, specialty, and address, in a format approved by the STATE using a current version of Excel. For MSHO, providers of Medicare and Medicaid services must be included. The MCO shall also submit an update of its list of Participating Providers, in the same format, by the 15th day of October of the Contract Year. (Note: this excludes pharmacies, transportation providers, and interpreters.)

(2) The MCO must submit annually by April 15th of the Contract Year a list of the names, types of service(s) provided, and counties of service of all Home and Community-Based Service and Nursing Facility Providers it uses for delivery of service, including county Participating Providers. This list is used for federal waiver reporting purposes. This list may be included in the same manner as the Provider information submitted above and must be updated according to the same schedule.

(3) The MCO will notify the STATE of terminations or additions to its contracted Care System, County Care Coordination System and Case Management System entities by April 15th of the Contract Year.

(E) Financial Statements. Financial statements and other information as specified by the STATE to determine the MCO's financial and risk capability, and for MSHO, all financial information required under applicable provisions of 42 CFR §422.516 and any other information necessary for the administration or evaluation of the Medicare program.

(F) HCC Risk Adjustment. The MCO SNP will notify the STATE or its actuarial firm of its restated mid-year HCC risk adjustment score and additional HCC Frailty factor score. Scores will be from restated data based upon the preceding calendar year as reported by CMS. The MCO SNP will send this information to the STATE, or its actuaries, within thirty (30) days of CMS making it available to the MCO. The

actuarial firm may share information about the risk score with the STATE, but the STATE will not receive copies of this information. The MCO must identify this information as trade secret prior to, or at the time of its submission for the STATE to consider classifying it as non-public, as described in section 9.6.

(G) HOS Health Outcomes Survey. By October 15th of each Contract Year, or within thirty (30) days of availability, the MCO will provide the STATE the current HOS report for MSHO submitted to CMS.

(H) Quality Assurance Materials. Information as specified in Article 7 on Quality Assessment and Performance Improvement.

(I) Grievance System Summaries. Information regarding Grievances, Appeals and Denial, Termination, or Reduction (DTR) Notices as required under Article 8.

(J) Administration and Subcontracting Information. The MCO must provide information relating to MCO administration and subcontracting arrangements, as specified by the STATE and CMS.

(K) Health Care Home; Alternative Models.

(1) The MCO shall require that the Health Care Home provider report data to the Department of Human Services and to the Minnesota Department of Health as required in Minnesota Statutes, § 256B.0751 as a condition of contracting between the MCO and Health Care Home.

(2) Reporting requirement.

(a) The MCO shall annually provide a description of each comprehensive payment arrangement and its proposed outcome or performance measures that the MCO will use as an alternative to Health Care Homes reporting under section 4.25.

(b) The MCO shall also provide actual results of such an alternative comprehensive payment arrangement.

(c) The descriptive report is due May 1 of the Contract Year; the summary of the actual results of performance measures and outcomes for the previous Contract Year is due at the end of the first quarter.

(L) Documentation of Care Management/ Case Management/ Care Coordination Plans. The MCO shall maintain documentation sufficient to support its Care Management/ Case Management/ Care Coordination responsibilities set forth in sections 6.1.3 and 6.1.4, and for Elderly Waiver services set forth in section 6.1.11. Upon request of the STATE, the MCO shall provide the STATE or its designee access to a random sampling of Care Management/Case Management/Care Coordination care plans of MCO Enrollees.

(M) Third Party Resources. Pursuant to section 11.2, the MCO shall report to the STATE any additional third party resources, including Long Term Care Insurance, except for Medicare.

(N) Third Party Payments. Pursuant to section 11.4 the MCO shall report all recovery/Cost Avoided amounts on the encounter claim as third party payments. For MSC+, Medicare cost avoidance and recovery amounts must include fee-for-service Medicare. For MSHO, the MCO shall also report an estimate of Medicare payment, and may base the estimate on the methodology used for submitting bids to CMS to derive the amount.

(O) Costs Avoided and Recovered. Pursuant to section 11.4, for MSHO, the MCO shall, on a quarterly basis, disclose to the STATE all Cost Avoided and recovered amounts. For MSC+, Medicare cost avoidance and recovery amounts must include fee-for-service Medicare. For MSHO, the MCO shall also report an estimate of Medicare payment, and may base the estimate on the methodology used for submitting bids to CMS to derive the amount.

(P) Quality Assurance Workplan. The MCO shall submit its Quality Assurance Workplan, pursuant to Article 7. If the MCO has submitted this report under its PMAP Families and Children contract, and that report addresses MSHO and MSC+ Enrollees, this report is waived.

(Q) Disclosure of Ownership Information. By September 1st of Contract Year, the MCO shall report to the State full disclosure information in order to assure compliance with 42 CFR § 438.610. The MCO shall also report full disclosure information within thirty-five (35) days of a request from the STATE or upon a change in MCO ownership. The required information includes:

(1) The name and address of each Person with an Ownership or Control Interest in the MCO or in any subcontractor in which the MCO has direct or indirect ownership of five percent (5%) or more;

(2) A statement as to whether any Person with an Ownership or Control Interest identified in (R)(1) is related to any other Person with an Ownership or Control Interest as a spouse, parent, child, or sibling; and

(3) The name of any other disclosing entity in which a Person with an Ownership or Control Interest in the MCO also has an ownership or control interest in the named disclosing entity.

(R) FQHCS and RHCS. The MCO shall provide to the STATE a monthly report. The report must identify MCO payments made to FQHCs and RHCs for all programs covered under this Contract.

(1) The STATE will provide to the MCO no later than the third business day of each month a list of all Providers currently qualified to be designated FQHCs or RHCs. If a new list is not provided, the MCO shall use the prior monthly listing. Any new

FQHC/RHC Providers identified after the third of the month will be added to the following monthly MCO report.

(2) Pursuant to the State's specifications in the document entitled "FQHC/RHC Payment Data Report," MCO reports will be submitted no later than the last day of the following month.

(3) Within eight (8) business days of receipt of this report, the STATE shall provide the MCO a return file that contains incorrect data lines that cannot be read by the system and loaded. The MCO must review the data lines and correct appropriately. Corrected data lines must be re-submitted with the next monthly report, and shall be reported separately as a corrected file. The MCO shall not re-submit data already submitted and accepted.

(4) In the event that a FQHC/RHC contacts the MCO regarding payments made to the FQHC/RHC during the previous month, but not included in the submitted report, the MCO shall review, and if appropriate, must submit the missing data on the following monthly report.

(S) MH/CD Provider Qualifications. Upon request by the STATE, the MCO will provide information about the qualifications of mental health and chemical dependency Providers, provided that such request be at least sixty (60) days in advance of the date such information is due.

(T) Health Care Expenditures. Pursuant to Minnesota Statutes, § 16A.725, the MCO shall provide to the STATE, no later than February 1st of each Contract Year, all health care service expenditures for the previous State fiscal year. The first report shall include expenditures certified by the MCO paid July 1st through June 30th of the year preceding the Contract Year, combining expenditures under all of the MCO's Minnesota Health Care Program contracts. The report must be submitted to the STATE in a format specified by the STATE, and include health care expenditures within the following groups and for each of the service categories:

(1) Major Program Groups (Medical Assistance and MinnesotaCare);

(2) Age Groups (Children under 18 years, and adults 18 and older, determined as of the date of service);

(3) Service Category (Inpatient Hospital, Ambulatory, Dental, Outpatient Hospital, Home Health, Pharmacy, and Skilled Nursing Facility).

(U) Chemical Dependency Room and Board Services. The MCO will provide a quarterly report to the STATE that identifies the CD room and board services that were authorized in combination with CD treatment pursuant to the Rule 25 assessment criteria. The report will be in accordance with the STATE's specifications and will include only those CD room and board services for which the MCO issued payment and submitted an encounter claim to the STATE. The report will be submitted no later than

thirty (30) days following the end of each quarter. The MCO must certify the quarterly report in accordance with section 9.17.

(V) Reporting Provider Payment Rates.

(1) According to guidelines developed by the State, in consultation with health care providers and MCOs, each MCO must annually provide to the State information on reimbursement rates paid by the MCO to providers and vendors for administrative services under contract with the MCO, pursuant to Minnesota Statutes, § 256B.69, subd. 9b (b). In addition, each MCO must provide to the State in the form and manner specified by the State:

(a) The amount of the payment received from the STATE under this contract that is paid to health care providers for patient care;

(b) Aggregate provider payment data, categorized by inpatient payments and outpatient payments, with the outpatient payments categorized by payments to primary care providers and non-primary care providers;

(c) The process by which increases or decreases in payments made to the MCO under this section, that are based on actuarial analysis related to provider cost increases or decreases, or that are required by legislative action, are passed through to health care providers, categorized by payments to primary care providers and non-primary care providers; and

(d) Specific information on the methodology used to establish provider reimbursement rates paid by the MCO.

(2) The MCO will submit the provider payment data report on August 15, of the Contract Year. This report will include aggregate provider payment data, information on legislatively mandated provider rate changes, and information and data on provider reimbursement rates and rate methodologies.

(3) The MCO agrees to participate in a workgroup with the STATE to develop a data allocation methodology for determining the Medicaid portion of provider payments, to be reported under section (2) above.

(W) Payment for *ad hoc* Reporting. The STATE may require reimbursement at standard rates for *ad hoc* reports requested of the STATE. For the purposes of this section, "standard rates" means those listed in the STATE policy "DHS Policies and Procedures for Handling Protected Information: 2.60 Data Requests and Copy Costs" available at http://www.dhs.state.mn.us/id_017855

(X) Medicaid Drug Report. The MCO will provide to the STATE Medicaid drug information in a format determined by the STATE for collection of the STATE's drug rebates. The report shall include the required data elements from the standard transaction format for the NCPDP 5.1 for pharmacy encounter claims submitted for outpatient pharmacy drugs provided on dates of service from March 23. 2010 through

December 31, 2010 to Medicaid eligible enrollees. The MCO must ensure that the report contains only information for which the MCO submitted a pharmacy encounter claim during the specified time frame. The report will also include any new data fields that were added to the pharmacy encounter data transaction format and identified by the STATE for the purpose of rebate collection. The report will be due sixty (60) days after the STATE provides the report specifications to the MCO.

3.4.3 Electronic Reporting Data Capability.

(A) With STATE. The MCO shall be capable of receiving the following data electronically from the STATE: price files, remittance advices, enrollment data, and rates files.

(B) With Providers. Pursuant to Minnesota Statutes § 62J.536 and the resulting uniform companion guides, the MCO must perform the following data exchanges electronically with applicable Providers:

(1) Accept and transmit eligibility transactions;

(2) Accept claims transactions by; and

(3) Transmit payment and remittance advice.

3.4.4 E-Mail Encryption. The MCO shall use the Pretty Good Privacy (PGP) and Security Multipurpose Internet Mail Extensions (S/MIME) standards for digital signing and encryption of e-mail communications to the STATE about Enrollees that contain Private Health Information. MCO may communicate with the STATE using MN-ITS, or request that the STATE initiate a secure e-mail exchange.

3.5 Participation Requirements.

3.5.1 Required MCO Participation in STATE Programs. The MCO must comply with Minnesota Statutes, §§ 256B.0644 and 62D.04, subd. 5.

3.5.2 MSC+ Participation Requirement. In Service Areas where multiple Medicaid MSC+ MCOs are operating, the MCO must establish and/or maintain MSC+ coverage under this contract that shall operate concurrently with MSHO. The MCO shall provide and make available an MSC+ product for Medical Assistance Enrollees who disenroll from the MCO's MSHO product but are required to remain in a managed care product. MCOs already approved to offer MSHO services may continue to offer MSHO coverage in Service Areas in which a single MSC+ contractor is approved and the MSHO MCOs are not required to offer an MSC+ product in that Service Area.

3.6 Health Care Homes in Integrated Programs. Pursuant to Minnesota Statutes, Ch. 256B.0751, subd. 4, the development of Health Care Homes does not preclude alternative models and payment mechanisms for persons who are enrolled in integrated Medicare and Medicaid programs under Minnesota Statutes, § 256B.69. The MCO shall participate in a work group with the STATE on development and implementation of alternative models.

3.7 Special Needs Plan Duties

3.7.1 Contract with CMS for Special Needs Plan. The MCO agrees to participate in Medicare Advantage as a Dual Eligible Special Needs Plan (SNP).

(A) The MCO shall notify the STATE, consistent with section 3.2.8, of any material changes in its contract with CMS as a Special Needs Plan, including but not limited to, termination of the contract by either party.

(B) The MCO shall inform the STATE regarding significant changes in its Medicare Program or the administration of Medicare Programs, in order to facilitate operating MSHO in as fully integrated a manner as possible.

(C) The MCO will notify the STATE of changes, including but not limited to terminations of SNP plans, changes in type of SNPs approved or applied for, denial of a SNP application, failure to meet the CMS Low Income Subsidy (LIS) requirements, Part D issues that may materially affect the SNP, or a decision to conduct a Federal investigative audit that may lead to termination of the SNP, within thirty (30) days of such actions. For any SNP that may enroll Dual Eligibles, the MCO also agrees to inform the STATE of any requests to CMS for Service Area changes in its SNP Service Area(s) within Minnesota, and of final approval, denial or withdrawal of such requests to CMS within fifteen (15) days of submission of such requests to CMS or within fifteen (15) days of receipt of notice from CMS, whichever is applicable.

(D) Additional Benefits and Premiums. The MCO/SNP will notify the STATE of proposed changes with the understanding that the STATE will not share this information. The process of notification is as follows:

(1) Prior to the submission of the initial annual Medicare Advantage bids to CMS, the MCO/SNP will consult with the STATE about any changes in proposed Plan Benefit Packages (PBPs), including proposed changes in current benefits or additional premiums the SNP is expecting to request to have approved through the bid; and

(2) Notify the STATE of the status of final changes to benefits or premium levels, on or before September 1st of each Contract Year.

(E) Corrective Action Requests. The MCO will notify the STATE and provide copies of any CMS corrective action requests and subsequent corrective plans submitted to CMS related to compliance with SNP Medicare Advantage or Part D requirements within thirty (30) days of submission to CMS.

3.7.2 Continued Integration of Medicare and Medicaid Benefits under MSHO.

The MCO will cooperate with the STATE to promote the continued integration of Medicare and Medicaid benefits for MSHO Enrollees. The MCO shall respond to reasonable requests from the STATE for SNP operational, benefit, network, financial and oversight information that directly impacts the continued integration of Medicare and Medicaid benefits in order to maintain a

seamless service delivery of Medicare and Medicaid benefits to Enrollees. The MCO shall notify the STATE of significant changes in Medicare information to beneficiaries, benefits, networks, service delivery, oversight results or policy that are likely to impact the continued integration of Medicare and Medicaid benefits under this contract. The STATE shall notify the MCO of Medicaid changes that are likely to affect its CMS SNP contract.

3.7.3 Proposed Plan Benefit Packages (PBPs) and Bids.

The MCO/SNP will provide a copy of its CMS submitted bid to the STATE's actuarial firm within thirty (30) days of submission to CMS for the purpose of assuring that the STATE does not duplicate payments on any provided services. The MCO will provide a copy of the MCO's approved CMS bid to the STATE's actuarial firm, if the approved bid differs significantly from the submitted bid. The STATE will not directly review this information. The MCO must identify information as trade secret prior to or at the time of its submission for the STATE to consider classifying it as non-public, as described in section 9.6.

3.7.4 SNP Participation Requirement for MSHO; Medicare Savings.

(A) The MCO agrees to meet CMS requirements as a low income benchmark plan.

(B) The MCO/SNP agrees to apply any Medicare savings not utilized to buy down the Medicare Part D premium to meet the LIS standard in accordance with CMS guidance or required to be returned to CMS, for the benefit of Dually Eligible Enrollees of the SNP and agrees to consult with STATE about any such benefits offered prior to the initial submission of the bids to CMS. If there are significant changes after CMS approval, the MCO agrees to notify the STATE of changes in such benefits following the approval of the bid.

Article. 4 Payments.

4.1 Payment of Capitation.

Except as noted below in section 4.1.1, on the STATE's first warrant date or the 14th day of each month, whichever is earlier, the STATE agrees to pay the MCO the following rates as specified in section 4.5 of this Contract, per month, per Recipient enrolled with the MCO as full compensation for Medical Assistance goods and services provided hereunder in that month, except for the Capitation Payment for those Enrollees who have been reinstated, for which the STATE agrees to pay the MCO on the next available warrant.

4.1.1 Exceptions. Section 4.1 does not apply to:

(A) Capitation Payments for services provided in the month of June, for which payment shall be made no earlier than the first day of each July, during the term of this Contract; and

(B) With thirty (30) days advance notice, at the request of the office of Minnesota Management and Budget for purposes of managing the state's cash flow, the STATE may delay the capitation payment for up to two full warrant cycles twice during the

course of this Contract. One delay may take place between January 1, 2011 and April 30, 2011. A second delay may take place between August 1, 2011 and December 31, 2011.

(C) Any excess of total payments to the MCO that exceed $99,999,999.99 in a single warrant period. The STATE shall pay any such excess in the next warrant period, up to $99,999,999.99, with any excess from that period to be paid in the following warrant period, and so on. At its option, the STATE may choose to make more than one payment in a warrant cycle.

(D) Pursuant to Minnesota Statutes, §256B.69, subd. 5, payment for EW services for MSC+ shall be made no earlier than the month following the month in which the services were rendered. This will be managed through postponement of the EW component of each monthly payment until the month following the date of service on the original claim.

(E) In the event of an Emergency Performance Interruption (EPI) that affects the STATE's ability to make payments, the STATE will make payments to the MCO in accordance with the STATE's Business Continuity Plan.

4.2 Medicaid Capitation Payment. The STATE will pay to the MCO a Medicaid Capitation Payment for each Enrollee in accordance with Article 4 for the month in which coverage becomes effective and thereafter until termination of Enrollee coverage becomes effective. Until disenrollment, for MSHO Enrollees with only Part A or Part B, the STATE will pay the Medicaid capitation until the Enrollee is disenrolled from MSHO. During periods when an Enrollee with only one part of Medicare is enrolled in MSHO, the MCO or its subcontractors may bill Medicare fee-for-service for services covered by Medicare.

4.3 Payment for CD Room and Board Services. The STATE will reimburse the MCO for room and board costs associated with CD treatment when such treatment is required by the Rule 25 assessment criteria. The STATE will not pay more than the rate specified in the host county contract in effect at the time the service was rendered. The STATE will make a warrant request within thirty (30) days of receipt of the MCO's quarterly report.

4.4 Description of Rate Cell Category Components.

4.4.1 For MSC+.

(A) The Institutionalized Rate Cell includes the following component, adjusted for age, sex, Medicare status and region or county:

(1) Medicaid Institutional Basic Care payment rate.

(B) The Community EW Rate Cell includes the following components, which are adjusted for age, sex, Medicare status and region or county:

(1) Medicaid MSC+ Non-Institutional Basic Care payment rate.

(2) Adjusted average monthly EW Waiver payment rate.

(3) Medicaid NF one hundred and eighty (180) day Add-On payment rate.

(C) The Community Non-EW Rate Cell includes the following components, which are adjusted for age, sex, Medicare status and region or county:

(1) Medicaid MSC+ Non-Institutional Basic Care payment rate.

(2) Medicaid NF one hundred and eighty (180) day Add-On payment rate.

4.4.2 For MSHO.

(A) The Institutionalized Rate Cell Category includes the following components, which are adjusted for age, sex and county:

(1) Medicaid Institutional Basic Care rate.

(B) Community EW Rate Cell Category includes the following components, which are adjusted for age, sex and county:

(1) Medicaid Non-Institutional Basic Care rate.

(2) Average monthly Elderly Waiver payment.

(3) Medicaid one hundred and eighty (180) day NF Add-On.

(C) Community Non-EW Rate Cell Category includes the following components, which are adjusted for age, sex and county:

(1) Medicaid Non-Institutional Basic Care rate.

(2) Medicaid one hundred and eighty (180) day NF Add-On.

(D) Community Non-EW Hospice Rate Cell Category includes the following components, which are adjusted for age, sex and county:

(1) Medicaid Non-Institutional Basic Care rate.

(E) Community EW Hospice Rate Cell Category includes the following components, which are adjusted for age, sex and county:

(1) Medicaid Non-Institutional Basic Care rate.

(2) 50% of the Average Monthly Elderly Waiver payment.

4.5 Senior Payment Rates. For MSHO and MSC+, monthly rates paid to the MCO shall be paid by the STATE according to the payment rates specified in Appendix II. The MCO shall receive for each Enrollee the rate of the county of residence.

4.5.1 Basic Care Rates for Seniors. For the Contract Year, monthly payments paid by the STATE to the MCO for Basic Care services for MSC+ and MSHO Enrollees shall be shown in the column titled, "*CY 2011 Plan Rate with Ratable Reduction*" in Appendix II. These payments shall:

(A) Be 100% demographically based for all Enrollees;

(B) Reflect removal of the MERC carve out from the base rates (amount shown in column titled, "MERC Carve Out"), excluding MSHO Dual Eligibles;

(C) Include Disproportionate Hospital Utilization (DHU) funding;

(D) Be reduced by 2.5% for a ratable reduction pursuant to Minnesota Statutes, §256B.69, subd. 5g and 5h.

4.5.2 Nursing Facility Add-on Rates for Seniors. Monthly payments paid by the STATE to the MCO for Nursing Facility services as described in section 4.26 of the contract shall be those identified in Appendix II.

4.5.3 Elderly Waiver Add-on Rates for Seniors. Monthly payments for Elderly Waiver services shall be made by the STATE to the MCO as shown in Appendix II, as applicable. The STATE agrees not to rebase the base rates for risk adjustment during the term of this Contract.

4.5.4 Long Term Care Elderly Waiver Risk Adjusted Payment System.

(A) Risk Adjustment Methodology. To account for variation in risk for the costs of EW services among Enrollees, the STATE will calculate an MCO-specific risk score for the EW add-on rate on an annual basis.

(1) Development of Factors. The State developed risk factors using individual data on costs and characteristics of EW recipients from the data available in the STATE's MMIS system including encounter data, LTCC screening document data submitted by MCOs and demographic information. See Appendix IV, Long Term Care Elderly Waiver Risk Adjusted Payment System.

(2) The 2011 risk factors for Customized Living/ Corporate Foster Care (CL / CFC) were based on the number of Customized Living and Corporate Foster Care recipient months, as a percentage of total EW recipient months, within each MCO. See Appendix IV, Long Term Care Elderly Waiver Risk Adjusted Payment System.

(3) Calculation of Annual MCO Elderly Waiver Risk Scores

(a) The MCO's risk score for the Contract Year is based on an Enrollee roster derived from paid MCO capitation claims for the month of November of the current Contract Year. Area, Age Group, and ADL Group factors for each EW recipient are derived from the MMIS Data Warehouse claims and LTCC Screening document tables as of the first data update in November of the year

prior to the start of the Contract Year. Elderly Waiver Enrollees without a valid and current LTCC Screening document are excluded from the calculation. CL / CFC percentages, rankings, and risk factors are derived from the previous calendar year's encounter data. See Appendix IV, Long Term Care Elderly Waiver Risk Adjusted Payment System.

(b) EW recipient-level risk scores will be averaged to derive the overall MCO risk score. The STATE will provide the MCO with EW recipient-level risk factors used in calculating the plan's overall risk score through its MN-ITS mailbox by November 30th.

(c) Scores will be held constant for the entire Contract Year.

4.5.5 Payment for Medicaid Covered Medicare Cost Sharing. The MCO is responsible for payment of Medicaid covered Medicare cost sharing where applicable. Medicaid covered Medicare cost-sharing is included in the rates in section 4.5.

4.5.6 Medical Education and Research Trust Fund Money (MERC).

(A) Appendix II includes for the Contract Year, for MSC+ :

(1) A set of capitation rates with MCO specific MERC and Disproportionate Hospital Utilization (DHU) funding in the rates;

(2) A set of capitation rates with MCO-specific MERC funding out of the rates; and

(3) The dollar difference between (1) and (2), which is the amount of the rate attributable to medical education and being removed ("carved out") from the rates prior to payment to the MCO.

(B) The STATE shall:

(1) Reduce the payments to the MERC Trust Fund on behalf of the MCO and reduce the payment to the MCO by the amount in section 4.5.6(A)(3) above.

(2) The STATE shall make payments to the MERC Trust Fund on behalf of the MCO in the amount of the lesser of section 4.5.6(A)(3) above or the aggregate dollar amount carved out of the Medical Assistance capitation rates and paid to the MERC Trust Fund in STATE fiscal year 2009 (the baseline year for MERC funds).

(3) The STATE shall reflect on the remittance advice the total reimbursement amount to the MCO, and the amount of medical education dollars carved out.

(4) Once the MERC limit described in 4.5.6(B)(2) above is reached, the carve-out will continue, but the transfer of the MERC funds will stop.

4.6 Basis of Assignment of Rate Cells. Assignment of Rate Cells may be made based on:

(A) Information on the STATE MMIS,

(B) Information entered into MMIS by the MCO,

(C) Information contained on the MCO Enrollment Form,

(D) The Capitation Payment rates specified in this Article, and

(E) As specified by the STATE and CMS.

4.7 Requirements for Assignment of Rate Cell Categories

4.7.1 For MSC+.

(A) Categories. The Rate Cell categories shall be assigned by the STATE upon receipt of the required information from the MCO as specified in this section. Rate Cells shall be assigned prospectively for the next available month.

(B) Changes. Changes in Rate Cell due to new living arrangement and/or Elderly Waiver Nursing Facility Certifiable (NHC) status must be entered in MMIS on or before the Capitation Cut-Off Date in order for the MCO to be paid at the rate corresponding to the new Rate Cell for the next available month. When a change to Rate Cell criteria has been entered in MMIS after the enrollment Cut-Off Date, the MCO will be paid at the rate corresponding to the new Rate Cell at the time of the MCO's next Capitation Payment, unless the requirements provided for in this section are met, and/or the payment is delayed according to section 4.7.1(D)(2) below.

(C) Community Non-Elderly Waiver (Community Non-EW) Rate Cell.

(1) The Community Non-EW Rate Cell will be assigned to those Recipients who, at capitation for MSC+, the time of enrollment in the MCO, are coded in MMIS to be in a community living arrangement and are not enrolled in Elderly Waiver for the 1st of the following month.

(2) The Community Non-EW Rate Cell will be assigned based on the Enrollee's living arrangement in MMIS, and absence of an EW Waiver span in MMIS.

(D) Community Elderly Waiver (Community EW) Rate Cell.

(1) The Community EW Rate Cell will be assigned to those Recipients who, at capitation for MSC+, are coded in MMIS to be in a community living arrangement and are enrolled in the Elderly Waiver for the 1st of the following month.

(2) Pursuant to Minnesota Statutes, §256B.69, subd. 5, payment for EW services shall be made no earlier than the month following the month in which the services were rendered. This will be managed through postponement of the EW component of each monthly payment until the month following the date of service on the original claim.

(3) EW services must be delivered to Enrollees who meet the EW Level of Care criteria based on demonstrated need, and are eligible for payment of LTC services. MCOs are responsible for delivery of EW services even if the EW Rate Cell component was not paid in a given month.

(E) Institutionalized Rate Cell.

(1) The Institutional Rate Cell will be assigned to those Recipients who, at capitation for MSC+, are coded in MMIS in an Institutionalized living arrangement.

(2) MCOs will be required to close waiver spans promptly following placement in a Nursing Facility of greater than thirty (30) days.

(F) The STATE reserves the right to retroactively recover overpayments of the EW rate component from the MCO that are identified as overpayments due to delays in closing EW spans.

(G) Change in Living Arrangement Prior to Effective Date of Enrollment Capitation Cut Off. If the MCO discovers and promptly notifies the STATE that an Enrollee was Institutionalized prior to the first effective date of MSC+ enrollment, and was assigned the Nursing Facility Benefit based on the information in MMIS at the time capitation ran, the STATE will: retroactively close the "P" span so that the MCO will not have liability for Medicaid Nursing Facility days for this Enrollee, unless the conditions for a new Nursing Facility Benefit Period are met.

4.7.2 For MSHO:

(A) Categories. Rate Cell Categories shall be assigned by the STATE upon receipt of the required information as specified in this section and section 3.1.4 above. Rate Cell Categories shall be assigned prospectively for the next available month.

(B) Changes. Rate Cell Category changes due to a new living arrangement and/or NHC status must be entered into MMIS on or before the enrollment Cut-Off Date in order for the MCO to be paid at the rate corresponding to the new Rate Cell Category at the time that the Capitation Payment is to be paid.

(C) Post-Cut-Off Changes. When a Rate Cell Category change has been entered in the STATE MMIS after the enrollment Cut-Off Date, the MCO will be paid at the rate corresponding to the new Rate Cell Category at the time of the MCO's next Capitation Payment, unless the requirements provided for in section 4.9 below are met.

(D) Community Non-EW (Rate Cell Category "A"):

(1) The Community Non-EW Rate Cell Category will be assigned to those Recipients who, at the time of enrollment in the MCO, are coded in a community living arrangement in MMIS and are not on the Elderly Waiver program for the 1st day of the following month.

(2) For changes in MSHO Rate Cell Categories after initial enrollment, the Community Non-EW Rate Cell Category will be assigned after the MCO notifies the STATE that an Enrollee is living in a community setting and has not been assessed to receive EW services.

(E) Community Elderly Waiver (Rate Cell Category "B"):

(1) The Community EW Rate Cell Category will be assigned to those Recipients who, at the time of enrollment in the MCO, are coded in MMIS to be in a community living arrangement and are enrolled in the Elderly Waiver for the 1st of the following month.

(2) For changes in MSHO Rate Cell Categories after initial enrollment, the Community EW Rate Cell Category will be assigned after the MCO:

(a) Notifies the STATE that an Enrollee is living in a community setting; and has indicated that the enrollee has received a Long Term Care Consultation and has been identified to be in need of Elderly Waiver services; and

(b) Enters into MMIS the Screening Document (DHS-3247) completed for that Enrollee.

(3) The Community EW Rate Cell Category will be assigned to those Recipients, who, at capitation, have an open EW span for the next available month.

(4) EW services must be delivered to Enrollees who meet the EW Level of Care criteria based on demonstrated need, and are eligible for payment of LTC services. MCOs are responsible for delivery of EW services even if the EW Rate Cell component was not paid in a given month.

(F) Institutionalized (Rate Cell Category "D"):

(1) The institutional Rate Cell Category will be assigned to those Recipients who, at the time of enrollment in the MCO, are coded in an Institutionalized living arrangement in MMIS.

(2) The Institutional Rate Cell Category will be assigned to those Recipients who, at capitation, do not have an open EW span for the next available month and have an institutional living arrangement.

(3) MCOs will be required to close waiver spans promptly following placement in a Nursing Facility of greater than thirty (30) days.

(G) The STATE reserves the right to retroactively recover overpayments of the EW rate component from the MCO that are identified as overpayments due to delays in closing EW spans.

4.8 Elderly Waiver Payment Adjustment for MSHO and MSC+. Once per Contract Year no later than September 1, the STATE shall deduct from the MCO's warrant an amount equal to all monthly Elderly Waiver Capitation Payments made in the calendar year prior to the current Contract Year after an MSHO/MSC+ Enrollee has been Institutionalized for sixty (60) days, or upon the prior year's Care Plan audit in section 6.1.11(B)(7) findings that an Enrollee was in an inappropriate Rate Cell. The STATE shall calculate the amount and notify the MCO 90 days prior to the adjustment of the warrant.

4.9 Change in Living Arrangement Prior to Capitation Cut-off. If the MCO discovers and promptly notifies the STATE that an Enrollee was Institutionalized prior to the first effective date MSC+ or MSHO enrollment, and was assigned an RCC of "A" or "B" for MSHO or the Nursing Facility benefit for MSC+, based on the information in MMIS at the time of enrollment, the STATE will retroactively close the "P" span so that the plan will not have liability for Medicaid Nursing Facility days for this Enrollee, unless the conditions for a new Nursing Facility Benefit Period are met.

4.10 Hospice for MSHO (Rate Cell Categories "E" and "F"). The following Rate Cell Categories will be assigned when an Enrollee elects Hospice:

(A) Community Non-EW Hospice (Rate Cell Category "E"): Indicates a Community Non-EW Enrollee who has elected Hospice.

(B) (Community EW Hospice (Rate Cell Category "F"): Indicates a Community EW Enrollee who has elected Hospice.

(C) Institutional Hospice: Rate Cell Category "D" will be assigned to Institutionalized Enrollees electing Hospice.

4.11 Actuarially Sound Payments. All payments for which the STATE receives Federal Financial Participation under this Contract, including risk adjusted payments and any risk sharing methodologies must be actuarially sound pursuant to 42 CFR § 438.6(c).

4.12 Waiver Obligations.

4.12.1 Duties of the STATE and the MCO include:

(A) The STATE shall provide the MCO on a monthly basis with data extracts containing monthly Recipient Waiver Obligation amounts for the MCO's Enrollees for the past thirty-six (36) months. The MCO shall reduce payments it makes to Providers of EW services by the amount indicated on the STATE files, and shall notify Providers of the amounts attributed to the Waiver Obligation.

(B) The MCO must reconcile Waiver Obligation changes and assure that they are communicated to Providers. The MCO shall make adjustments to the payment made to the EW Provider when a change in the waiver obligation amount is reported on the data extract from that State. A Waiver Obligation may not be deducted until the service is provided. The Enrollee is not obligated to pay the full amount of the Waiver Obligation each month if the services are not utilized.

(C) The MCO may delegate the billing and collection of the Waiver Obligation of Enrollees to its EW service Providers.

(D) The MCO must require Providers to refrain from denying services because of non-payment of the Waiver Obligation without proper notice to the Enrollee and the MCO. If a Provider denies services because of non-payment of the Enrollee's non-payment Waiver Obligation, the MCO is obligated to find the Enrollee another Provider for the service.

(E) The MCO must update this process when changes are made and provide an updated copy, or notice of no change as applicable, to the STATE each Contract Year by April 15th.

4.13 STATE Request for Data. In accordance with Minnesota Rules, Part 9500.1460, subpart 16, the MCO shall comply with the STATE's requests for data from the STATE or its actuarial agent that is required by the STATE for rate-setting purposes. The MCO shall make the data available within thirty (30) days from the date of the request and in accordance to the STATE's specifications.

4.14 Payment of Clean Claims. The MCO shall promptly pay all Clean Claims, and interest on Clean Claims, when applicable, whether provided within or outside the Service Area of this Contract consistent with §§1816(c)(2), 1842(c)(2) and 1902 (a)(37) of the Social Security Act (42 U.S.C. §1395(h)(C)(2), 42 U.S.C. §1395u(c)(2), 42 U.S.C. §1396a(a)(37)), 42 CFR Parts 447.45 and 447.46, and Minnesota Statutes, §256B.69, subd. 6(b), §16A.124, and §62Q.75.

4.15 Renegotiation of Prepaid Capitation Rates. The prepaid capitation rates for Recipients enrolled in the MCO shall be subject to renegotiation not more than annually unless required by State or federal law, regulation or directive, or necessary due to changes in eligibility and benefits. Renegotiated rates will require CMS approval according to section 4.18.

4.16 No Recoupment of Prior Years' Losses. The capitation rate shall not include payment for recoupment of losses incurred by the MCO from prior years or under previous contracts.

4.17 Assumption of Risk. The MCO shall assume the risk for the cost of comprehensive services covered under this Contract and shall incur the loss if the cost of those services exceed the payments made under this Contract, except as otherwise provided in this Contract.

4.18 CMS Approval of Contract. Approval of the Contract by CMS is a condition for Federal Financial Participation (FFP). Payment of rates is conditional upon CMS approval and if not approved would reopen negotiations pursuant to section 4.15. If CMS approval is not received, payment continues at rates established in the most recent contract, pending federal approval of renegotiated rates and will be adjusted to the new rates as of the federally approved effective date.

4.19 Medical Assistance Copayments for MSHO and MSC+

4.19.1 Exemptions from Copayments.

(A) The following Enrollees or services are exempt from copayments:

(1) Pregnant women;

(2) Enrollees expected to reside for thirty (30) days or more in an institution;

(3) Enrollees receiving Hospice care;

(4) An American Indian who receives services from an Indian Health Care Provider or through contracted health services (IHS CHS) referral from an IHS facility;

(5) Emergency Services;

(6) Family Planning;

(7) Services paid for by Medicare for which Medical Assistance pays the coinsurance and deductible;

(8) Copayments that exceed one per day per Provider non-emergency visits to a hospital-based emergency room; and

(9) Chemical dependency treatment services pursuant to Minnesota Statutes, §254B.03, subd. 2.

4.19.2 Copayments: Enrollees must make copayments for the services listed below:

(A) Prescription drugs ($3 per prescription for brand name drugs, $1 per prescription for generic drugs, with a maximum of $7.00 per month; except that no copayment is required for anti-psychotic drugs).

(B) Non-Emergency Use of Emergency Departments. Enrollees shall have a copayment for non-emergency use of the emergency department of three dollars and fifty cents ($3.50) per visit, Copayments shall be limited to one per day per Provider.

4.19.3 Collection of Copayment. The MCO may delegate to the Providers of these services the responsibility to collect the copayment.

4.19.4 Inability to Pay Copayment. The MCO must also ensure that no Provider denies Covered Services to an Enrollee because of the Enrollee's inability to pay the copayment pursuant to 42 CFR §447.53. The MCO must ensure that Enrollees retain the ability to seek services from other Providers.

4.19.5 Copayment and Residents of Nursing Facility. For MSC+ Enrollees, upon notification to the MCO that a Medical Assistance Enrollee has been a resident of a Nursing Facility for thirty (30) days or more, the MCO shall ensure that its Providers do not require the Enrollee to pay any copayments, and shall reimburse its Providers any copayment amount paid. The MCO may submit an invoice and a data certification to the STATE for all copayments the MCO has reimbursed to its Providers in the previous quarter, no more often than quarterly. The

STATE shall verify the Medical Assistance Enrollee's living arrangement, and date of service on the encounter claim, prior to payment to the MCO for the amounts the MCO claims to have reimbursed to its Providers.

4.19.6 Copayment and Family Income. For MSC+ only, individuals identified by the commissioner with income at or below one hundred percent (100%) of the federal poverty guidelines, total monthly co-payments must not exceed five percent (5%) of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on co-payments as authorized by Minnesota Statutes, § 256B.0631, subd. 1(b)(3).

4.19.7 MCO Waiver of Medicaid Copays for MSHO Community Enrollees. The MCO has chosen to waive Medicaid copayments for MSHO community Enrollees for the term of this Contract. The MCO shall have a uniform policy to assure that the same amounts of copayments for the same types of services are waived for all MSHO community Enrollees. Copays for the following services will be waived for MSHO community Enrollees for:

(A) Non-emergency use of the emergency department

(B) Medicaid prescription drugs (those prescription drugs covered by Medicaid rather than Medicare for dually eligible Medicare Enrollees).

4.19.8 Notification to Enrollees of Copayments. The MCO shall explain the copayment policy in the MCO's Certificate of Coverage and other materials for Enrollees. The MCO shall not offer waiver of copayment as an inducement to enroll for MSHO unless CMS has approved waiver of payment of copayments by the MCO as an additional benefit in the MCO's Medicare bid process, and such waiver cannot be described in any of the MCO's Marketing Material.

4.20 Medicaid Managed Care Withhold. For Capitation Payments made on or after January 1, 2011, the STATE shall withhold nine point five percent (9.5%) from the Basic Care Rate portion of the MCS+ and MSHO rates of the MCO's payments. MSHO and MSC+ Medicaid Nursing Facility and Home and Community Based Services payments are excluded from the withhold provision.

4.20.1 Return of Withhold. Of the total, 52.63% (50 divided by 9.5 x 100) of the withheld funds shall be returned no sooner than July 1st and no later than July 31st of the following year only if, in the judgment of the STATE, performance targets in section 4.20.3 are achieved. The remaining 47.37% (4.5 divided by 9.5 x 100) of withheld funds shall be returned with no consideration of performance, no sooner than July 1st and no later than July 31st of the subsequent Contract Year as required by Minnesota Statutes, § 256B.69, subd. 5a.

4.20.2 Withhold Return Scoring for the Contract Year.

(A) The withheld funds will be returned to the MCO for the Contract Year based on the following scoring system for each of the performance targets listed below:

(1) Denial, termination or reduction of services (DTR) notice shall be worth a total of twenty (20) points;

(2) Grievance and Appeal reporting shall be worth a total of twenty(20) points;

(3) Provider Number measures shall be worth a total of thirty (30) points, ten (10) points for each measure;

(a) Valid Treating Provider, ten (10) points;

(b) NPI Pay-To-Provider, ten (10) points; and

(c) Valid treating provider PCA UMPI/NPI, ten (10) points.

(4) Repeat deficiencies on the MDH QA Examination, for Minnesota Health Care Programs, shall be worth a total of ten (10) points;

(5) Completion of and submission to STATE of the Care Plan audit in section 7.9.3, following the care planning audit data abstraction protocol developed by the Care Plan audit work group, shall be worth five (5) points; and

(6) Initial Health Risk Screening or Assessment. Completion of initial health risk screening or assessments within seventy-five (75) calendar days for community non-EW Enrollees new to the MCO (that is, newly enrolled with the MCO during calendar year 2011 and enrolled a minimum of sixty (60) days) shall be worth five (5) points. The State will provide two mid-year MCO interim progress reports in regard to this measure.

(B) The percentage of the MCO's withheld funds to be returned shall be calculated by summing all earned points, dividing the sum by ninety (90), and converting to a percentage. No partial whole number of points will be assigned if the MCO fails to completely meet performance targets described in section 4.20.3. Points assigned for these performance targets will be all or none (e.g. 20 points or 0 points in a 20-point measure), except DTR, Grievance and Appeal Reporting worth five points for each quarter submission, and the ED Utilization measure explained above.

(C) If the STATE determines that any of the performance target measures are not dependable, the measure(s) will be eliminated and the MCO shall be scored based on the remaining performance target measures.

(D) Managed Care Withhold Measures. The measure for identifying treating Providers (section (4.20.3(C)) will be calculated from: (1) encounter data submitted no later than May 31st of the year subsequent to the Contract Year by the MCO to the STATE, pursuant to section 3.4.1; (2) additional data sources approved by the STATE and in the STATE's possession; or (3) as otherwise stated below. The following provider number measures shall be computed out to the second decimal (e.g. 45.63). These measures include:

(1) Valid Treating Provider,

(2) NPI Pay-To-Provider,

(3) PCA Treating provider UMPI/NPI.

4.20.3 Administrative and Access/Clinical Performance Targets for MSHO and MSC+. Pursuant to the specific terms in section 4.20.3, the points assigned to each performance target will be awarded to the MCO, if the MCO meets all of the requirements of the specific performance target for MSHO and MSC+ combined, or MSHO only as outlined below:

(A) Denial, Termination, or Reduction Notice Reporting.

(1) Correctly submits to the STATE the completed Denial, Termination or Reduction Notice (DTR) report as required in section 8.7 for MSHO and MSC+ combined and as stated below, or

(2) Reports that it has no DTR activity for a given quarter, and notifies the STATE'S Ombudsman Office by e-mail or in writing by the 30th day of the month following the quarter.

(B) Grievance and Appeal Reporting.

(1) Correctly submits to the STATE the completed Grievance and Appeal report as required in sections 8.6 and 8.8, and as stated below; or

(2) Reports that it has no Grievance and Appeal activity for a given quarter, and notifies the STATE'S Ombudsman Office by e-mail or in writing by the 30th day of the month following the quarter.

(C) Identifying Valid Treating, Pay-To and PCA Treating Provider UMPI/NPI Provider Encounters.

(1) There are three measures of National Provider Identification numbers (NPI or UMPIs) in submitted encounter data. The methods for the calculation of the 2011 NPI Treating Provider, NPI Pay-To Provider and PCA UMPI/NPI treating provider are posted on the DHS Partners and Providers, Managed Care Organizations website at www.dhs.state.mn.us/dhs16_139763 .

(a) Valid NPI Treating Provider Measure. Provides valid treating Provider information in the submitted encounter data for listed procedure codes, as required in the most recent version of the STATE document titled "*2011 NPI Treating Provider, NPI Pay-To Provider and PCA UMPI/NPI Treating Provider Lead Screening and ED Utilization Managed Care Withhold Technical Specifications Managed Care Withhold Technical Specifications*." If the percentage is ninety-five percent (95%) or greater, the MCO will receive all ten (10) points.

(b) Valid NPI Pay-To Provider Data Measure. Assess all non-pharmacy encounters for completeness of Pay-To Provider NPI data. This measure shall include all managed care encounter claims except pharmacy, transportation, Elderly Waiver and interpreter services encounters. If the percentage is ninety-five percent (95%) or greater, the MCO will receive all ten (10) points.

(c) Valid PCA Treating Provider UMPI/NPI Measure. Provide valid PCA treating provider UMPI (or NPI for any PCA provider who has an NPI) information in the submitted encounter data for T1019 procedure code. If the percentage for Contract Year is ninety-five percent (95%) or greater, the MCO will receive all ten (10) points.

(2) The STATE shall inform the MCO twice each year, in April for the previous calendar year's data and September for the first six months of the current year's data, of the MCO's preliminary NPI Treating Provider, NPI Pay-To Provider and PCA treating provider UMPI/NPI Measure percentages. These reports contain measurement estimates and are not the final rates that will be used to determine if the MCO achieved its performance targets. The STATE provides these estimates to aid the MCO's compliance efforts.

(D) Minnesota Department of Health (MDH) QA Final Examination Deficiencies.

(1) Comply with the MDH licensing requirements and have no repeated deficiencies related to Minnesota Health Care Programs that remain after the MCO's corrective action(s) that initially resulted from the MCO's MDH QA Examination, or

(2) If the MCO is not examined during the Contract Year, but remains in compliance with MDH licensing requirements and any corrective actions assigned by MDH, the MCO will receive all points available for this performance target.

(E) Care Plan Audit. Completion of and submittal to the STATE of the Care Plan audit in section 7.9.3, following the care planning audit data abstraction protocol developed by the Care Plan audit work group.

(F) Initial Health Risk Screening or Assessment. The MCO shall conduct an initial risk screening or assessment of each new MSHO and MSC+ non-EW community Enrollee's health needs in accordance with sections 6.1.3(A)(1) and 6.1.4(A)(1) of this contract. The State will then calculate the timeliness of the assessment by using the following formulas:

(1) Completed initial health risk assessments for community non-EW Enrollees new to the MCO, that is, newly enrolled with the MCO for a minimum of sixty (60) days, and completed within seventy-five (75) calendar days; and

(2) Initial health risk assessments completed by the MCO or its designees using data submitted to the State no later than May 31, 2011, for new MSHO and MSC+ enrollments opened from January 1, 2011, through December 31, 2011.

(a) Timeliness will be determined by the date of enrollment compared to the date the initial health risk screening or assessment is completed.

(b) The STATE will exclude retro-enrollment dates for this calculation, and will also exclude Enrollee refusals.

(c) To qualify for the five (5) points allotted to this performance measure, the MCO must show that combined, initial health risk screenings or assessments were completed in a timely manner for fifty (50%) of MSHO and MSC+ new Enrollees.

(d) Transition plans submitted by the MCO and approved by the State under 6.1.3(A)(1)(a) and 6.1.4(A)(1)(a) will be accounted for in the calculation.

4.21 Return of Withheld Funds for Contract Year 2011. The funds returned shall be calculated as follows:

(A) The difference between:

(1) The total Contract Year 2011 Basic Care Rate portion of the MSHO Capitation Payments and the total Contract Year 2011 MSC+ Capitation payments made to the MCO, (as of May 31st of the year subsequent to the Contract Year), divided by 0.905 (90.5%); and

(2) The total Contract Year 2011 Basic Care Rate portion of the MSHO Capitation Payments and the total Contract Year 2011 MSC+ Capitation Payments made to the MCO (as of May 31 of the year subsequent to the Contract Year).

(3) This amount has been reduced to reflect removal of the MERC funding (for MSC+) and the legislated rate reduction of 2.5% for the Basic Care Rate portion of the capitation.

(B) The amount of the withheld funds to be returned to the MCO shall be calculated as follows:

(1) The amount determined in 4.21(A) shall be multiplied by 0.5263 (5.0 divided by 9.5) or 52.63%.

(2) The amount in 4.21(B)(1) shall be multiplied by the percentage determined in 4.20.2(B), subject to the limitation in 4.21(B)(3) below.

(3) The difference between 4.21(B)(1) and 4.21(B)(2), the amount of the unreturned funds that are kept by the STATE, shall not exceed twenty percent (20%) of all funds withheld from the MCO under this Contract in 4.21(B)(1).

(4) The amount in 4.21(A) shall be multiplied by 0.4737 (4.5 divided by 9.5) or 47.37%.

(5) The resulting amount from the calculation in 4.21(B)(2) and 4.21(B)(4) will be returned to the MCO.

4.22 Payment Error in Excess of $500,000. If the STATE determines that there has been an error in its payment to the MCO pursuant to Article 4 that resulted in overpayment or underpayment in excess of $500,000, due to reasons not including rate-setting methodology, or Fraud or Abuse by the MCO or the Enrollee, the STATE or the MCO may make a claim under this section.

4.22.1 Independent Audit. The STATE or the MCO may request an independent audit of the payment error prior to recovery or offset by the STATE of the overpayment or underpayment amount.

(B) The STATE shall select the independent auditor and shall determine the scope of the audit, and shall involve the MCO in discussions to determine the scope of the audit and selection of the auditor.

(C) The MCO must request the audit in writing within sixty (60) days from actual receipt of the STATE's written notice of overpayment.

(D) Neither the STATE nor the MCO shall be bound by the results of the audit.

(E) The STATE shall not be obligated to honor the MCO's request for an independent audit if in fact sufficient funds are not available for this purpose or if in fact an independent auditor cannot be obtained at a reasonable cost. This does not preclude the MCO from obtaining an independent audit at its own expense; however the MCO must give reasonable notice of the audit to the STATE and must provide the STATE with a copy of any final audit results.

4.22.2 Inspection Procedures. The STATE and the MCO shall work together to develop reasonable procedures for the inspection of STATE documentation to determine the accuracy of payment amounts pursuant to Article 4.

4.22.3 Two Year Limit to Assert Claim.

(A) The STATE shall not assert any claim for or seek the reimbursement of or make any adjustment for any alleged overpayment made by the STATE to the MCO pursuant to this section, more than two years after the date such payment was actually received by the MCO from the STATE.

(B) The MCO shall not assert any claim for or seek the reimbursement of or make any adjustment for any alleged underpayment made by the STATE to the MCO pursuant to this section, more than two years after the date such payment was actually received by the MCO from the STATE.

(C) Payment Offset. When possible, a recovery for an overpayment or reimbursement due to an underpayment shall be offset against or added to future payments made according to this Article.

(D) Notice. The parties shall notify each other in writing of intent to assert a claim under this section.

4.23 Payment Error Not in Excess of $500,000. If the STATE determines there has been an error or errors in its payment to the MCO pursuant to Article 4 that resulted in overpayment or underpayment to the MCO not in excess of $500,000, and if such an error or errors occurred because of reasons other than rate-setting methodology, or Fraud or Abuse by the MCO or the Enrollee, the STATE or the MCO may make a claim under this section.

4.23.1 One Year Limit to Assert Claim.

(A) The STATE shall not assert any claim for or seek the reimbursement of or make any adjustment for any alleged overpayment made by the STATE to the MCO under this section more than one year after the date such payment was actually received by the MCO from the STATE. This one year limitation, along with the notice requirement described in section 4.23.1(C), does not apply to duplicate payments made because of multiple identification numbers for the same Enrollee, payments for full months for a Medical Assistance Enrollee who is incarcerated in a facility, and payments for full months after the death of the Enrollee.

(B) The MCO shall not assert any claim for or seek the reimbursement of or make any adjustment for any alleged underpayment made by the STATE to the MCO more than one year after the date such payment was actually received by the MCO from the STATE.

(C) Notice. The parties shall notify each other in writing of any intent to assert a claim under this section.

4.24 Premium Tax. Pursuant to Minnesota Statutes, §297I.15, subd. 4, the MCO shall be taxed on the premiums paid by the STATE under the Medical Assistance program. If the MCO is exempt or is no longer required to pay the premium tax, the MCO's base rate will be adjusted to reflect that change.

4.25 Health Care Home Care Coordination Payment for Integrated Programs; Variance.

(A) The MCO shall pay a care coordination fee to Providers for qualified Enrollees of a certified Health Care Home within the MCO Provider network, unless the MCO is using an alternative comprehensive payment arrangement. The fee schedule for Health Care Homes must be stratified according to the stratification criteria developed by the STATE, pursuant to Minnesota Statutes § 256B.0751 et seq. In addition:

(1) The MCO will consider Medicare status, and any additional Medicare resources that may be available when determining Health Care Home care coordination payment rates for Dual Eligible Enrollees; and

(2) If a clinic or clinician is a certified Health Care Home and but the MCO has an alternative comprehensive payment arrangement that is inclusive of care

coordination and tied to outcome measures related to patient health, patient experience and cost effectiveness with that clinic or clinician, upon documentation of the alternative comprehensive payment arrangement and its proposed performance and outcome measures, the STATE will provide a variance from the stratified fee schedule in 4.25(A) above and from any additional Health Care Home care coordination fee. See section 3.4.2(K)(2) for documentation of the comprehensive alternative payment arrangement. The MCO is not required to pay both a Health Care Home care coordination fee and a fee based on a more comprehensive payment arrangement.

(B) DHS will make payment to the MCO for Enrollees in or above Tier One of the classifications developed in Minnesota Statutes, § 256.0753.

4.26 Skilled Nursing Facility/Nursing Facility Benefit.

4.26.1 180-Day SNF/NF Benefit Period For MSHO. The MCO is responsible for services covered under the Medicare Advantage SNF benefit regardless of whether NF liability is indicated on the STATE's Medical Assistance file.

(A) For any Recipient who enrolls in MSHO while in a community setting (i.e. is assigned to Rate Cell category A or B) the MCO shall have financial responsibility for Nursing Facility services for one hundred eighty (180) days. The 180 days begin at the time of the Enrollee's date of admission to a Skilled Nursing Facility (SNF) or Nursing Facility (NF) on or after the first effective date of enrollment. Both Medical Assistance and Medicare covered days shall be counted toward the 180-day Benefit Period, except that the MCO shall not pay for Nursing Facility services for new admits to a facility that occurs during Denial of Payment for New Admits (DOPNA) violation periods, since these days are not covered under the STATE's fee-for-service program. The 180 days shall be counted cumulatively. The 180 day Benefit Period may be applied to an Enrollee more than once if the requirements of the one hundred and eighty (180) day separation period are met as specified in section 4.26.5. The MSHO MCO is responsible for services covered under the Medicare Advantage SNF benefit regardless of whether NF liability is indicated on the STATE's Medical Assistance file.

(B) The MCO may accrue the following types of days toward the cumulative 180-day Benefit Period:

(1) Medicare SNF days. Medicare SNF days incurred during the 180 day period may count towards the 180 day Benefit Period.

(2) Swing Bed Days. These include Medicare SNF days and Medicaid room and board days provided in swing beds that meet all other requirements for use of swing beds, including claims processing procedures and Minnesota Department of Health approval.

(3) Medicaid NF Days. These may include Medicaid leave days. Leave days must be for hospital or therapeutic leave of an Enrollee who has not been discharged from a long term care facility. According to current Medical Assistance standards,

payments for hospital leave days are limited to eighteen (18) consecutive days for each separate and distinct episode of Medically Necessary hospitalization, and payments for therapeutic leave days are limited to thirty-six (36) leave days per calendar year.

(C) The MCO may not accrue the following types of days toward the cumulative one hundred eighty (180) day Benefit Period for MSHO:

(1) Days during a Denial of Payment for New Admissions (DOPNA) period do not count towards the Medicaid or Medicare Benefit Period.

(2) Respite days do not count towards the Medicaid or Medicare Benefit Period.

(3) Institutional SNF or NF days that accrue during a Hospice election period do not count toward the one hundred eighty (180) day SNF/NF Benefit Period. Institutional room and board for these days is paid by the STATE on a FFS basis.

(4) Medicare SNF days for the Enrollee incurred prior to the begin date of the one hundred and eighty (180) day NF benefit do not count toward the one hundred and eighty (180) day benefit.

(D) The MCO agrees to waive the Medicare requirement of a three (3) day hospital stay prior to SNF admission for MSHO Enrollees.

(E) The MCO shall provide information required by subcontractors to fulfill delegated administrative responsibilities, for example, NF liability spans.

(F) The MCO remains liable for the one hundred and eighty (180) day SNF/NF benefit across Contract Years.

4.26.2 Responsibility for Tracking the 180-Day Benefit. The MCO shall be responsible for tracking accrual of days toward the 180-day SNF/NF Benefit Period for Enrollees to whom the benefit applies. During the 180-day Benefit Period, reimbursement for NF services provided by a Nursing Facility subcontractor can only be made through the MCO and not through the Medical Assistance fee-for-service claims system. Before Medicaid NF claims can be paid by the STATE, the MCO shall be required to provide documentation to the STATE demonstrating that it has paid for 180 days of SNF/NF services and the STATE will verify the information documented by the MCO. Acceptable documentation shall include a claims record that contains the number of days paid to the Nursing Facility by the MCO. Acceptable notification shall include but is not limited to the following:

(A) Provider claims submitted to the MCO for Nursing Facility and Medicare Skilled Nursing services;

(B) Internal patient account summaries;

(C) Service Authorizations if used by the MCO;

(D) Claim denials for any days billed after the MCO'S 180-day Benefit Period has ended; or

(E) Other documentation as agreed upon by the STATE, the MCO and the Nursing Facility.

4.26.3 Responsibility for Payment of Medicare SNF Days.

After the one hundred and eighty (180) day Benefit Period for MSHO is expended, the MCO shall retain responsibility for Medicare SNF days according to Medicare SNF benefit policy.

4.26.4 Responsibility for Payment of Medical Assistance NF days.

After the one hundred eighty (180) day Benefit Period for MSHO is expended, the STATE shall assume responsibility for Medical Assistance Nursing Facility days.

4.26.5 180-Day Separation Period for MSHO.

(A) Continuous Separation Period.

(1) If the MCO has already been liable for 180 days of SNF/NF services, then the 180-day Separation Period is defined as one hundred and eighty (180) consecutive Institutional or community days after the MCO has already been liable for 180 days of SNF/NF services. After this separation period has expired, the MCO shall be liable for a new, distinct 180-day SNF/NF Benefit Period for any Enrollee who is still community-based (i.e., an Enrollee is in MSHO Rate Cell Category A or B, on the last day of the separation period. If an Enrollee becomes Institutionalized (i.e., has been assigned to Rate Cell Category "D" for MSHO) prior to the end of the separation period, no new SNF/NF Benefit Period is applied.

(2) If the MCO has not previously had liability for SNF/NF services for an enrollee and the enrollee leaves the NF, there is no separation period and the MCO will be assigned NF liability for the enrollee upon return to the community.

(B) If an MSHO Enrollee is hospitalized and/or placed in a Nursing Facility during the 180-day Separation Period for thirty (30) days or less, the MSHO Enrollee shall still be considered to be residing in the community and these days shall be counted toward the 180-day Separation Period. If the Enrollee spends more than thirty (30) days in a hospital and/or Nursing Facility, the counting of the 180-day Separation Period shall begin over again if and when the Enrollee returns to the community.

(C) The STATE shall have the responsibility for tracking the 180-day Separation Period. The MCO shall cooperate with the STATE in verifying the one hundred and eighty (180) day Separation Period. On a monthly basis, the STATE shall identify community MSHO Enrollees for whom the 180-day NF benefit is not in effect. Of these, if the Enrollee is not within a 180-day separation period, the STATE shall begin a new 180 day NF Benefit Period on the first day of the next available month.

(D) The STATE enrollment data will contain information indicating the MCO's Nursing Facility Benefit Period.

4.26.6 180 Day SNF/NF Benefit for MSC+.

(A) For any Recipient who is enrolled into MSC+ while in a community setting (i.e. Community EW and Community Non-EW payment categories), the MCO shall have financial responsibility for Nursing Facility services for one hundred eighty (180) days. The 180 days begin at the time of the MSC+ Enrollee's date of admission to a Skilled Nursing Facility (SNF) or Nursing Facility (NF) on or after the first effective date of enrollment. Both Medical Assistance and Medicare covered days shall be counted toward the 180-day Benefit Period, except that the MCO shall not pay for Nursing Facility services for new admits to a facility that occurs during Denial of Payment for New Admissions (DOPNA) violation periods, since these days are not covered under the STATE's fee-for-service program. The 180 days shall be counted cumulatively. The MCO shall be responsible for paying any coinsurance for Medicare covered days during the 180-day Benefit Period. The 180-day Benefit Period may be applied to an Enrollee more than once if the requirements of the 180-day Separation Period are met as specified in section 4.26

(B) The MCO may accrue the following types of days toward the cumulative 180-day benefit period:

(1) Medicare SNF days;

(2) Swing Bed Days. These include Medicare SNF days and Medicaid room and board days provided in swing beds that meet all other requirements for use of swing beds, including claims processing procedures and Minnesota Department of Health approval.

(3) Medicaid NF days. These may include paid Medicaid leave days. Leave days must be for hospital or therapeutic leave of an Enrollee who has not been discharged from a long term care facility. According to current Medical Assistance standards, payments for hospital leave days are limited to eighteen (18)consecutive days for each separate and distinct episode of Medically Necessary hospitalization, and payments for therapeutic leave days are limited to thirty-six (36) leave days per calendar year.

(C) The MCO may not accrue the following types of days toward the cumulative one 180-day Benefit Period for MSC+:

(1) Days during a DOPNA period do not count towards the Medicaid or Medicare Benefit Period;

(2) Respite days do not count towards the Medicaid or Medicare Benefit Period; and

(3) Institutional SNF or NF days that accrue during a Hospice election period do not count toward the 180-day SNF/NF Benefit Period. Institutional room and board for these days is paid by the STATE on a fee-for-service basis.

(4) Medicare SNF days for the Enrollee incurred prior to the begin date of the 180-day NF benefit do not count toward the one hundred and eighty (180) day benefit.

(D) The MCO shall provide information required by subcontractors to fulfill delegated administrative responsibilities, for example, NF liability spans.

(E) The MCO will remain liable for the one hundred eighty (180) -day SNF/NF benefit across contract years.

4.26.7 Responsibility for Tracking 180 Day Benefit for MSC+. The MCO shall be responsible for tracking accrual of days toward the 180-day SNF/NF benefit period for MSC+ Enrollees to whom the benefit applies. During the 180-day Benefit Period, reimbursement for NF services provided by a Nursing Facility subcontractor can only be made through the MCO and not through the Medical Assistance fee-for-service claims system. Before Medicaid NF claims can be paid by the STATE, the MCO shall be required to provide documentation to the State demonstrating that it has paid for the 180-day SNF/NF benefit and the STATE will verify the information documented by the MCO. Acceptable notification shall include but is not limited to the following:

(A) Provider claims submitted to the MCO for Nursing Facility services;

(B) Documentation of Medicare covered days, including coinsurance claims for Medicare covered days;

(C) Internal patient account summaries;

(D) Service Authorizations if used by the MCO;

(E) Claim denials for any days billed after the MCO'S 180-day Benefit Period has ended; or

(F) Other documentation as agreed upon by the STATE, the MCO and the Nursing Facility.

4.26.8 Responsibility for Payment of Medical Assistance NF Days. After the 180 day Benefit Period is expended for MSC+, the STATE shall assume responsibility for Medical Assistance Nursing Facility Days.

4.26.9 180 Day Separation Period for MSC+.

(A) Continuous Separation Period.

(1) If the MCO has already been liable for 180 days of SNF/NF services, then the one hundred eighty (180) day Separation Period is defined as one hundred eighty

(180) consecutive Institutional or community days after the MCO has already been liable for 180 days of SNF/NF services. After this separation period has expired, the MCO shall be liable for a new, distinct 180-day SNF/NF Benefit Period for any Enrollee who is still community-based (i.e. Community EW or Community Non-EW payment category) on the last day of the separation period. If an Enrollee becomes institutionalized prior to the end of the separation period, no new SNF/NF Benefit Period is applied.

(2) If the MCO has not previously had liability for SNF/NF services for an enrollee and the enrollee leaves the NF, there is no separation period and the MCO will be assigned NF liability for the enrollee upon return to the community.

(B) If an Enrollee is hospitalized and/or placed in a Nursing Facility during the one hundred eighty (180) day Separation Period for thirty (30) consecutive days or less, the Enrollee shall be still be considered to be residing in the community and these days shall be counted toward the one hundred eighty (180) day Separation Period. If the Enrollee spends more than thirty (30) consecutive days in a hospital and/or Nursing Facility, the counting of the one hundred eighty (180) day Separation Period shall begin over again if and when the Enrollee returns to the community.

(C) The STATE shall have the responsibility for tracking the one hundred eighty (180) day Separation Period. The MCO shall cooperate with the STATE in verifying the one hundred eighty (180) day Separation Period. On a monthly basis, the STATE shall identify community MSC+ Enrollees for whom the 180 day NF benefit is not in effect. Of these, if the Enrollee is not within a one hundred and eighty (180) day separation period, the STATE shall begin a new 180-day NF Benefit Period on the first day of the next available month.

(D) The STATE enrollment data will contain information indicating the MCO's Nursing Facility Benefit Period.

4.27 End Stage Renal Disease (ESRD) Payments. For MSHO Enrollees identified by CMS as having ESRD, the MCO shall receive an adjusted Medicare Payment rate for Medicare Parts A and B that shall be determined by CMS. The MCO shall continue to receive the Medicaid Basic Care, Nursing Facility Add-On and Elderly Waiver rate components as appropriate for these Enrollees.

4.28 Long Term Care Ineligibility Periods. The STATE will notify the MCO when a Recipient has an ineligibility period. As long as the Recipient remains enrolled in MSHO or MSC+, the MCO shall be required to reassume financial responsibility for all services covered under MSHO or MSC+ after the ineligibility period has passed. During the ineligibility period payment for Nursing Facility and Elderly Waiver services will be the responsibility of the Enrollee.

4.29 Other Remedies. Nothing in this Article is intended to limit the MCO from seeking other remedies to which it may be entitled by law.

Article. 5 Term, Termination and Partial Breach.

5.1 Term. The term of this Contract shall be Contract Year from **January 1, 2011** (Effective Date), and shall remain in effect through **December 31, 2011**, (Termination Date). Coverage will begin at 12:00 a.m. on January 1st and end at 11:59:59 p.m. on December 31st (Central Standard Time) unless this Contract is: (1) terminated earlier pursuant to section 5.2; (2) extended through: (a) an amendment pursuant to Article 21, or (b) automatic renewal pursuant to section 5.1.1; or (3) replaced by a Renewal Contract pursuant to section 5.1.2.

5.1.1 Automatic Renewal. This Contract will renew for an additional one year term unless the MCO or the STATE provides notice of termination or non-renewal in accordance with section 5.2. If the Contract automatically renews for an additional one year term under the current terms pursuant to this section and without a renewal Contract being entered into between the parties, the STATE shall pay the MCO the rates under this Contract in effect at the time of the automatic renewal, minus any legislated rate reductions. In addition, the Termination Date and Contract Year will advance by one calendar year, unless the MCO has provided the STATE with notice of non-renewal under section 5.2.

5.1.2 Renewal Contract. The Commissioner of Human Services shall have the option to either provide the MCO with a notice of non-renewal, or to offer to enter into negotiations for a renewal of this Contract on an annual basis (Renewal Contract), upon a one hundred and twenty (120) day written notice to the MCO. The MCO has the right to decline the option to renew this Contract. If the MCO declines this offer, this Contract will automatically renew in accordance with section 5.1.1 unless the MCO or the STATE provides notice of termination or non-renewal. If the Parties negotiate and execute a Renewal Contract with the intent that it takes effect upon the termination of this Contract on its original or modified Termination Date, this Contract will so terminate and the Renewal Contract will replace it upon the Renewal Contract's effective date.

5.1.3 Notice of County-Based Purchasing. For MSC+, after the STATE approves any new counties for County Based Purchasing, the STATE shall provide the MCO with no less than one hundred and eighty (180) days written notice of intent to remove any counties from the MCO's Service Area.

5.1.4 Notice of Other MCO Termination or Service Area Reduction In the event that any other MCO under contract with the STATE for the provision of services to Enrollees similar to those covered by this Contract either (a) terminates its contract with the STATE, or (b) reduces its Service Area in a way that impacts the MCO's Service Area, the STATE shall provide the MCO with written notice within five working days of receipt by the STATE of termination notice or notice of reduction of the Service Area (as described above) from any other such MCO. This paragraph does not apply to procurement decisions.

5.2 Contract Non-Renewal and Termination Provisions.

5.2.1 MCO Notice of Non-Renewal Prior to the End of the Contract. The MCO shall provide the STATE with at least one hundred and fifty (150) days written notice prior to the end of the contract term if the MCO chooses not to renew or extend this Contract at the end of the

contract term. If the MCO provides the STATE with such notice, the Contract will end on the Termination Date.

5.2.2 Termination Without Cause. This Contract may be terminated by the STATE, Department of Administration, or CMS at any time, without cause, upon a one hundred twenty (120) calendar day written notice to the MCO, unless CMS terminates its agreement with the SNP in which case notice to the MCO shall be ninety (90) calendar days.

5.2.3 Termination for Cause.

(A) By the MCO. This Contract may be terminated by the MCO, in the event of the STATE's material breach of this Contract, upon a one hundred and fifty (150) calendar day advance written notice to the STATE. In the event of such termination, the MCO shall be entitled to payment, determined on a pro rata basis, for work or services satisfactorily performed through the effective date of cancellation or termination.

(B) By the STATE.

(1) 150-Day Notice. The STATE may terminate this Contract for any material breach by the MCO after one hundred and fifty (150) days from the date the STATE provides the MCO notice of termination. The MCO may request, and must receive if requested, a hearing before the mediation panel described in section 5.5, prior to termination.

(2) 30-Day Notice. In the event of a material breach as stated below, termination may occur after thirty (30) days from the date the STATE provides notice. Material breach, for purposes of this paragraph, that may be subject to a thirty (30) day termination notice includes:

(a) Fraudulent action by the MCO;

(b) Criminal action by MCO;

(c) For MCOs certified as a health maintenance organization, a determination by the Minnesota Department of Health that results in the suspension or revocation of the assigned certificate of authority, for failure to comply with Minnesota Statutes, §§ 62D.01 to 62D.30;

(d) For County Based Purchasing MCOs, a determination by the Minnesota Department of Health that the MCO no longer satisfies the requirements for assurance of consumer protection, provider protection, and fiscal solvency of chapter 62D, applicable to health maintenance organizations, as stated in Minnesota Statutes, § 256B.692, subd. 2(b), or otherwise results in a determination that the CBP is no longer authorized to operate; or

(e) Loss of Medicare contractual agreement with CMS.

(C) Legislative Appropriation. Continuation of this Contract is contingent upon continued legislative appropriation of funds for the purpose of this Contract. If these funds are not appropriated, the STATE will immediately notify the MCO in writing and the Contract will terminate on June 30th of the Contract Year.

5.2.4 Contract Termination Procedures. If the contract is terminated:

(A) Both parties shall cooperate in notifying all MCO Enrollees covered under this Contract in writing of the date of termination and the process by which those Enrollees will continue to receive medical care, at least sixty (60) days in advance of the termination, or immediately as determined by the STATE, if termination is for a material breach listed in 5.3.2(B)(2). Such notice must be approved by the STATE and CMS. Such notice must include a description of alternatives available for obtaining Medicare services after contract termination.

(B) The MCO shall assist in the transfer of medical records of Enrollees from Participating Providers to other Providers, upon request and at no cost to the Enrollee.

(C) Any funds advanced to the MCO for coverage of Enrollees for periods after the termination of coverage for those Enrollees shall be promptly returned to the STATE.

(D) The MCO will promptly supply all information necessary for the reimbursement of any medical claims that result from services delivered after the date of termination.

(E) Written notice by the parties shall be sent by U.S. Postal Service certified mail, return receipt requested. The required notice periods set forth in section 5.2 of this Contract shall be calendar days measured from the date the receipt is signed.

(F) Termination under section 5.2 of this Contract shall be effective on the last day of the calendar month in which the notice becomes effective. Payment shall continue and services shall continue to be provided during that calendar month.

5.3 Deficiencies.

5.3.1 Quality of Services. If the STATE or CMS finds that the quality of care or services offered by the MCO is materially deficient, the STATE has the right to terminate this Contract pursuant to section 5.2.3(B)(1), or to enforce remedies pursuant to section 5.4.

5.3.2 Failure to Provide Services. The MCO shall be subject to one of the remedies listed in section 5.4.1 if the MCO fails substantially to provide Medically Necessary items and services that are required to be provided to an Enrollee covered under this Contract, and if the failure has adversely affected or has a substantial likelihood of adversely affecting the Enrollee.

5.4 Partial Breach. The STATE and the MCO agree that if the MCO does not perform any of the duties in this Contract, the STATE may, in lieu of terminating this Contract, enforce one of the remedies listed in section 5.4.1, at the STATE's option. Enforcing one of the remedies shall not be construed to bar other legal or equitable remedies that may be available to the

STATE, including, but not limited to criminal prosecution. Concurrent breaches of the same administrative functions may be construed as more than a single breach.

5.4.1 Determination of Remedy. In determining the remedy, the STATE shall consider the following factors:

(A) The number of Enrollees or Recipients affected by the breach;

(B) The effect of the breach on Enrollees' or Recipients' health and access to health services;

(C) If only one Enrollee or Recipient is affected, the effect of the breach on that Enrollee's or Recipient's health;

(D) Whether the breach is an isolated incident or part of a pattern of breaches; and

(E) The economic benefits derived by the MCO by virtue of the breach.

5.4.2 Opportunity to Cure. The STATE shall give the MCO reasonable written notice of a breach by the MCO prior to imposing a remedy under this section. The MCO shall have a period of time not to exceed sixty (60) calendar days from the date it receives the notice of breach, unless a longer period to cure the breach is mutually agreed upon, to cure the breach if the breach can be cured. In urgent situations, as determined by the STATE, the STATE may establish a shorter time period to cure the breach.

5.4.3 Remedies for Partial Breach. If the STATE determines that the MCO failed to cure the breach within the time period specified in section 5.4.2, the STATE may enforce one or more of the following remedies, which shall be consistent with the factors specified in section 5.4.1:

(A) Withhold Medical Assistance capitation or a portion thereof until such time as the partial breach is corrected to the satisfaction of the STATE.

(B) Monetary payments from the MCO to the STATE in the amount of up to one thousand dollars ($1,000) per day, offset against payments due the MCO by the STATE, until such time as the problem is corrected to the satisfaction of the STATE.

(C) Monetary payments from the MCO to the STATE in the amount of up to one thousand dollars ($1,000) per day, offset against capitation payments, from the time the notification by the MCO should have occurred or the time the correction should have been made until the time when notification by the MCO is actually made or the correction is made. This paragraph allows the STATE to enforce a remedy against the MCO for actions that have been corrected prior to coming to the attention of the STATE.

(D) Not offer the MCO as an enrollment choice for Recipients in the affected county until thirty (30) days after the Local Agency receives the required Marketing and enrollment materials.

(E) If the MCO does not comply with the Marketing requirements specified in section 3.2 of this Contract, the STATE may require the MCO to cease all MSHO Marketing activities until such time as the MCO has complied with section 3.2 as defined by the STATE.

(F) Provide to the STATE and CMS, or designated CMS evaluator, data abstracted from medical records comparable to the data that would have been available from encounter reporting required in this Contract, if encounter data are not submitted pursuant to section 3.4.1.

(G) Payments provided for under the contract will be denied for new Enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements in 42 CFR §438.730.

5.4.4 Temporary Management. In addition to the remedies listed in section 5.4.3, the STATE shall impose temporary management of the MCO pursuant to 42 CFR §438.706(b) if the STATE finds that the MCO has repeatedly failed to meet the substantive requirements of §1903(m) or §1932 of the Social Security Act. When imposing this sanction the STATE shall:

(A) Allow Enrollees the right to terminate enrollment without cause and notify the affected Enrollees of their right to disenroll;

(B) Not delay the imposition of temporary management to provide a hearing; and

(C) Maintain temporary management of the MCO until the STATE determines that the MCO can ensure that the sanctioned behavior will not recur.

5.4.5 Notice. If the STATE enforces a remedy under this section, the STATE shall provide the MCO written notice of the remedy to be imposed.

5.5 Mediation Panel. The MCO may request the recommendation of a three-person mediation panel within three business days of receiving notice of a remedy, a one hundred and fifty (150) day notice of termination, or notice of non-renewal from the STATE. The mediation panel shall meet, accept both written and oral argument as requested, and make its recommendation within fifteen (15) days of receiving the request for recommendation unless the parties mutually agree to a longer time period. The Commissioner shall resolve all disputes after taking into account the recommendations of the mediation panel and within three days after receiving the recommendation of the mediation panel.

5.5.1 Non-CBPs: For non-CBP MCOs, the panel shall be composed of one designee of the Minnesota Council of Health Plans, one designee of the Commissioner of Human Services, and one designee of the Commissioner of Health.

5.5.2 CBPs: For CBP MCOs, the three-person mediation panel shall be composed of one designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one person selected jointly by the designee of the commissioner of human services and the designee of the Association of Minnesota Counties. The State shall not require that contractual disputes between county-based purchasing entities and the

State be mediated by a panel that includes a representative of the Minnesota Council of Health Plans. Minnesota Statutes, § 256B.69, subd. 3a(d) and (f).

Article. 6 Benefit Design and Administration. All terms of Article 6 apply to MSHO and MSC+, unless otherwise stated. Medicare Services provided by the MCO must comply with the requirements of this Article.

6.1 Covered Services. The MCO shall provide, or arrange to have provided to Enrollees comprehensive preventive, diagnostic, therapeutic and rehabilitative and long term care health care services as defined in Minnesota Statutes, § 256B.0625 and corresponding Minnesota Rules, Parts 9505.0170 to 9505.0475, and, for MSHO and MSC+, Elderly Waiver services pursuant to §1915(c) of the Social Security Act, 42 U.S.C. §1396 and Minnesota Statutes, §256B.0915. Except for sections 6.1.29 (Prescription Drugs and Over-the-Counter Drugs.) and 6.1.40 (Transplants.), and or as otherwise specified in the Contract, these services shall be provided to the extent that the above law and rules were in effect on the effective day of this Contract. Services in sections 6.1.29 and 6.1.40 shall be provided to the extent that the above law and rules are in effect.

The MCO shall also provide, or arrange to have provided to MSHO Enrollees Medicare benefits as provided pursuant to 42 U.S.C. §1395, and specialized Medicare Advantage (MA) plans for Special Needs Enrollees, known as Special Needs Plans (SNPs), established by the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, pursuant to the MCO's MA/SNP contract with CMS, and the Memorandum of Understanding between CMS and the STATE.

All covered benefits, except for Home and Community Based Services and services mandated by STATE or federal law, are subject to determination by the MCO of Medical Necessity, as defined in section 2.80. For purposes of this paragraph, mandated services do not include the benefits described in Minnesota Statutes, Chapter 256B.

Consistent with 42 CFR 438.206(b)(4) if the MCO's Provider network is unable to provide necessary medical services covered under the contract to a particular Enrollee, the MCO must adequately and timely cover these services out of network for the Enrollee.

The MCO shall provide services that shall include but are not limited to the following:

6.1.1 Advanced Practice Nurse Services. Certified Advanced Practice Nurse Services are services provided by nurse practitioners, nurse anesthetists, nurse midwives and clinical nurse specialists.

6.1.2 Cancer Clinical Trials. Routine care that is provided through the administration or performance of items or services that are 1) required as part of the protocol treatment in a high-quality cancer Clinical Trial, 2) usual, customary and appropriate to the Enrollee's condition and 3) would be typically provided to that Enrollee when cared for outside of a Clinical Trial, including those items or services needed for the prevention, diagnosis or treatment of adverse effects and complications of the protocol treatment.

6.1.3 Care Coordination Services for MSHO. The MCO must provide Care Coordination/Case Management services that are designed to ensure access and integrate the delivery of all Medicare and Medicaid preventive, primary, acute, post acute, rehabilitation, and long term care services, including State Plan Home Care Services under section 6.1.14, and Elderly Waiver services to MSHO Enrollees. The MCO shall also coordinate the services it furnishes to its Enrollees with the services an Enrollee receives from any other MCO. The MCO shall develop and maintain written descriptions as provided in section 3.4.2(C), and policies and procedures for operation of the Care Coordination/Case Management system in accordance with this section that shall be made available as part of an EQRO review, and for CMS EW waiver reviews.

(A) MSHO Care Coordination Components. The Care Coordination system must be designed to ensure communication and coordination of an Enrollee's care across the Medicare and Medicaid network Provider types and settings, to ensure smooth transitions for Enrollees who move among various settings in which care may be provided over time, and to strive to facilitate and maximize the level of Enrollee self-determination and Enrollee choice of services, Providers and living arrangements. The Care Coordination system should provide each Enrollee with a primary contact person who will assist the Enrollee in simplifying access to services and information. The system must be designed to promote and assure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, culturally appropriate care and fiscal and professional accountability. The system may differ for Institutional, Community NHC and community members but at a minimum, the Care Coordination system must incorporate the following elements for all MSHO Enrollees:

(1) Comprehensive Assessment. Within thirty (30) calendar days of enrollment, and annually thereafter, the MCO shall make a best effort to conduct a health risk assessment of each Enrollee's health needs. All assessments shall be kept in the individual Enrollee health record at the MCO, care system or county care coordination system. The assessment should address medical, social and environmental and mental health factors, including the physical, psychosocial, and functional needs of the Enrollee. MCOs must integrate required Medicare assessments, LTCC assessments under section 6.1.11(B) and any additional comprehensive assessments being conducted for enrollees to the extent possible. LTCC assessments and reassessments to determine access to home and community based services and/or home care services performed as part of this assessment process must meet requirements outlined in 6.1.11(B).

(a) In the event of a large transfer of enrollees into the MCO with the same initial enrollment date and if the MCO determines that meeting the timelines indicated in this section cannot be met, the MCO may submit a transition plan to DHS, for review and approval, indicating the timeline in which they expect to be able to conduct this initial assessment required for new enrollees.

(b) For Nursing Facility Enrollees, the STATE recommends that the assessment be conducted by a geriatric nurse practitioner as a part of a health history and exam.

(c) For community Enrollees, Activities of Daily Living (ADLs) should be included in the assessment. The MCO shall enter the ADL information collected during the assessment into MMIS according to section 3.1.3(A).

(d) For community non-EW Enrollees, if the comprehensive assessment results in a referral for the LTCC, then the LTCC assessment must be completed within fifteen (15) calendar days of the referral date in accordance with section 6.1.11(B)(6).

(2) Comprehensive Care Plan Development. A comprehensive Care Plan shall be developed within 30 days from the completion of the health risk assessment based on available information including but not limited to issues or needs identified by risk and comprehensive assessments, medical records and/or previous utilization to the extent records are available, and Enrollee and/or family input. In addition for Nursing Facility Enrollees, information located at the Nursing Facility should be considered. The Care Plan should incorporate an interdisciplinary/holistic and preventive focus and include advance directive planning and Enrollee participation. For Elderly Waiver Enrollees, the comprehensive Care Plan shall also meet the specifications for the Care Plan pursuant to section 6.1.11(C)

(a) Interdisciplinary/Holistic Focus. The Care Plan shall employ an interdisciplinary and holistic approach by incorporating the unique primary care, acute care, long term care, mental health and social service needs of each Enrollee with appropriate coordination and communication across all Providers. For Nursing Facility Enrollees this includes review of the Nursing Facility chart, gathering input from Nursing Facility staff, participating in facility meetings and family conferences and communication and coordination with other Providers. For community and Community NHC Enrollees this includes appropriate written or verbal communication with physician or other Providers, attending appointments with Enrollees as needed and involving family members as appropriate in the care planning process and visits.

(b) Preventive Focus. For Nursing Facility Enrollees a preventive focus may include but is not limited to a medical history review for immunization status and health risks, prevention of wounds and wound care management when necessary and appropriate interventions and preventive activities to maintain or improve functioning. For community and Community NHC Enrollees a preventive focus may include but is not limited to written and verbal reminders about immunizations, tobacco and alcohol use, fall risk, medications and nutrition. Identification of selected diseases and adoption of protocols and best practices for prevention of deterioration and maintaining functioning are encouraged. The Care Plan must include identification of any risks to health and safety and plans

for addressing these risks, including Informed Choices made by Enrollees to manage their own risk, and back-up plans for emergency situations.

(c) Advance Directive Planning. For all Enrollees, advance directive planning shall be an ongoing process based on individual Enrollee needs and cultural considerations. Discussion shall be initiated with the Enrollee and/or authorized family member or guardian if appropriate, when the lack of a documented Advance Directive is identified through the assessment process. For Nursing Facility Enrollees, advance directives may be addressed at Nursing Facility care conferences. For community and Community NHC members, a best effort must be made to document advance directive information in the Enrollee record and communication must be made with the physician.

(d) MSHO Enrollee Participation. The MCO shall ensure that the care coordinator works in partnership with the Enrollee and/or authorized family members, responsible parties or guardians and the Primary Care physician, and in consultation with any specialists caring for the Enrollee. The care coordinator shall cooperate with the Enrollee in developing, coordinating and, in some instances, providing supports and services identified in the Enrollee's Care Plan and obtaining consent to the medical treatment or service. Care Coordination is provided at a level of involvement based on the needs and choices made by the Enrollee and/or authorized family members or guardian, and as appropriate to implement and monitor the Care Plan.

(3) Care Plan Implementation. For each Enrollee, a Care Plan is implemented based on the needs assessment, the establishment of goals and objectives, the monitoring of outcomes through regular follow up, and a process to ensure that Care Plans are revised as necessary. These plans must be designed to accommodate the specific cultural and linguistic needs of MSHO Enrollees. For Nursing Facility residents, Care Coordination communication with facility staff and Primary Care as part of an interdisciplinary team must be established to address risk areas and manage services as needed. For Community NHC members and community members, services shall be coordinated with Providers based on the results of the assessment and with input from the Enrollee, family members as appropriate, Primary Care and the Care System team. Primary Care for Enrollees who have not had access to these services in the past must be arranged.

(4) Care Plan Evaluation. For Nursing Facility Enrollees, routine Care Plan evaluations shall be conducted to support a proactive, preventive approach. More extensive evaluations may be required based on clinical needs or changes in condition. For Community NHC Enrollees, a comprehensive reassessment shall be conducted annually or upon change of condition. For community members, risk assessments shall be conducted annually or upon change in condition followed by a comprehensive assessment as needed based on identified risk. A schedule for regular contact with the Enrollees by the care coordinator shall be established in order to identify and monitor changes in condition.

(5) Care Coordinator Caseload Ratios. The MCO shall establish policies and criteria for Care Coordination case load ratios for care coordinators serving all MSHO Enrollees. The MCO will submit these policies and procedures to the STATE for review. Criteria used to develop ratios will include but not be limited to: 1) non-English speaking or need for translation; 2) case mix; 3) Rate Cell designation; 4) need for high intensity acute Care Coordination; 5) mental health status; 6) travel time; and 7) lack of family or informal supports. The MCO will follow their established and submitted policy in assigning case loads to case coordinators or include them in their Care System contracts for the following year. Audits of these criteria will become a part of the Care System audit required in section 9.3.9.

(6) Evaluation of Care Coordinator Performance. The MCO shall have a process to evaluate the performance of individual care coordinators including Enrollee input. As a part of this process, the MCO must also have a process on how Enrollees can request and be offered a different care coordinator. These processes should be described in the Care Coordination System description required in section 3.4.2(C). If the process includes the use of subcontractors, the process should be reviewed as a part of the review in section 9.3.9.

(B) Care Coordinator Responsibilities for MSHO. The MCO shall designate a care coordinator and/or nurse practitioner who shall have lead responsibility for creating and implementing the Care Plan unless otherwise designated by the MCO or Care System. The care coordinator or nurse practitioner shall perform the activities as specified below:

(1) Arrange for the initial assessment, and periodic reassessment as necessary, of supports and services based on the Enrollee's strengths, needs, choices and preferences in life domain areas;

(2) Facilitate annual physician visits for primary and preventive care.

(3) Develop and update the Enrollee's Care Plan based on relevant ongoing assessment;

(4) Arrange and coordinate the provision of supports and services identified in the Enrollee's Care Plan, including knowledgeable and skilled specialty services and prevention and early intervention services;

(5) Assist the Enrollee and their legal representatives, if any, to maximize Informed Choices of services and control over services and supports;

(6) Monitor the progress toward achieving the Enrollee's outcomes in order to evaluate and adjust the timeliness and adequacy of services;

(7) Coordinate with Local Agency case managers, financial workers and other staff, as necessary, including use of the DHS form "Case Managers/Financial Worker Communication," Form # 5181 as provided by the STATE.

(8) The MCO will communicate with lead agencies on the authorization of medical assistance home care services using the DHS form "Managed Care Organization/Lead Agency Communication Form - Recommendation for Authorization of MA Home Care Services," Form # 5841 as provided by the STATE.

(9) Communications include the transfer of an Enrollee from one MCO to another MCO or Local Agency in the event an Enrollee is disenrolled from the MCO, using the Universal Transfer Form (UTF) as provided by the STATE;

(10) Solicit and analyze relevant information;

(11) Communicate effectively with the Enrollee and with other individuals participating in the Enrollee's Care Plan;

(12) Educate and communicate to the Enrollee about good health care practices and behaviors which prevent putting the Enrollee's health at risk;

(13) Be informed of basic Enrollee protection requirements, including data privacy; and

(14) Inform, educate, and assist the Enrollee in identifying available services Providers and accessing needed resources and services beyond the limitations of the Medical Assistance and Medicare Benefit sets.

(C) Other Care Coordination/Case Management Requirements for MSHO. The MCO shall provide the following:

(1) Rehabilitative Services. Services include procedures for promoting rehabilitation of Enrollees following acute events, and for ensuring smooth transitions and coordination of information between acute, subacute, rehabilitation, Nursing Facilities and Home and Community Based Services settings.

(2) Range of Choices. Procedures for ensuring access to an adequate range of Elderly Waiver and Nursing Facility Services and for providing appropriate choices among Nursing Facilities and/or Elderly Waiver services to meet the individual needs of Enrollees who are found to require a Nursing Facility Level of Care. These procedures must include methods for supporting and coordinating services with informal support systems provided by families, friends and other community resources. These procedures must also include strategies for identifying Institutionalized Enrollees whose needs could be met as well or better in non-Institutional settings and methods for meeting those needs, and assisting the Institutionalized Enrollee in leaving the Nursing Facility. For purposes of this section, the word "assisting" includes, but is not limited to, discharge planning and care management responsibilities described in section 6.1.3(A)(2).

(3) Coordination with Social Service Needs. A method for coordinating the medical needs of an Enrollee with his/her social service needs including coordination with

social service staff and other community resources such as Area Agencies on Aging. Coordination with Local Agency social service staff is required when an Enrollee is in need of the following services:

(a) Pre-petition Screening;

(b) OBRA Level II Screening;

(c) Spousal Impoverishment Assessments;

(d) Adult Foster Care;

(e) Group Residential Housing Room and Board Payments;

(f) Chemical Dependency room and board Services covered by the Consolidated Chemical Dependency Treatment Fund; or

(g) Adult Protection.

(h) The MCO shall coordinate with Local Human Service Agencies for assessment and evaluation related to judicial proceedings.

(4) Notification of Care Coordinator/Case Manager.

(a) The MCO or its subcontractor must provide the name and telephone number of the care coordinator/Case Manager assigned to the Enrollee within ten (10) days of the initial assessment, new assignment or change in case manager.

(b) For new Enrollees, if the name of the care coordinator/case manager is not included in the new member materials, the MCO must include in those materials a phone number that an Enrollee can call for care coordination assistance prior to the assignment and notification of the care coordinator/Case Manager required in (a).

(c) The MCO will have a process in place which assists providers, county staff, family members or others who are calling the MCO requesting the identification of a member's current care coordinator and contact information. This process must be efficient and not require callers to make multiple phone calls to find the requested information.

(5) Coordination with Veterans Administration. The MCO shall make reasonable efforts to coordinate with services and supports provided by the Veterans Administration for Enrollees eligible for VA services.

(6) Referrals to Specialists. Procedures and criteria for making referrals to specialists and sub-specialists including those with geriatric expertise when appropriate.

(7) Identification of Special Needs. Capacity to implement and coordinate with when indicated, other Care Management and risk assessment functions conducted by appropriate professionals, including Long Term Care Consultation and other screenings to identify special needs such as common geriatric medical conditions, functional problems, difficulty living independently, polypharmacy problems, health and long term care risks due to lack of social supports; mental and/or chemical dependency problems; developmental disability; high risk health conditions; and language or comprehension barriers. The MCO shall share with other MCOs serving the Enrollee with special health care needs the results of its identification and assessment of that Enrollee's needs to prevent duplication of those activities.

(8) Reporting Requirements. The MCO shall meet the reporting requirements specified in section 3.4.

6.1.4 Case Management for MSC+. The MCO shall have in place processes and procedures for coordinating services provided by the MCO/MSC+ with Medicare services provided through Medicare Part D and through Medicare fee-for-service. The MCO shall also coordinate the services it furnishes to its Enrollees with the services an Enrollee receives from any other MCO. The MCO shall develop and maintain written descriptions as provided in section 3.4.2(C) including policies and procedures for the operation of the Case Management system in accordance with this section that shall be made available as part of an EQRO review, and for CMS EW waiver reviews.

(A) Case Management for Community Non-Elderly Waiver MSC+ Enrollees: The Case Management system must incorporate the following elements for all Community non-EW MSC+ Enrollees:

(1) Risk Screening and Assessment. Within sixty (60) calendar days of enrollment for new Enrollees and annually for all Enrollees, the MCO shall conduct an initial risk screening or assessment of each Enrollee's health needs. The screening may be conducted by phone, mail or face-to-face. The screening should address medical, social, environmental, and mental health factors. A risk assessment tool may be used with follow-up assessments conducted based on level of risk. LTCC assessments and reassessments to determine access to home and community based services and/or home care services performed as part of this assessment process must meet requirements outlined in 6.1.11(B).

(a) In the event of a large transfer of enrollees into the MCO with the same initial enrollment date and if the MCO determines that meeting the timelines indicated in this section cannot be met, the MCO may submit a transition plan to DHS for review and approval indicating the timeline in which they expect to be able to conduct this initial risk assessment required for new enrollees.

(b) All screening and assessments shall be kept in the individual Enrollee health record at the MCO or its designee. Activities of Daily Living (ADLs) should be included in the assessment. The MCO shall enter the ADL information collected during the assessment into MMIS according to section 3.1.3(A).

(c) If the comprehensive assessment results in a referral for the LTCC, then the LTCC assessment must be completed within fifteen (15) calendar days of the referral date and must meet all applicable requirements outlined in section 6.1.11(B).

(2) The MCO Case Management system will encourage that each Enrollee has an established relationship with a Primary Care Physician or clinic. The MCO Case Management system will develop and employ protocols to facilitate annual physician visits for primary and preventive care.

(3) The MCO Case Management system will establish a communication system of significant health events between Primary Care and the MCO or its designees, such as case managers who coordinate other plan services that may include home care services. Significant health events include, but are not limited to, Emergency Room use, hospital or Nursing Facility admissions.

(B) Case Management System for Community Elderly Waiver MSC+ Enrollees. The MCO must provide Case Management services that are designed to ensure access to, and coordinate the delivery of preventive, primary, acute, post acute and rehabilitation services. The Case Management system must incorporate the following elements for all Community EW MSC+ Enrollees:

(1) Risk Screening and Assessment. Within thirty (30) calendar days of enrollment for new Enrollees and annually for all Enrollees, the MCO shall conduct an initial risk screening or assessment of each Enrollee's health needs. The screening may be conducted by phone, mail or face-to-face. The screening should address medical, social, environmental, and mental health factors. A risk assessment tool may be used with follow-up assessments conducted based on level of risk. All screening and assessments shall be kept in the individual Enrollee health record at the MCO or its designee. ADLs should be included in the assessment. The MCO shall enter the ADL information collected during the assessment into MMIS according to section 3.1.3(A). LTCC assessments and reassessments to determine access to home and community based services and/or home care services performed as part of this assessment process must meet requirements outlined in 6.1.11 (B).

(a) In the event of a large transfer of Enrollees into the MCO with the same initial enrollment date and the MCO determines that meeting the timelines indicated in this section cannot be met, the MCO may submit a transition plan to DHS for review and approval indicating the timeline in which they expect to be able to conduct this initial risk assessment required for new Enrollees.

(2) MCOs will provide case management as required by the STATE's Home and Community-Based Waiver.

(3) Each Community Elderly Waiver Enrollee will be assigned a case manager to assist with coordination of Elderly Waiver services, State Plan Home Care Services and other informal or formal services.

(4) For MSC+ Elderly Waiver Enrollees, a Care Plan shall be developed in accordance with the specifications for the Elderly Waiver Care Plan pursuant to section 6.1.11(C) based on a face-to-face needs assessment according to the specifications provided in section 6.1.11(B). The Care Plan should incorporate an interdisciplinary, holistic and preventive focus and include advance directive planning and Enrollee/family participation.

(5) Care plans must be maintained and updated as required under 6.1.11, and must be maintained in a clearly identifiable manner by the MCO or their designee for a minimum of three (3) years.

(6) The MCO will establish a written triage protocol and will follow that protocol in assuring a regular schedule of case management contacts with each Community Elderly Waiver Enrollee based on health, and long term care needs.

(7) Annual face-to-face reassessments must be conducted according to section 6.1.11(D).

(8) The MCO case management system must provide for communication of the Care Plan to the Primary Care Physician.

(9) The MCO must establish a system of communication of significant health events including, Emergency Room use, hospital and Nursing Facility admissions between Primary Care and Elderly Waiver case managers.

(10) The case management system must include procedures for promoting rehabilitation of Enrollees following acute events and for ensuring smooth transitions and coordination of information and services between acute, subacute, rehabilitation and Nursing Facilities and Home and Community Based Services settings.

(11) Case management must facilitate consumer and family involvement in care planning and must preserve consumer choices as required under section 6.1.11(A).

(12) The case management system must provide care giver supports and facilitation of care giver respite to assist Enrollees to remain at home.

(13) The case management system must continue to facilitate and coordinate with informal supports and address preservation of community relationships.

(14) The case management system must provide that consumer directed options such as PCA Choice and consumer directed consumer supports waiver services are offered and facilitated at the consumer’s choice.

(15) Care Plans must be designed to identify, address and accommodate the specific cultural and linguistic needs of MSC+ Enrollees.

(16) The MCO shall designate a case manager who shall have lead responsibility for creating and implementing the Care Plan unless otherwise designated by the MCO. The Case Manager shall perform the activities as specified below:

(a) Arrange for the initial assessment, and periodic reassessment as necessary, of supports and services based on the Enrollee's strengths, needs, choices and preferences in life domain areas;

(b) Develop and update the Enrollee's Care Plan based on relevant ongoing assessment;

(c) Arrange and coordinate the provision of supports and services identified in the Enrollee's Care Plan, including knowledgeable and skilled specialty services and prevention and early intervention services that include the facilitation of annual physician visits for primary and preventive care;

(d) Assist the Enrollee and their legal representatives, if any, to maximize Informed Choices of services and control over services and supports;

(e) Monitor the progress toward achieving the Enrollee's outcomes in order to evaluate and adjust the timeliness and adequacy of services;

(f) Coordinate with Local Agency case managers, financial workers and other staff, as necessary using use of the DHS form "Case Managers/Financial Worker Communication," form # 5181 as provided by the STATE.

(g) The MCO will communicate with lead agencies on the authorization of medical assistance home care services using the DHS form "Managed Care Organization/Lead Agency Communication Form - Recommendation for Authorization of MA Home Care Services," # 5841 as provided by the STATE.

(h) Communications include the transfer of an Enrollee from one MCO to another MCO or Local Agency in the event an Enrollee is disenrolled from the MCO, using the Universal Transfer Form (UTF) as provided by the STATE;

(i) Solicit and analyze relevant information;

(j) Communicate effectively with the Enrollee and with other individuals participating in the Enrollee's Care Plan;

(k) Educate and communicate to the Enrollee about good health care practices and behaviors which prevent putting the Enrollee's health at risk;

(l) Be informed of basic Enrollee protection requirements, including data privacy; and

(m) Inform, educate, and assist the Enrollee in identifying available services, Providers, and accessing needed resources and services beyond the limitations of the Medical Assistance and Medicare Benefit sets.

(17) Evaluation of Case Manager Performance for MSC+ EW Case Management. The MCO shall have a process to evaluate the performance of individual case managers including Enrollee input. As a part of this process, the MCO must also have a process on how Enrollees can request and be offered a different case manager. These processes should be described in the Case Manager System description required in section3.4.2(C). If the process includes the use of subcontractors, the process should be reviewed as a part of the review in section 9.3.9

(C) Case Management for MSC+ Nursing Facility Residents. The Case Management system must incorporate the following elements for Nursing Facility residents:

(1) The case management system must assist with transition during placement of Enrollees in Nursing Facilities and with discharges back to the community.

(2) For Enrollees placed in the Nursing Facility under MCO payment responsibilities, the case management system must establish a periodic review to determine whether discharge to the community is feasible.

(3) The MCO must provide Relocation Targeted Case Management services for any Nursing Facility resident Enrollee who is planning to return to the community and who requires support services to do so.

(D) Other Case Management Requirements. The MCO shall provide the following:

(1) Case Management Caseload Ratios. The MCO shall establish policies and criteria for case management case load ratios for case managers serving MSC+ Enrollees receiving Elderly Waiver services and will submit this to the STATE for review. Criteria used to develop ratios will include but not be limited to: non-English speaking or need for translation, case mix, Rate Cell designation, care management needs related to chronic condition, mental health status, travel time, and lack of family or informal supports. The MCO will follow this policy in assigning case loads to case managers. MCO case load policies will be shared with the EQRO and the EQRO will review periodically to determine whether the MCO is following their policy.

(2) The MCO shall meet the reporting requirements specified in section 3.4.

(E) Range of Choices. Procedures for ensuring access to an adequate range of Elderly Waiver and Nursing Facility Services and for providing appropriate choices among Nursing Facilities and/or Elderly Waiver services to meet the individual needs of MSC+ Enrollees who are found to require a Nursing Facility Level of Care. These procedures must include methods for supporting and coordinating services with informal support systems provided by families, friends and other community resources. These procedures must also include strategies for identifying Institutionalized Enrollees whose

needs could be met as well or better in non-Institutional settings and methods for meeting those needs, and assisting the Institutionalized Enrollee in leaving the Nursing Facility. For purposes of this section, the word "assisting" includes, but is not limited to, discharge planning and care management responsibilities described in section 6.1.3(A)(2).

(F) Coordination with Social Service Needs. A method for coordinating the medical needs of a MSC+ Enrollee with his/her social service needs including coordination with social service staff and other community resources such as Area Agencies on Aging. Coordination with Local Agency social service staff is required when an Enrollee is in need of the following services:

(1) Pre-petition Screening;

(2) OBRA Level II Screening;

(3) Spousal Impoverishment Assessments;

(4) Adult Foster Care;

(5) Group Residential Housing Room and Board Payments; or

(6) Chemical Dependency room and board Services covered by the Consolidated Chemical Dependency Treatment Fund, and;

(7) Adult protection.

(8) The MCO shall coordinate with Local Human Service Agencies for assessment and evaluation related to judicial proceedings.

(G) Notification of Case Manager.

(1) The MCO or its subcontractor must provide to the Enrollee the name and telephone number of the Case Manager assigned to the Enrollee within ten (10) days of a new assignment or change in case manager.

(2) For new Enrollees, if the name of the Case Manager is not provided upon initial enrollment, the MCO must provide each Enrollee with a phone number of a person who is knowledgeable about the MSHO/MSC+ program, that a member can call for case management assistance prior to the assignment and notification of the Case Manager required in (a).

(3) The MCO will have a process in place which assists providers, county staff, family members or others who are calling the MCO requesting the identification of an Enrollee's current Case Manager and contact information. This process must be efficient and not require the callers to make multiple phone calls to find the requested information.

(H) Coordination with Veterans Administration. The MCO shall make reasonable efforts to coordinate with services and supports provided by the Veterans Administration, for Enrollees eligible for VA services.

(I) Referrals to Specialists. Procedures and criteria for making referrals to specialists and sub-specialists, including those with geriatric expertise when appropriate.

(J) Identification of Special Needs. Capacity to implement and coordinate with when indicated, other Care Management and risk assessment functions conducted by appropriate professionals.

(K) Screening. Long Term Care Consultation in accordance with 6.1.11 (B).and other screenings to identify special needs such as common geriatric medical conditions, functional problems, difficulty living independently, polypharmacy problems, health and long term care risks due to lack of social supports; mental and/or chemical dependency problems; developmental disability; high risk health conditions; and language or comprehension barriers. Upon request, the MCO shall share with other MCOs serving the Enrollee with special health care needs the results of its identification and assessment of that Enrollee's needs to prevent duplication of those activities.

(L) Reporting Requirements. The MCO shall meet the reporting requirements specified in section 3.4.

6.1.5 Care Management Services for All Enrollees. The MCO shall be responsible for the Care Management of all Enrollees. The MCO's Care Management system for Enrollees must be designed to coordinate the provision of Primary Care and all other Covered Services to its Enrollees and must promote and assure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, the provision of culturally appropriate care, and fiscal and professional accountability. At a minimum, the MCO's Care Management system for Enrollees must incorporate the following elements.

(A) Procedures for the provision of an individual needs assessment, diagnostic assessment, the development of an individual treatment plan as necessary based on the needs assessment, the establishment of treatment objectives, the monitoring of outcomes, and a process to ensure that treatment plans are revised as necessary. These procedures must be designed to accommodate the specific cultural and linguistic needs of the MCO's Enrollees.

(B) Protocols to facilitate annual physician visits for primary and preventive care.

(C) A strategy to ensure that all Enrollees and/or authorized family members or guardians are involved in treatment planning and consent to the medical treatment.

(D) A method for coordinating the medical needs of an Enrollee with his/her social service needs. This may involve working with Local Agency social service staff or with the various community resources in the county. Coordination with the Local Agency social service staff will be required when the Enrollee is in need of the following services:

(1) Case Management for Serious and Persistent Mental Illness;

(2) Case Management for pre-petition screening;

(3) Court ordered treatment, developmental disabilities, assessment of medical barriers to employment; or

(4) A State medical review team or social security disability determination.

(5) Services offered through social service staff or county attorney staff, for Enrollees who are the victims or perpetrators in criminal cases.

(6) If the MCO determines that an assessment is required in order for the Enrollee to receive Covered Services related to these conditions, the MCO is responsible for payment of the assessments, unless the requested assessment has been paid for by an MCO within the previous one hundred eighty (180) days.

(E) Procedures and criteria for making referrals to specialists and sub-specialists.

(F) Capacity to implement, when indicated, Care Management functions such as individual needs assessment, including screening for special needs (e.g. mental health and/or chemical dependency problems, developmental disability, high risk health problems, difficulty living independently, functional problems, language or comprehension barriers); individual treatment plan development; establishment of treatment objectives; treatment follow-up; monitoring of outcomes; or revision of treatment plan. The MCO shall coordinate with Local Agency human service agencies for assessment and evaluation related to judicial proceedings.

(G) Procedures for coordinating care for American Indian Enrollees.

6.1.6 Chemical Dependency (CD) Treatment Services. CD treatment services do not include detoxification (unless it is required for medical treatment). The MCO is responsible for all CD treatment services including room and board as determined necessary by the assessment. Notwithstanding section 6.20.2(C), CD services shall be provided in accordance with 42 CFR §8.12, and Minnesota Statutes § 254B.05, subd. 1.

(A) CD treatment services will also include utilization of the Screening and Brief Intervention and Referral to Treatment (SBIRT) tool designed to improve the effectiveness of early detection of at risk or harmful substance abuse and to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. The SBIRT may be offered in a primary care or emergency care setting.

(B) Additionally, the MCO agrees to participate in a workgroup that will focus on the implementation of Screening, Evaluation, and Treatment (SET) for alcohol abuse and dependence, that may be used in combination with SBIRT in primary care clinic settings by providing immediate treatment options and using the NIAAA Clinician's Guide entitled Helping Patients Who Drink Too Much, and associated tools.

6.1.7 Chiropractic Services. Chiropractic services up to the service limits described in Minnesota Statutes 256B.0625, subd. 8, which may be subject to service authorization. The MCO may authorize medically necessary services that exceed the limit.

6.1.8 Clinic Services.

6.1.9 Community Health Worker Services.

6.1.10 Dental Services. Pursuant to Minnesota Statutes, § 256B.0625, subd. 9, dental services include the following.

(A) Services for adults who are not pregnant are limited to the following services:

(1) comprehensive exams, limited to once every five years;

(2) periodic exams, limited to one per year;

(3) limited exams;

(4) bitewing x-rays, limited to one per year;

(5) periapical x-rays;

(6) panoramic x-rays, limited to one every five years except (1) when medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma, or (2) once every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;

(7) prophylaxis, limited to one per year;

(8) application of fluoride varnish, limited to one per year;

(9) posterior fillings, all at the amalgam rate;

(10) anterior fillings;

(11) endodontics, limited to root canals on the anterior and premolars only;

(12) removable prostheses, each dental arch limited to one every six years;

(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;

(14) palliative treatment and sedative fillings for relief of pain; and

(15) full-mouth debridement, limited to one every five years.

(B) In addition to the services specified in (A), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:

(1) periodontics, limited to periodontal scaling and root planing once every two years;

(2) general anesthesia; and

(3) full-mouth survey once every five years.

6.1.11 Elderly Waiver Services for MSHO and MSC+.

(A) Authority and Purpose. Elderly Waiver services, also known as Home and Community-Based Services (HCBS), are authorized under §1915(c) of the Social Security Act and federal waivers under 42 U.S.C. §1396n, and Minnesota Statutes, § 256B.0915 and shall be provided pursuant to the current waiver plan approved by CMS when necessary to prevent or avoid Institutional placement to community Enrollees who have received a Long Term Care Consultation and who but for the provision of such services, would require a Nursing Facility (NF) Level of Care, the cost of which could be reimbursed under the Medicaid State Plan. See section 6.24. STATE's authority to develop Elderly Waiver services includes subd. 9 of Minnesota Statutes, § 256B.0915 authorizing tribal management of Elderly Waiver Services.. Waiver requirements include:

(1) An individual written Care Plan must be developed for each enrollee as specified in this contract. Services included in the Care Plan must be necessary to meet a need identified in the enrollee's assessment and be fore the sole benefit of the enrollee and related to the enrollee's condition.

(2) The waiver shall cover only those goods and services authorized in the Care Plan that collectively represent a feasible alternative to institutional care. Services not included in the Care Plan are not covered by Elderly Waiver.

(B) Long Term Care Consultation (LTCC), Assessment and Support Planning Services.

(1) Lead Agency Role: The MCO is the Lead Agency responsible for conducting required face to face assessments and reassessments and support planning services for its enrollees to determine the need for an institutional level of care under Minnesota Statutes, § 256B.0911, subdivision 4, paragraph (a) and for determination of home and community based waiver service eligibility including level of care determination for individuals who need an institutional level of care as defined under § 144.0724, subdivision 11, or § 256B.092, and for service eligibility including State Plan home care services identified in Minnesota Statutes, § 256B.0625 subdivisions 6, 7, and 19, paragraphs (a) and (c). Determinations must be based on assessment and support plan development with appropriate referrals.

(2) Cost Effective Alternatives: Pursuant to § 256B.0911, subdivision 1 (b), the MCO providing long term care consultation services shall offer a variety of cost effective alternatives to institutional care and shall encourage the use of volunteers from families, religious organizations, social clubs and similar civic and service organizations to provide community based services.

(3) Use of Certified Assessors: By a date determined by the State with a 90 day notice to the MCO, and provided required training has been made available to those the MCO has designated, the MCO shall use certified assessors who have completed training and the certification process as determined by the State. The MCO shall designate persons who will perform Long Term Care Assessments including the assessment for State Plan home care services on behalf of the MCO and therefore must be certified according to State standards. The MCO must assure that is has sufficient numbers of certified assessors to provide assessment and support planning within the timelines and parameters of the service.

(4) Certified Assessors: Certified assessors are persons with a minimum of a bachelor's degree in social work, nursing with a public health nursing certificate, or other closely related field with at least one year of home and community based services experience, or a two year registered nursing degree with at least three years of home and community based services experience, that have received training and certification specific to assessment and consultation services for long term care services in Minnesota. Certified assessors shall demonstrate best practices in assessment and support planning including person-centered planning principles and have a common set of skills to ensure consistency and equitable access to services statewide. Assessors must be part of a multidisciplinary team of professionals that includes public health nurses, social workers and other professionals as defined in this section. Certified assessors must be recertified every three years.

(5) For Enrollees with complex health care needs a public health nurse or registered nurse from a multidisciplinary team must be consulted..

(6) Initial evaluation of Level of Care to determine eligibility for Elderly Waiver services must be performed, using the form designated by the STATE, within fifteen (15) calendar days after a request for such evaluation by the Enrollee or legal representative, or referral by other competent authority, such as a doctor, discharge planning team or social worker.

(a) Such assessment shall be conducted by a professional as listed in section 2.70 using the form designated by the STATE to determine eligibility for Nursing Facility placement and/or Elderly Waiver services according to the Level of Care Criteria, and pursuant to Minnesota Statutes, § 256B.0911.

(b) The MCO shall maintain the assessment form in the Enrollee's medical record for a minimum of three years. When such assessment is completed, the MCO must complete the screening document and enter the screening document into MMIS.

(7) Long Term Care Consultation Audits. As a part of the Care Plan Audits required in section 7.9.3, documents will be audited to ensure that the assessment of the Enrollee clearly indicates that he or she meets Level of Care Criteria, and to ensure consistency between the Enrollee's Level of Care and the services to be provided. As a part of the STATE's review of the Care Plan Audit, if the audit reveals placement of Enrollees in inappropriate Rate Cells, the Rate Cell will be corrected prospectively by the STATE, and any retrospective amounts may be collected by the STATE according to the process in section 4.7.1(F) or 4.7.2(G). All Long Term Care Consultation documents and forms completed under this Contract with a Local Agency will be subject to the same audits or verifications applied by the STATE to Long Term Care Consultations performed outside of the MSHO and MSC+ contract.

(8) When an Enrollee is determined to require a Nursing Facility Level of Care, the Enrollee or his or her legal representative will be:

(a) Informed of feasible alternatives to Nursing Facility care; including a choice of Home and Community-Based Services and consumer directed options and if needs can be met using State Plan services.

(b) Offered a plan of care consistent with the screening assessment which is designed to meet the needs of the Enrollee and protect his or her health and safety;

(c) Informed of the right to Appeal the screening decision as required under Article 8 of this Contract and pursuant to Minnesota Statutes, §256.045.

(d) In addition to the right to Appeal in (c) above, the MCO shall have a process for review of the assessment results in all cases where an Enrollee who previously was determined to meet Nursing Facility Level of Care but upon subsequent assessment is determined to no longer meet the Nursing Facility Level of Care criteria. This review shall determine the appropriateness of the reduction of level of care prior to implementation of the change and issuance of a DTR, and will ensure that the revised Care Plan addresses health and safety needs appropriately.

(C) Care Plan. For each MSC+ or MSHO Enrollee who is assessed and determined to require Elderly Waiver services, the MCO shall develop a Care Plan in accordance with section 6.1.3(A)(2) for MSHO Enrollees and 6.1.4 for MSC+ Enrollees. Care Plans for EW Enrollees shall meet the following requirements:

(1) The Care Plan shall include the Community Support Plan (DHS-2925), or all elements thereof, based on a face-to-face needs assessment The Community Support Plan includes a section titled Community Services and Support, that authorizes EW services and contains at minimum; services to be furnished, the amount, frequency and duration of each service, and the type of Provider furnishing each service, including non-paid caregivers and other informal community supports or community resources.

(2) The Care Plan for EW Enrollees shall be completed and implemented within thirty (30) days of LTCC assessment.

(3) The Care Plan shall involve the Enrollee and/or authorized representative, and requires that an explanation of home and community-based and consumer directed support services be provided to the Enrollee or authorized representative, in order for Enrollee to make Informed Choices as required by the Social Security Act, §1929(f)(2)(A), 42 CFR §441.353 subpart (d), and Minnesota Statutes §256B.0911 subd.3(a)(e).

(4) The Care Plan shall include consultation with the Enrollee's family, primary care-givers and other care disciplines as appropriate.

(5) The Enrollee or authorized representative must sign a summary of the Care Plan that contains at a minimum, the Community Support Plan or all elements thereof.

(6) The MCO shall provide a copy of the summary of the Care Plan to the Enrollee.

(7) The MCO shall provide a copy of the Care Plan to the STATE upon request.

(D) Reassessment. The MCO shall provide a face-to-face re-evaluation of the Enrollee's Elderly Waiver services Level of Care, eligibility for Elderly Waiver services and care needs at least every twelve (12) months after Elderly Waiver services have begun. Reassessment must be conducted in a manner and frequency to ensure that the services furnished are consistent with the nature of the Enrollee's needs. Re-evaluations are conducted using the forms designated by the STATE. The Long Term Care Consultation Form must be maintained in the Enrollee's record along with the Plan of Care. When a reassessment is conducted, the MCO must enter the information into MMIS within thirty (30) days of the reassessment.

(E) OBRA (Omnibus Budget Reconciliation Act) Screening. The Long Term Care Consultation shall include the completion of the questions on the OBRA Level I screening form. If mentally ill (MI) or developmentally disabled (DD, formerly known as MR) diagnoses are indicated and the Enrollee is to be admitted to the NF, the MCO must refer the Enrollee to the Local Agency for further OBRA Level II screening prior to the NF admission.

(F) Tribal Assessments and Care Plans. The MCO will accept the results of EW assessments, reassessments and the resulting care plans developed by tribal assessors for Tribal Community Members as determined by the tribe. Referrals to non-tribal providers for services resulting from the assessments must be made to providers within the MCO's network. This applies to services requested by Tribal Community Members residing on or off the reservation.

(G) Spousal Impoverishment. Any married Enrollee who becomes a Recipient of Elderly Waiver services or is admitted to a certified Nursing Facility must be referred by the MCO to the appropriate Local Agency Medical Assistance Eligibility office for an asset assessment.

(H) Eligibility and Limitations. The MCO shall provide Elderly Waiver services necessary to prevent or avoid Nursing Facility placement to community Enrollees who have received a Long Term Care Consultation and who have been determined to meet Nursing Facility Level of Care Criteria as documented on forms designated by the STATE, and for whom it has been determined that but for the provision of waiver services, would require a Nursing Facility. The MCO must determine whether or not the Enrollee's needs can safely be met through the provision of Elderly Waiver services and develop and implement a Plan of Care based on information in the Long Term Care Consultation assessment in the least restrictive alternative in a community-based setting.

(I) Conversions. Elderly Waiver services shall also be provided to convert Enrollees residing in the Nursing Facility to allow them to return to a community setting pursuant to Minnesota Statutes, § 256B.0915, subd. 3b. The MCO shall provide transitional services to assist the Enrollee in returning to a community setting as described in section 6.1.11(K)(19).

(J) EW Cost. The MCO may refuse to offer Elderly Waiver services to any Enrollee for whom it can reasonably be expected that the cost of Elderly Waiver services furnished to that Enrollee would exceed the cost of Nursing Facility Level of Care. For conversions, the MCO must calculate a monthly conversion limit for the cost of Elderly Waiver services for those Enrollees who are residing in a Nursing Facility for at least thirty (30) days and who wish to return to a community setting pursuant to Minnesota Statutes, § 256B.0915, subd. 3b. Elderly Waiver services will not be furnished to an Enrollee while the Enrollee is an inpatient of a hospital, NF or ICF/DD (formerly known as ICF/MR), except for respite care as provided for in section 6.1.11(M)(2). The MCO may limit the amounts of services provided under Home and Community Based Services (HCBS) to the limits specified in the Minnesota Health Care Programs manual.

(K) Elderly Waiver Covered Services. Elderly Waiver services include the following, as detailed below:

(1) Homemaker services

(2) Respite care services (In Home and Out of Home)

(3) Adult day services (ADS)

(4) Adult companion services

(5) Specialized medical supplies and equipment

(6) Extended State Plan home health care services, including home health aide and skilled nursing services

(7) Extended State Plan Private Duty Nursing

(8) Extended State Plan Personal Care Assistance services

(9) Family and care giver training and education services

(10) Home delivered meals

(11) Residential care services

(12) Customized Living services

(13) 24-Hour Customized Living

(14) Adult Foster Care services (Corporate and Family)

(15) Environmental accessibility adaptations

(16) Chore services

(17) Consumer directed community supports

(18) Transportation

(19) Transitional supports services

(20) Adult day service bath

(L) Choice of EW Providers. MCO EW networks must make a best effort to offer a choice of EW Providers within each of the EW service and support categories required to be provided.

(M) Elderly Waiver Services and Provider Qualifications.

(1) Homemaker Services. Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for his or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the STATE for the provision of these activities. Homemaker services may also include assistance with bathing, toileting, grooming, eating and ambulating; provide companionship, emotional support and social stimulation; and setting up transportation. Agencies that provide homemaker services must meet the requirements of Minnesota Statutes, §§ 144A.43 to 144A.461, and must meet the standards defined in Minnesota Rules, 4668. The license required is Class B, C or F home care license. Individual homemakers who are not employed by an agency, must meet the standards under Minnesota Rules, part 9565.1200 to 1300. Lead agencies make the determination whether to grant a variance from the training requirements of a certified homemaker and whether the provider of homemaker service is able to perform the duties assigned. Individual homemakers must have a certificate of housing with services registration in accordance with Minnesota Statutes, § 144A.461. This service is not covered as a separate service when the

Enrollee resides in a licensed foster care home or supervised living facility, or receives residential care, Customized Living or 24-Hour Customized Living services.

(2) Respite Care. Services provided to Enrollees unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons who normally provide the care and who are not paid for their services, or are only paid for a portion of the total time of care and supervision that they provide.. Services will include relief of an informal caregiver from otherwise unpaid support. Respite care is limited to thirty (30) consecutive days per respite stay in accordance with the plan of care. Enrollees living in settings that are responsible to provide twenty-four (24)-hour supports are not eligible for this service. The person or people who provide the care or supervision and for whom respite is to provide relief shall not be paid to provide the respite service.

(a) Respite care will be provided in the following locations: the Enrollee's home or place of residence, a licensed adult foster care home, a Medicaid certified hospital, a Medicaid certified NF, a building registered as a Housing with Services establishment with services delivered by a licensed Home Care Provider, or a private residence that is identified by the Enrollee or his or her legal representative and approved by the MSHO care coordinator. The unlicensed home and caregiver cannot otherwise be in the business or routine practice of providing respite services. Enrollees who live in settings that are responsible to provide twenty-four (24) hour care, supervision, or supports are not eligible for this service. The MCO may limit an out-of-home respite care stay in a facility that is not a private residence to thirty (30) consecutive days per respite stay in accordance with the plan of care. Out-of-home facility-based respite care will be provided in a hospital, Nursing Facility, foster care, licensed day care. Out-of-home facility-based respite care must be provided in a facility approved by the Local Agency. Facilities must meet all licensing and/or certification requirements

(b) Out-of-home private respite care may be provided in a private unlicensed home when it is determined by the care coordinator that the services and setting can safely meet the Enrollee's needs. The care coordinator must take into account the accessibility and condition of the physical plant, ability and skill level of the caregiver, and the Enrollee's needs and preferences. The unlicensed home and caregiver cannot otherwise be in the business or routine practice of providing respite services. The Lead Agency must evaluate and document whether the Provider meets the standards to provide respite services. In addition, the standards in Minnesota Statutes, Chapter 245C concerning criminal background studies must be applied to determine whether the Provider is disqualified. The Lead Agency makes this determination.

(c) In-home respite care Providers must be registered or licensed practical nurses, home health aides, personal care assistants, or able to demonstrate to the Care Coordinator that they can provide the care on a temporary and short term basis.

(d) Facilities must meet all licensing and/or certification requirements to provide care in Minnesota. In-home respite Providers must meet the licensing or certification standard specific to the Level of Care they are providing and receive supervision as required by their respective license or service standard.

i) Hospitals are an acute care institution defined in Minnesota Statutes, §144.696, subd. 3, licensed under Minnesota Statutes, §§ 144.50 through 144.58.

ii) Adult Foster Care is licensed under Minnesota Rules, Parts 9555.5105 through 9555.6265.

iii) Long Term Care Facilities (Skilled Nursing Facilities and Intermediate Care Facilities for the Developmentally Disabled (ICF/DD, formerly known as ICF/MR) must meet the standards under Minnesota Rules, Part 9505.0175, subpart 23, and must be licensed in accordance with Minnesota Statutes Chapter 144A.

iv) Housing with Services Establishments must meet the standards specified in Minnesota Statutes, Chapter 144D.01, subd. 4, and be licensed as a Class A or Class F facility under Minnesota Rules, parts 4668.002 to 4668.0870.

v) Home Health Aides must meet the standards under Minnesota Rules part 9505.0290, subpart 3B.

(e) Coverage for respite care provided in licensed facilities will include both services and Room and Board as appropriate. Room and Board are not covered for Respite care provided in the Enrollee's family home or in an unlicensed private home .

(f) Pending federal approval, in the event of a community emergency or disaster that requires an emergency need to relocate an Enrollee, out-of-home respite services may be provided whether the primary caregiver is paid or unpaid, provided that the STATE approves the request as a necessary expenditure related to the emergency or disaster. Other limitations on respite services may be waived by the STATE as necessary in order to ensure that necessary expenditures related to protecting the health and safety of Enrollees are reimbursed.

(3) Adult Day Service (ADS). Services furnished two (2) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the Enrollee. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day). Transportation between the Enrollee's place of residence and the adult day service health center, and the costs of this transportation, is not included in the rate paid to the Provider of adult day health services. Adult day service centers must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730. Providers must also meet the requirements and standards established under Minnesota Statutes, §245A.01 through 245A.16. Adult

Day service programs provided in Nursing Facilities, hospitals and board and care settings must be licensed under Minnesota Rules parts 9555.9600 to 9555.9730 with the exception of Nursing Facilities, hospitals and board and care settings that serve five (5) or fewer people who are not residents or patients in the setting, or because they are exempted from the licensing requirement to provide ADC. The provider must also meet the requirements and standards in Minnesota Statutes, Chapter 245A.01 through 245A.16, with the exception of Ch. 245A.143. Individuals licensed to provide Family Adult Day Service (FADS) must be licensed under Minnesota Statutes, 245A.143, and must also meet the standards stated in § § 245A.01 to 245A.16. FADS must be provided in the license holder's primary residence.

(4) Adult Companion Services: These services include non-medical care services, supervision and socialization services which are provided to a functionally impaired adult. Companions may assist or supervise the Enrollee with such tasks as meal preparation, laundry and shopping, but must not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care, but may include verbal instruction or cueing.

(a) Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the client. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature. Any person related to the Enrollee by blood, marriage, or adoption cannot be paid for providing companion services.

(b) Companions must be able to read, write, and follow written and oral instructions. Companions must have had experience and/or training in homemaking skills, and/or in care of individuals with cognitive or physical limitations or other functional impairments. Companions may be required to pass a job related physical examination prior to appointment. They must have good physical and mental health, and maturity of attitude toward work assignments. They must have the ability to converse effectively on the telephone, to work under intermittent supervision, to deal with minor emergencies and crises and to report these to the care coordinator. Companions must understand, respect and maintain confidentiality in regard to details of case circumstances. Organizations that provide Adult Companion services must meet the standards established by the Corporation for National and Community Services.

(5) Specialized Medical Supplies and Equipment: Equipment and supplies include devices, controls or medical appliances, mobility aids, and assistive technology devices including augmentative communication devices and personal emergency response systems, controls or medical appliances as specified in the care plan that enable enrollees to increase their abilities to perform activities of daily living, or to perceive, control, interact or communicate with their environment. This service may cover evaluation of the need for equipment and/or device and, if appropriate, subsequent selection and acquisition. This service also includes equipment rental during a trial period, customization, training and technical assistance to enrollees, maintenance, repair of devices, and rental of equipment during periods of repair.

Medical supplies and equipment are defined in accordance with the STATE Plan, except that the limitations on the amount, duration and scope of these supplies and equipment do not apply. All safeguards and Provider standards continue to apply. The limitation for each Enrollee will be specified in the Care Plan and monitored by the care coordinator. Supplies and equipment includes durable and non-durable medical supplies and equipment that are provided as a necessary adjunct to direct treatment of the Enrollee's condition. Providers include Medicaid and Medicare enrolled home health agencies, pharmacies, and medical suppliers (including wheelchair and oxygen vendors). For State Plan medical equipment and supplies, see Minnesota Rules, part 9505.0310, subpart 1. Provider participation is defined under Minnesota Rules, part 9505.0195.

(a) This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment that are not covered under the state plan. Items covered by the waiver shall be in addition to any medical equipment and supplies covered by the state plan.

(b) Equipment and supplies that exceed the limits set for the State Plan may be covered.

(c) Items that are not of direct medical or remedial benefit to the participant are not covered, including any related assessments, repairs and service.

(d) All prescriptions and over-the counter medications, compounds and solutions, and related fees including premiums and copayments are not covered.

(e) Items that are covered by the State Plan as durable medical equipment are not covered under this section of Specialized Medical Supplies and Equipment. State plan medical equipment and supplies are defined under Minnesota Rules, part 9505.0310. Providers must also meet the definition under Minnesota Rules, part 9505.0195.

(f) For Enrollees who reside in settings that are responsible to provide twenty-four (24) hour supervision, emergency response systems are not covered as a separate item or service, nor may they be used in lieu of staff supervision in accordance with the service description. This does not preclude covering emergency response technology (e.g. pendant call systems) that may be appropriate for enrollees to use outside of the residential setting.

(6) Extended State Plan Home Health Care Services : The scope of home health services are defined in accordance with the Medicaid State Plan and include home health aide and skilled nursing services. The limits, as stated in the State Plan, regarding the number of visits, reimbursable hours, amount of intermittent care or part time care do not apply. All safeguards and Provider standards under the State Plan continue to apply. Limitations on the amount, duration and scope of home health services will be specified in the individual plan of care.

(a) Extended home health services are limited to home health aide and skilled nursing services. The Enrollee must exhaust the available benefit limit for an authorized service each month in order to be eligible for an extension of the authorized service. Providers must be Medicare-certified home care agencies with a class A license, registered nurses or licensed practical nurses. Home health aide providers and home health aides must meet the standards as specified under the Medicaid State Plan and Minnesota Rules, part 9505.0290. Registered nurses and licensed practical nurses must be licensed under Minnesota Statutes, §§ 148.171 through 148.285 and 148.29 to 148.299. Home health aides must meet the standards under Minnesota Rules, Part 9505.0290, subpart 3(B).

(b) Medical supplies and equipment, audiology services, specialized maintenance therapies and therapy services including those provided by therapy assistants are not covered under Extended State Plan Home Health Care.

(c) Extended State Plan Private Duty Nursing (PDN). PDN services are defined in the State Plan. The State Plan includes limits on the amount (number of units) and duration of the service (the period the service may be authorized) do not apply. To be eligible for extended PDN, the Enrollee must receive and exhaust the PDN benefit for each month that the extended service is authorized. Registered Nurses must be licensed under Minnesota statutes, §§ 148.171 to 148.284 Licensed Practical Nurses must be licensed under Minnesota Statutes, §§ 148.29 to 148.299. LPNs must also have a Class A license. LPNs must be supervised by an RN and may only provide care that is delegated by the RN. A PDN Class A licensed agency must be licensed as a Class A home care provider.

(7) Extended State Plan Personal Care Assistance Services: Extended Personal Care Assistance services are defined in accordance with the Medicaid State Plan except that the limitations on the number of hours or visits reimbursed do not apply. To be eligible, the Enrollee must receive and exhaust the PCA benefit for each month that the extended services are authorized (see section 6.1.14(A)(3) below). In addition, care direction for those who cannot direct their own care must be provided by the Enrollee's responsible party. All other safeguards and Provider standards under the State Plan continue to apply. Limitations on the amount, duration and scope of Personal Care Assistance services will be specified in the Enrollee's Care Plan.

(a) Extended PCA services include assistance with activities of daily living including eating, bathing, dressing, personal hygiene, grooming, transferring, mobility, positioning and toileting. This service may also include meal preparation and housekeeping chores that are essential to the health and well-being of the Enrollee, such as making beds, dusting, and vacuuming. The Provider must be a Personal Care Assistant (PCA) employed by a PCPA Supervision of a PCA is provided by a QP as defined in section 2.118. PCPAs must meet the standards under Minnesota Rules, Part 9505.0335. PCAs must meet the standards under Minnesota Statutes, §256B.0655 and Minnesota Rules, Part 9505.0335.

(b) A PCA must be able to show successful completion of one or more of the following:

i) a nursing assistant training program or its equivalent, for which competency is determined by the State Board of Vocational Technical Education; or

ii) a homemaker/home health aide pre-service training using a curriculum recommended by the Minnesota Department of Health; or

iii) an accredited educational program for registered nurses or licensed practical nurses; or

iv) a training program that provides the assistant with skills required to perform personal care assistance services; or

v) a determination by a supervising QP that the assistant has the skills required through training and experience, to perform personal care services. Relatives may provide PCA services if they meet one of the qualifications for a PCA, and are an employee of a PCPA organization.

(8) Family and Caregiver Training and Education: These services include training, education and counseling services for caregivers who provide direct and ongoing services to Enrollees. Caregivers may include a parent, spouse, children, relatives, foster family, in-laws, or other informal caregivers. Training includes instruction about treatment regimens, disease management, caregiver roles, and use of equipment specified in the Care Plan, and shall include updates as necessary to safely maintain the Enrollee at home. Counseling includes coaching, guidance, or instructions directly related to providing care to the person on the waiver. All caregiver training and counseling must be included in the Enrollee's Care Plan pursuant to section 6.1.11(C).

(a) This service is limited to paying for the cost of training and counseling (i.e. paying professionals, course or conference registration fees and materials) Costs related to transportation, travel and lodging are not covered. Individuals who are employed or who volunteer through an organization in order to care for the Enrollee may not access family and caregiver training services.

(b) Providers may be Health Care Professionals, such as public health nurses, registered nurses, licensed practical nurses, physicians, social workers, rehabilitation therapists, gerontologists, pharmacists, vocational and technical colleges offering home health aide and certified nursing assistant training. Training and education of care givers must be provided by Health Care Professionals, such as public health nurses, registered nurses, licensed practical nurses, physicians, social workers, rehabilitation therapists, gerontologists, and pharmacists, who have at least one year of experience in providing Home Care or long term care services to the Elderly, or at least one year of experience providing training or education to caregivers of elderly persons.

(c) Physical cares requiring a specific technique for the safety of both the care giver and care receiver must be taught by a professional specializing in such techniques. These professionals include public health nurses, registered nurses and licensed practical nurses.

(d) Training and education of care givers may also be provided by vocational and technical schools offering courses such as home health aide and certified nursing assistant training, or provided by care or support-related organizations (e.g. Alzheimer's Association) when it is determined by the care coordinator that the content of the training or conference directly applies to the care and well being of the Enrollee. Suppliers must have the ability to train the caregiver on the use of specialized equipment that relates to the needs of the enrollee.

(9) Home Delivered Meals: This service includes an appropriate, nutritionally balanced meal that contains at least one-third of the current daily recommended dietary allowance (RDA), as established by the Food and Nutrition Board of the National Academy of Sciences, National Research Council, served to the Enrollee in the building in which he or she resides.

(a) Whenever the Enrollee is eligible, the cost for home delivered meals will be reimbursed by Title III C of the Older Americans Act. A unit of service equals one meal. The MCO is not required to provide more than one meal per day. Home delivered meals are not covered for enrollees who live in settings licensed for foster care or board and lodge.

(b) The need for a home delivered meal must be approved by the care coordinator as part of the individual Care Plan. Agencies providing home delivered meals will be monitored by the (b) care coordinator. Home delivered meals will be provided to persons who are unable to prepare their own meals and for whom there are no other persons available to do so, or where the provision of a home delivered meal is the most cost-effective method of delivering a nutritionally adequate meal. Modified diets, where appropriate, will be provided to meet the Enrollee's requirements.

(c) Providers may be hospitals, schools, restaurants or any entity providing home delivered meals. Menu plans will be reviewed and approved by a registered dietician. Any agency providing home delivered meals must comply with all state and local health laws and ordinances concerning preparation, handling and serving of food as defined under Minnesota Rules parts 4626.0010 through 4626.1870. Insulated hot and cold containers must be used on delivery routes to assure that food reaches clients at appropriate temperatures.

(10) Residential Care Services. These services are supportive services which include up to twenty-four (24) hours of supervision.

(a) Residential Care Services may include the following:

i) Meal preparation;

ii) Individualized home management tasks,

iii) Socialization,

iv) Money management,

v) Assisting enrollees with arranging meetings and appointments for medical and social services, and

vi) Coordinating or providing transportation.

(b) Residential care services may also include minimal assistance with dressing, grooming and bathing, and reminding enrollees to take medications and assistance with medication storage.

(c) Residential Care Home services include services received in residential care homes currently licensed as a board and lodging establishment, and registered with the Minnesota Department of Health as board and lodging establishments providing specialized services according to Minnesota Statutes, § 157.15 to § 157.17. Service direction must be provided by the enrollee or by the residential care home staff with oversight by the case manager. Homemaker and chore services are not covered as separate services for enrollees receiving residential care services. Residential care services do not include room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Personal Care assistance services provided to enrollees who receive residential care must be furnished by another provider and may not duplicate services covered in the rate paid to the residential care provider. Residential care services are defined as “supportive services” and ”health related services.”

(d) Supportive services means the provision of up to twenty-four (24) hours of supervision and oversight. Supportive services include providing transportation (when provided by the residential care home only), socialization (when socialization is part of the plan of care, has specific goals and outcomes established and is not a diversion or recreational in nature), assisting clients in setting up meetings and appointments, assisting clients in setting up medical and social services, providing assistance with personal laundry (such as carrying the client's laundry to the laundry room). Individuals receiving residential care services cannot receive both personal care services and residential care services. Effective August 10, 2010, PCA services provided to Enrollees who receive residential care must be furnished by another provider and may not duplicate services covered in the rate paid to the residential care provider. Assistance with personal laundry does not include any laundry (such as bed linen) that is included in the room and board rate.

(e) Health related services are limited to minimal assistance with dressing, grooming and bathing and to providing reminders to residents to take medications that are self-administered or providing storage for medications, if requested.

Service direction must be provided by the client or by residential care home staff with oversight by the care coordinator.

(f) Residential care service Providers must meet standards of licensor, certification or registration where they exist either in state law or administrative rule. Current standards for residential care services are in Minnesota Statutes, § 157.15 to § 157.17 and must be exempt from the requirement to register as a Housing with Services establishment as defined in Minnesota Statutes, §144D.01, subd. 4. The residential care home must meet the appropriate local building codes and be licensed by the Minnesota Department of Health (MDH) as a board and lodging establishment. Providers must be registered with MDH as a provider of specialized services.

(g) Residential services must be provided by the management of the residential care home. For staff providing assistance with dressing, grooming, bathing, or providing medication reminders or storage of medication, eight hours of training and orientation of staff by a registered nurse is required. If medications are to be distributed or stored, a registered nurse must provide supervision of this process. In addition, staff providing supervision, oversight and supportive services must be able to read and write and follow written and oral instructions. They must have had experience and/or training in caring for individuals with functional limitations. They must have good physical and mental health, and maturity of attitude towards work assignment. They must have the ability to converse on the telephone, to work under intermittent supervision, to deal with minor emergencies arising in connection with the assignment, and work under stress in a crisis situation. They must understand, respect and maintain confidentiality. They must have a valid State driver's license, if they provide transportation to residents.

(11) Customized Living Services: These services are a service or group of customized services provided by or arranged for by the management of a "Housing with Services Establishment" and provided by a licensed class A or class F Provider. Services may also be provided to an Enrollee in a "Housing with Services Establishment" by a licensed Class F Home Care Agency, or provided to a client by a licensed Class A or Class F Home Care Provider in a residential center which is not registered as a "Housing with Services Establishment," but services are to be arranged by the MCO with a Class A home care agency.

(a) In order for Customized Living services to be covered by the waiver, Enrollees must have an individualized service plan based on their documented needs. This is a separate and distinct plan from the Care Plan developed by the case manager that includes all waiver services. Service plans that include supervision of the Enrollee must have documentation of the Enrollee's specific needs for supervision and the plan to provide supervision including frequency and mode of contact, and the time of day the contact will occur. The Enrollee must be given the opportunity to accept, reject or revise the service plan and the case manager determines whether the plan is approved as part of the Enrollee's overall Care Plan.

(b) Room and board costs are not covered by this service.

(c) Payment for Customized Living services shall be a monthly rate authorized within the parameters established by the STATE. The payment rate must be based on the amount of component services to be provided utilizing component rates established by the STATE. Component service rates must not exceed payment rates for comparable Elderly Waiver or Medical Assistance services and must reflect economies of scale.

(d) Services provided or arranged for by the Customized Living Provider may include

i) Up to twenty-four (24) hours of supervision,

ii) Supportive services (Assisting consumers in setting up meetings and appointments, assisting clients with managing funds, assisting consumers in setting medical and social services, arranging for or providing transportation. Socialization is an allowable component when: It is individualized, it is not primarily diversional or recreational in nature, the plan is designed to support the individual in socially valued roles of their choice, such as volunteering, it is specifically included in customized living plan of care and that plan has established goals and outcomes for socialization),

iii) Individualized home care aide tasks (Preparing modified diets that are prescribed by a physician, which require separate preparation and for which a registered dietician or registered nurse provides oversight. Reminding consumers to take regularly scheduled medications or perform exercises, assisting with dressing, oral hygiene, hair care , grooming and bathing. Oral hygiene means care of teeth, gums, and oral prosthetic devices),

iv) Individualized home health aide-like tasks (Administration of medications per Minnesota Rules, Ch. 4668 (home care license), performing routine delegated medical or nursing or assigned therapy procedures, per Minnesota Rules, Ch. 4668, assisting with body positioning or transfers of consumers who are not ambulatory, feeding of individuals who, because of their condition, are at risk of choking, assisting with bowel and bladder control, devices and training programs, assisting with therapeutic or passive range of motion exercises, providing skin care, including full or partial bathing and foot soaks), and

v) Individualized home management tasks (Snack and/or meal preparation, personal laundry, house keeping/ cleaning, and shopping). Individualized means that services are chosen and designed specifically for each Enrollee's needs.

vi) Central storage of medication, administration of medications, individualized home health aide tasks, home health aid like tasks and incidental nursing services may be provided as allowed by the home care

license. Providers must furnish each Enrollee with a means to effectively summon assistance. Staff in the congregate living setting who are providing supervision, oversight and supportive services must have: experience and or training in caring for individuals with functional limitations; the physical ability to provide the services identified in the enrollees service plans and if they provide transportation, must have a valid Minnesota drivers license and required insurance.

vii) Customized Living Service Providers must be licensed as a Class A or Class F under Minnesota Rules, Chapters 4668 and 4669 and Minnesota Statute 144A.4605. The Providers must be registered with the STATE under Minnesota Statutes §144D (Housing with Services Registration Act) to provide Customized Living Services. Customized Living Service Providers who are not licensed under Minnesota Rules, Parts 9555.5105 through 9555.6265 (AFC) and who provide services in settings with 1 to 5 residents, must comply with Minnesota Rules, Parts 9555.6205, subparts 1 to 3, Parts 9555.6215, subparts 1 and 3, and Parts 9555.6225, subparts 1, 2, 6, and 10. Enrollees cannot receive homemaking services if they are receiving this service.

viii) Supervision is defined as a service which includes an on-going awareness of the residents' needs and activities, which is provided by an employee of the Customized Living Provider who is not a Recipient of services, whose primary job responsibility is to provide supervision to residents of the congregate living setting. Supervision must be provided by a person who is adequately qualified to meet the needs and provide services as outlined in each Enrollee's housing with services contract and their individualized Care Plan. Staff providing supervision must also:

1. Work onsite in the customized living setting;

2. Have their primary work responsibility be the supervision of enrollees in the customized living setting;

3. Have an on going awareness of the enrollees needs and activities; and

4. Be able to respond to an enrollee within a time frame that meets the enrollees needs and that does not exceed 10 minutes;

5. All staff and supervisors must be capable of communicating with residents, capable of recognizing the need for assistance, capable of providing the assistance required or summoning appropriate assistance; and capable of following directions.

(e) The environment must provide the Enrollee with a means to summon assistance, and the employee must be able to respond, in person, to the request for assistance within a reasonable amount of time, not to exceed 10 minutes, depending on the physical plant.

(f) Supportive services may include socialization, assisting Enrollees in setting up medical and social services, assisting clients with funds, and arranging for or providing transportation.

(g) Central storage of medication, individualized home health aide tasks, individualized home aide-like tasks and incidental nursing services may be provided as allowed by home care licensure.

(h) For payment of Customized Living under the Elderly Waiver, the setting must be registered with the Minnesota Department of Health as a "Housing with Services" Establishment. Each setting must be individually registered. Customized Living settings are required to deliver services under a Class A home care license (Medicare certified or non-Medicare certified) or an Customized Living Home Care Provider license (available only to a setting registered as a Housing with Services Establishment), or a Class F home care license. The Class F home care license is available only if the setting is a residential center (three or more separate living units in one building) and the license holder cannot deliver any of the home health aide-like services listed above. Housing with Services Establishments must meet the standards as specified in Minnesota Statutes, Chapter 144D. Class A, Class F, or Customized Living home Provider licenses are issued by the Minnesota Department of Health under Minnesota Rules, Parts 4668.0002 to 4668.0870 and Minnesota Statutes, §144A.46.

(i) Customized Living Services may not include payment for the cost of room and board or rent or direct food costs. These costs must be funded by Enrollee resources such as retirement income or Supplemental Security Income (SSI) or public assistance programs such as Group Residential Housing (GRH) payments or Minnesota Supplemental Aid (MSA) grants. The MCO is not required to provide or cover the cost of room and board or rent. Enrollees receiving Customized Living Services are not eligible for Homemaking Services.

(12) 24-Hour Customized Living Services: A group of services that may include all the services listed in section 6.1.11(M)(11) above, with additional requirements. Room and board costs are not covered by this service. The Provider must furnish twenty-four (24) hour supervision. The Enrollee's assessed needs and care plan must document the need for twenty-four (24) hour supervision and any other services identified in the Customized Living service plan. The setting must:

(a) Be registered as a "Housing with Services Establishment" under Minnesota Statutes, Chapter 144D, or be a Provider under contract with the Housing with Services Establishment or a Class A home care Provider under contract with the lead agency;

(b) Have a Class A or Class F Home Care License;

(c) Provide services in one of the following qualified settings:

i) A setting of one to five (1-5) unrelated persons living together in a residential unit, or

ii) A setting of five (5) or more unrelated persons which is licensed by the Department of Health as a "board and lodge 1," or

iii) A residential center which is a building or complex of contiguous or adjacent buildings of three (3) or more separate and distinct living units (apartments) which clients rent or own; provide each client with means to effectively summon assistance, and employ staff who meet the requirements listed in the Minnesota Department of Human Services Bulletin #10-25-03, incorporated into this Contract by reference as applicable.

iv) In order for twenty-four (24) hour Customized Living services to be covered by the waiver, Enrollees must have an individualized service plan based on documented needs. For all new Enrollee participants enrolled in the program on or after January 1, 2011, and all other Enrollee participants at their first reassessment after January 1, 2011, dependency in at least two of the following activities of daily living is required for 24-Hour Customized Living, as determined by assessment under Minnesota Statutes, § 256B.0911: bathing; dressing; grooming; walking or eating; In addition Enrollee must need medication management, and at least 50 hours of services per month.

v) Service plans must document the need for 24-hour supervision of the Enrollee and must include documentation of the Enrollee's specific needs for supervision and the plan to provide supervision including the frequency, mode of contact, and the time of day it will occur. The Enrollee must be given the opportunity to accept, reject or revise the service plan and the case manager determines whether the plan is approved as part of the Enrollees overall Care Plan. The Enrollee must be provided a means to effectively summon assistance at any time.

vi) For the purposes of this service, 24-hour supervision means that the Enrollee requires assistance due to needs related to one or more of the following:

1. Cognitive behavior issues;

2. Medication management in certain circumstances. Enrollees who require medication management must also need a minimum of fifty (50) hours of direct services per month identified in the service plan and furnished by the Customized Living provider.

3. A medical condition that requires clinical monitoring.

4. Intermittent assistance with toileting, positioning or transferring, and

5. Other conditions or needs as defined by the STATE.

(d) For Enrollees receiving 24-Hour Customized Living services, Homemaker and chore services are not covered as separate waiver services. Personal emergency response systems and home monitoring devices are not covered under specialized supplies and equipment.

(e) The payment rate for 24-Hour Customized Living services must be based on the amount of component services to be provided and utilizing component rates established by the commissioner. Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale. The individually authorized 24-Hour Customized living payments in combination with the payment for other Elderly Waiver services must not exceed the recipients community budget cap.

(13) Adult Foster Care: Adult Foster care is ongoing residential care and supportive services and includes personal care assistant services, homemaker, chore, companion services, and medication oversight (to the extent permitted under state law) provided in a licensed private home by a principal care provider. Adult Foster Care is furnished to enrollees who receive these service in conjunction with residing in the home. The total number of enrollees (including waiver enrollees) living in the home who are diagnosed with serious and persistent mental illness or a developmental disability and who are unrelated to the principal care provider cannot exceed four; otherwise the total number of individuals(including waiver enrollees) living in the home, who are unrelated to the principal care provider cannot exceed five. The Care Plan must indicate what services the foster care provider will provide and these services cannot be duplicated by other Medicaid or Medicare services. Care direction must be provided by the Enrollee or by the foster care Provider with oversight by the care coordinator.

(a) Costs for room and board must be covered by other resources such as Social Security Disability Insurance, General Assistance, Minnesota Supplemental Aid, or Supplemental Security Income.

(b) Service Providers must meet standards of licensor or certification where they exist either in State law or administrative rule. Persons providing care outside of formal licensor or certification requirements will be monitored by the care

coordinator. Standards for certification of these foster care homes are set by the Local Agency. In these instances, caregivers would require pre-training, approval of care techniques, and periodic evaluation of care received by the client.

(c) Providers of adult foster care must be licensed under Minnesota Rules, parts 9555.5105 through 9555.6265 and 2960.3000 to 2960.3230 and Minnesota Statutes, § 245A.03. Providers must also meet all the requirements in Minnesota Statutes § 256B.0919, subd. 1 and 2.

(d) For Relative Adult Foster Care Providers counties will evaluate and issue certifications to provide foster care for relatives who meet the criteria. Must meet the requirements in Minnesota Statutes, § 256B.0919, sub 3.

(e) Items not covered: items of comfort or convenience; payments directly or indirectly to the enrollee and the costs of facility maintenance, upkeep and improvement are not covered. Homemaker and chore services are not covered as separate services.

(14) Environmental Accessibility Adaptations. These services include those minor physical adaptations to the home required by the Enrollee's plan of care, that are necessary to ensure the health, welfare and safety of the Enrollee with mobility problems, sensory deficits or behavior problems, or which enable the Enrollee to function with greater independence in the home and without which the Enrollee would require institutionalization. For purposes of the waiver, home means the Enrollee's primary place of residence.

(a) Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the Enrollee. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the Enrollee, such as carpeting, roof repair, central air conditioning, household appliances, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. Modifications and adaptations are not covered in congregate or shared living areas of: (1) homes that are licensed to provide foster care where the license holder does not reside in the home and (2) in settings that are registered as a housing with services establishment. This does not preclude coverage of modifications and adaptations to living areas that are not shared such as an Enrollee's bathroom or bedroom when the space is used solely by the enrollee or the Enrollee and one roommate. All services shall be provided in accordance with applicable state or local building codes.

(b) Environmental modifications also include modifications to vehicles that will allow the Enrollee to function with greater independence in the community. Such modifications include: wheelchair lifts, adapted seating, door widening, door handle replacements, wheelchair securing devices, etc. Environmental

modifications also include modifications to adaptive equipment (such as adaptive furniture and utensils) required by the Enrollee. Minor adaptations to a home or vehicle or adaptive equipment may be limited to a combined total of up to the limits specified in Chapters 46 and 34 of the STATE's online manual, titled "Minnesota Health Care Program Provider Manual," per year. Coverage is limited to modifications and adaptations to one operating vehicle and to the enrollee's primary residence. The limit of one vehicle does not prohibit coverage for vehicle modifications or adaptations when the vehicle must be replaced.

(c) Providers of modifications must have a current license or certificate, if required by Minnesota Statutes or administrative rules, to perform their services. A Provider of modifications service must meet all professional standards and/or training requirements required by Minnesota Statutes or administrative rules for the services that they provide. The MCO or its agent must enter into a contract or purchase agreement with Providers of this service.

(d) Modifications and adaptations to home or vehicle or adaptive equipment are limited to a combined total of ten thousand dollars ($10,000) per Enrollee per waiver year. This service limit may be subject to the same percentage rate changes authorized by the Minnesota Legislature for Home and Community-Based Waiver services.

(15) Chore Services: Services needed to maintain the home in a clean, sanitary and safe environment. Additional services that may be covered include heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, basic home maintenance or moving or removal of heavy items of furniture or other large or heavy household items in order to provide safe access and egress or prevent falls. These services will be provided only in cases where neither the Enrollee, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision.

(a) In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

(b) Chore Services can also include customary charges made for the delivery of grocery store products, no more than once every seven days.

(c) Services may also include extermination and pest control. Extermination and pest control services are limited to a reasonable number of treatments required to alleviate the pest problem. Structural pest control applicators must meet the standards and requirements under Minnesota Statutes, Chapter 18B.

(16) Consumer Directed Community Supports (CDCS): CDCS services are an array of cost effective services and durable goods that are defined in an Enrollee's Care Plan, help prevent Institutionalization and/or maintain independent living and are

uniquely designed, chosen and controlled by the Enrollee within a budget developed by the Enrollee and the care coordinator or MCO's designee. Enrollees must have a community support plan that is developed through a person-centered process that addresses all the assessed needs of the Enrollee. Enrollees are required to develop their own plan or have a person they select and/or hire to help them.

(a) Services include but are not limited to the traditional Elderly Waiver Services provided under this section (e.g., personal care). Services may include other alternatives to current Elderly Waiver Services that support the Enrollee. The plan can be a mix of paid and non-paid services and formal and informal supports. Enrollees living in licensed foster care settings licensed by DHS or MDH, or registered as a Housing with Services Establishment with MDH, are not eligible for this service. Services must not duplicate other services provided, must be necessary to ensure health and safety, enable the Enrollee to function with greater independence, be of direct and specific benefit to the Enrollee's condition and/or be directly related to the support needed for the Enrollee to remain in the home, must not be covered by other funding sources and must be cost effective in comparison to alternative services. Enrollees may choose to include all or part of their Elderly Waiver Services in this option.

(b) Enrollees choosing the CDCS option must be capable of directing their own care or have an authorized representative, responsible party or legal representative available to direct their care, and must sign a written agreement regarding their responsibilities under this service option.

(c) Services that require professional certification or license by Minnesota Statutes or federal standards or are identified in the Enrollee's Care Plan as requiring a license or certification must be provided by individuals or agencies who meet the qualifications. Other persons providing flexible support services must be trained to meet the Enrollee's needs, and be trained and understand the Vulnerable Adult Act.

(d) The care coordinator or other MCO designee must work with the Enrollee requesting this service to design an individual budget and Care Plan based on the Enrollee's need for Home and Community Based Services, their personal preferences and available resources. Services must be authorized by the care coordinator or other MCO designee as part of the Care Plan and must be directed at the desired personal outcomes specified in the Care Plan while assuring health and safety. Services may be paid through a fiscal intermediary enrolled with the STATE.

(e) Enrollees living in licensed foster care settings, settings licensed by DHS or the Minnesota Department of Health (MDH) or registered as a housing with services establishment with MDH are not eligible for CDCS.

(f) Detailed information on the CDCS Program can be found in the CDCS Lead Agency Manual on the STATE's website.

(17) Transportation: Transportation service is offered to enable the Enrollee to gain access to community services, activities, and resources as specified in the Enrollee Care Plan, in addition to and not to replace Medical Transportation provided under the acute care services, pursuant to the STATE Plan. The need for Waiver Transportation Services must be documented in the Enrollee's Care Plan, and must be related to a specific goal.

(a) Provider Qualifications: Providers of Common Carrier Transportation are bus, taxicab, other commercial carrier, private automobile, or a county-owned or leased vehicle. Private individuals may be designated to provide transportation when they meet the consumer's needs and preferences in a cost-effective manner. Drivers must have a valid driver's license and adequate insurance coverage, as required by Minnesota Statutes, Chapter 65B. Providers of special transportation, not excluded in Minnesota Statutes, §174.30, must be certified by the Minnesota Department of Transportation under Minnesota Statutes, §§174.29 through 174.30.

(b) Individuals who are not common carriers may provide transportation only if the individual has a valid Minnesota drivers' license and adequate insurance coverage that includes auto insurance, as required under Minnesota Rules part 9505.0315.

(18) Transitional Support Services: Community transitional support services include expenses related to establishing community-based housing for Enrollees transitioning to an independent or semi-independent community residence from the following licensed settings: hospitals licensed under Minnesota Statutes § 144.50 to 144.58; adult foster care homes licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, certified Nursing Facilities, and intermediate care facilities licensed under Minnesota rules part 9505.0175 subpart 23. Examples of expenses that may be covered include: lease or rental deposits; essential furniture; utility set up fees and deposits; costs associated with moving personal items from the licensed facility to the home; personal supports to assist in locating and transitioning to the community based housing, basic kitchen items, personal items, a one-time pest and allergen treatment of the setting, and basic linen items.

(a) The expenses must be reasonable and may not include recreational or diversional items or expenses related to ongoing rent or housing costs, food, or clothing expenses. This service does not include services or items that are covered under other waiver services such as chore, homemaker, home modifications and adaptations, or supplies and equipment. To be eligible an Enrollee must: 1) not have another source to fund or attain the items; 2) be moving from a living arrangement where these items were provided; 3) be moving to a residence where these items are not normally furnished (e.g. these items cannot be provided for by group living environments); and 4) if the Enrollee is not already receiving waiver services, they must be reasonably expected to be open to the waiver within one hundred and eighty (180) days, and actually incur the expense within ninety (90) days of waiver eligibility.

(b) The care coordinator must assure that the transitional support items are necessary and reasonable for the Enrollee to establish an independent or semi-independent household. The items must be listed in the Enrollee's individualized Care Plan. Used items may be purchased if they are safe by reasonable standards and determined appropriate by the care coordinator, and documented in the Enrollee's case file. The MCO is not required to have contracts or purchase agreements with vendors for this service with the exception of those providing personal supports.

(c) Provider Qualifications: Providers of personal supports must, as determined by the MCO, have all of the following qualifications:

i) General knowledge of disabilities and chronic illnesses and their effect on an Enrollee's ability to live independent in the community;

ii) The ability to assess the Enrollee's community-based housing needs;

iii) Functional knowledge of housing options in the community desired by the Enrollee;

iv) A sufficient understanding of housing procurement procedures and funding mechanisms to adequately advise the Enrollee regarding these matters;

v) The ability to assist the Enrollee in attaining the services and supports that are covered by transitional services;

vi) A contract with the Local Agency that outlines their service responsibilities including maintaining client confidentiality.

(19) Adult Day Service Bath. Providers may provide a bath to an Enrollee attending adult day service if required by the Enrollee, and the bath is specified on the Enrollee's individual plan of care. MSHO and MSC+ Enrollees receive this service as part of their Basic Care benefit as stated in section 6.1.14. The MCO may choose to contract with and pay the adult day service provider to provide the bath. Providers of adult day services must meet the standards authorized by Minnesota Rules, parts 9555.9600 through 9555.9730. Adult Day Service programs must comply with Minnesota Statutes sections 245A.01 to 245A.16 and Minnesota Rules parts 9555.9600 to 9555.9730..

6.1.12 Treatment of End Stage Renal Disease (ESRD).

6.1.13 Family Planning Services.

(A) The MCO must comply with the sterilization consent procedures required by the federal government and must ensure open access to Family Planning Services pursuant to 42 CFR § 431.51 subpart (a)(3), and services prescribed by Minnesota Statutes, § 62Q.14.

(B) The MCO may not restrict the choice of an Enrollee as to where the Enrollee receives the following services, pursuant to Minnesota Statutes, § 62Q.14:

(1) Voluntary planning of the conception and bearing of children, provided that this clause does not refer to abortion services;

(2) Diagnosis of infertility, including counseling and services related to the diagnosis (e.g., Provider visit(s) and test(s) necessary to make a diagnosis of infertility and to inform the Enrollee of the results);

(3) Testing and treatment of a sexually-transmitted disease; or

(4) Testing for AIDS and other HIV-related conditions.

(C) The MCO may require family planning agencies and other Providers to refer patients back to the MCO under the following circumstances for other services, diagnosis, treatment and follow-up:

(1) Abnormal pap smear/colposcopy;

(2) Infertility treatment;

(3) Medical Care other than Family Planning Services;

(4) Genetic testing; and

(5) HIV treatment.

(D) Pursuant to 42 CFR § 433.116(f)(2) the MCO shall not specify confidential services, as defined by the STATE in any Notices sent to the Enrollee, including but not limited to Explanation of Benefit and/or Explanation of Medical Benefit Notices.

6.1.14 Home Care Services. Services covered under Minnesota Statutes, §256B.0625, subds. 6a, 7 and 19a and c, §§ 256B.0651; 256B.0653; 256B.0654; 256B.0655, and § 1861(m) of the Social Security Act.

(A) Home Care Services include:

(1) Skilled Nursing visits provided by a certified Home Health Care Agency, for Medical Assistance, up to the service limit described in Minnesota Statutes, §256B.0651, subd. 6(b), 256B.0653, subds. 4, and subd. 2(m), telehomecare skilled nurse visit.

(2) Home Health Aide services provided by a certified Home Health Care Agency, for Medical Assistance, up to the service limit described in Minnesota Statutes, § 256B.0651, subd. 6(b), and § 256B.053, subd. 3, and for MSHO, for Medicare, as long as the Enrollee meets Medicare criteria.

(3) Personal Care Assistance Services (PCA), Services as specified in Minnesota Statutes 256B.0659 Subdivisions (1)-(30) and below, with the exception of Subdivision (5) (c) (d), and (e).

(a) PCA Assessment/ LTCC Assessment. The MCO must provide assessments for PCA services as required under 256B.0659 subdivision 3a, or for MCOs who are lead agencies, under 256B.0911, and must authorize home care services utilizing the home care rating criteria, service amounts and limits under 256B.0659, subd. 4. An in-person assessment must occur at least annually or when there is a significant change in the enrollee's condition or when there is a change in the need for PCA services. A service update may substitute for an in-person assessment when there is no significant change in the enrollee's condition or a change in the need for PCA services. MCO will work with the STATE on implementation of changes in the ADL assessment requirements scheduled to be effective July 1, 2011. MCO will identify and notify Enrollees who will no longer qualify for PCA services under these changes.

(b) Personal Care Assessment and Service Plan. Pursuant to Minnesota Statutes, § 256B.0659, subd. 6, the MCO must require that the service plan be completed by the assessor with the Enrollee and responsible party, on a form provided by the STATE. The PCA Assessment and Service Plan must include a summary of the assessment with a description of the need and authorized amount of Personal Care Assistance services. The Enrollee and the provider must be given a copy of the completed service plan within ten working days of the date of the home visit for the assessment. The Enrollee must also be given information by the assessor about the options in the Personal Care Assistance program to allow for review and decision making. The MCO must ensure that an Enrollee who appeals a reduction in previously authorized home care services has been provided the most recent PCA Assessment and Service Plan with an explanation of the ADL, complex health-related needs and behavior areas that have changed since the last assessment, including notice of the amount of time per day reduced, and the reasons for the reduction in the Enrollee's Notice of Denial, Termination or Reduction.

(c) Personal Care Assistance Care Plan. The MCO must require that the provider and the QP working for the PCPA provide each enrollee with a current Personal Care Assistance plan consistent with the service plan. The care plan must meet the requirements of Minnesota Statutes, § 256B.0659 subd. 7, and must be completed by the QP and the Enrollee or responsible party based on the service plan.

i) The care plan must be completed within seven (7) calendar days after the start of services with a PCPA and must be updated as needed when there is a change in need for PCA services.

ii) A new care plan is required annually at the time of reassessment.

iii) A copy of the care plan must be kept in the Enrollee's home and in the Enrollee's file at the PCA agency. The care plan must include provisions for measures to address identified health and safety and vulnerability issues, including a back up staffing plan, the responsible party and instructions for contact, a description of the Enrollee's needs for assistance with activities of daily living, instrumental activities of daily living, health related tasks and behaviors, and must be signed and dated by the Enrollee or responsible party, and QP. The care plan must also include instructions and comments about the Enrollee's needs for assistance and any special instructions or procedures required. The month-to-month plan for the use of PCA services is part of the care plan.

(d) Disenrollment or Change in MCO. The MCO will comply with Minnesota Statutes, § 256B.0651, subd. 7(b), which provides that the amount and type of PCA services authorized based on the assessment and service plan must remain in effect for the one year period of the most recent valid assessment for the Enrollee whether the Enrollee chooses a different provider or enrolls or disenrolls from a managed care plan under Minnesota Statutes, § 256B.0659, unless the service needs of the Enrollee change and a new assessment is warranted under (a) above.

(e) MCO Authorization of PCA Services. The MCO is responsible for reviewing the PCA Assessment and Service Plan, and authorizing the amount, duration and frequency of the PCA services.

i) If the MCO authorization requires changes to the PCA Assessment and Service Plan due to a required reassessment, to avoid duplication of services or due to an Enrollee's request, the MCO is responsible for ensuring the PCA Provider, Primary Care Physician and Enrollee are notified of this change in writing. The MCO must assure that the provider and the Enrollee are notified in writing of the updated written service plan, including reasons for any changes.

ii) The MCO shall direct the provider to adjust the care plan to reflect the changes in i) above and to provide an updated care plan to the Enrollee.

(f) MCO Authorizations Continue after Disenrollment. The MCO must cooperate with provisions under Minnesota Statutes, § 256B.06512, Subd 14, paragraph (5) for extension of authorizations of PCA services for enrollees who are temporarily disenrolled from the MCO and enrollees who return to the MCO.

i) If a Recipient enrolled in managed care experiences a temporary disenrollment from the MCO, the Department of Human Services FFS system shall accept the current MCO authorization for up to sixty (60) days, provided the request is received within the first thirty (30) days of disenrollment.

ii) If the Recipient's reenrollment in managed care is after sixty (60) days and before ninety (90) days, the PCA provider must request an additional 30-day extension of the current MCO authorization,

iii) An MCO authorization is valid in the FFS system for a total limit of ninety (90) days from the date of disenrollment.

(g) The MCO will participate in the MCO Personal Care Assistance (PCA) workgroup to develop additional implementation plans for the processes as specified in Minnesota Statutes, § 256B.69, subd. 5a, if required.

(h) 30- Day Notice: The MCO shall provide notice to the Enrollee thirty (30) days prior to the effective date of any change in the PCA services, pursuant to Minnesota Statutes, § 256B.0659, subd. 30. An Enrollee whose PCA services will be reduced or terminated due to the requirements of Minnesota Statutes, § 256B.0659 may request continued services pending appeal within the time period allowed to request an appeal. The Enrollee may request a copy of the care plan and/or authorization document from the MCO or its subcontractor for PCA hours of service at the previously authorized level, if the Enrollee has requested services pending an appeal.

(i) Foster Care. The MCO must not authorize PCA services in a housing setting where the foster care license holder is also the PCA provider or personal care assistant unless the foster home is the licensed provider's primary residence as defined in § 256B.0625, subdivision 19a, paragraph (c) The MCO must ensure that PCA Providers keep specific documentation on file for each Enrollee, pursuant to § 256B.0659, subds. 12 and 28, including but not limited to a service plan, care plan and timesheets.

(j) PCA services are no longer covered when the owner of a PCA Provider Agency who is not related by blood, marriage or adoptions owns or otherwise controls the living arrangement, pursuant to Minnesota statute, § 256B.0659, subdivisions 3b and 29.

i) Provider owned or controlled housing includes but is not limited to Corporate Foster Care, Assisted Living, Housing with services and other models where there is an expectation that services are included with housing.

ii) The STATE considers a living arrangement to be controlled by a provider if any of the following are true:

1. Entity that controls the living arrangement is using PCAs as shift staff. This includes unlicensed group residences, corporate foster care, assisted living and any other model with an expectation that PCA services are included with the housing.

2. Landlord actively markets one or more PCA providers to its residents

3. Landlord places any restrictions on residents based on their MHCP enrollment status, amount of service authorized or the PCA provider used.

4. Landlords provide incentives, such as discounts in rent or higher personal needs allowances, to recipients of one or more PCA services

5. Living arrangement is made contingent upon the need for or authorization of PCA services

6. Recipient needs to move in order to choose a new PCA Provider.

(k) PCA Options. The MCO shall ensure that the flexible use, shared and PCA choice options are provided in accordance with Minnesota Statutes, § 256B.06595, subdivisions. 15, 16 and 18 through 20, including but not limited to the limitations and Service Authorization for the option for flexible use of PCA hours and as described in the on the DHS PCA Portal at http://www.dhs.state.mn.us/main/dhs16_145201#

(l) Responsible Party. The MCO must have mechanisms in place to ensure that PCA providers require that responsible parties meet the definitions outlined in Minnesota Statutes, § 256B.0659 Subd. 9, and that they carry out their duties as required under § 256B.0659, Subd. 10, including that the responsible party enter into a written agreement with the PCPA, using the "PCA Program Responsible Party Agreement and Plan," form # 5856, provided by the STATE.

(m) Ineligible PCAs. If the STATE provides the MCO notice that an individual is ineligible to participate as a PCA in the Minnesota Health Care Programs, the MCO will ensure that funds received by the MCO from the STATE are not used to pay the individual for PCA services.

(n) PCA Qualifications. MCOs must make reasonable efforts to assure that PCAs are in compliance with Minnesota Statutes, § 256B.0659, subdivision 11. This compliance includes but is not limited to the PCA being:

i) Employed by a personal care assistance provider agency, with completion of a background study according to Minnesota Statutes, § 245C;

ii) Supervised by a qualified professional according to section 6.1.14(A)(4) below; and

iii) Limited to providing and being paid for up to 275 hours per month of PCA services regardless of the number of Enrollees being served or the number of PCPAs the PCA is enrolled with. The STATE shall provide to the MCO on a monthly basis a report identifying an individual PCA who has exceeded the monthly 275 hour limit. The report will provide how many units of service exceeded 275 hours for that PCA in that month. The MCO must reprocess the original claim and take back the reimbursement for service provided above the 275 hour limit. The MCO will also submit either a void or replacement encounter claim for action taken on the original claim.

(o) PCPA Qualifications; Enrollee Right to Choose. MCOs must make reasonable efforts to assure that PCPAs are in compliance with Minnesota Statutes, § 256B.0659, subdivision 21. This compliance includes (but is not limited to) assurance by the MCO that the PCPA does not limit Enrollees' right to choose service providers. This includes that the PCPA may not require its PCAs to

i) Agree not to work with any particular Enrollee, or

ii) Agree not to work for another PCPA, after leaving the PCPA.

iii) The MCO must assure that the PCPA is not taking action on any such agreements or requirements regardless of the date signed.

(4) Qualified Professional (QP) supervision of PCA Services as described in Minnesota Statutes, § 256B.0659, subd. 13 and 14. All personal care assistants must be supervised by a QP. The QP is responsible for assisting the enrollee in developing a plan for use of the PCA time authorized and will assure how those hours are used throughout the month. -

(5) Private Duty Nursing Services, for Medical Assistance, up to the limits established in Minnesota Statutes, § 256B.0654, subd. 2 and 2b, and § 256B.0652. The MCO shall also use the criteria established in Minnesota Statutes, § 256B.0654, subd. 4, in order to determine whether or not to grant a hardship waiver for these services to an Enrollee's parent, spouse, legal guardian, or family foster care parent.

(6) Therapy Services, including physical therapy, occupational therapy, speech therapy and respiratory therapy, for Medical Assistance, up to the limits established in Minnesota Statutes, § 256.0653 and Minnesota Rules, Part 9505.0390.

(7) Medical Equipment and Supplies, pursuant to section 6.1.21.

(B) For Enrollees who are ventilator-dependent, limits described in section 6.1.14(A) above do not apply; the limits for these Enrollees are as described in Minnesota Statutes, § 256B.0652, subd. 7.

(C) Nursing Facility Certifiable: Those Enrollees in MSHO and MSC+ who are NHC shall also receive Elderly Waiver services from the MCO, as needed.

(D) Service Authorization: If the MCO requires Service Authorization for Home Care Services, it shall comply with section 6.19 of this Contract.

(E) Tribal Assessments and Service Plans. The MCO will accept the results of home care assessments, reassessments and the resulting service plans developed by tribal assessors for Tribal Community Members as determined by the tribe. Referrals to non-tribal providers for home care services resulting from the assessments must be made to providers within the MCO's network. This applies to home care services requested by Tribal Community Members residing on or off the reservation.

(F) Certified Assessors and Assessment. By a date determined by the STATE and upon ninety (90) days notice, and provided required training and testing have been provided, the MCO is required to utilize DHS certified assessors and the STATE-approved assessment system for home care services as provided in Minnesota Statutes, § 256B.0911 subds. 2b and 2c.

(G) Sanctioned Home Health Care Agencies.

(1) In the event of a termination due to sanction under MS § 256B.064 or an MCO action, the MCO must make reasonable efforts to assure that home health care agencies will provide or have provided each Enrollee with a copy of the home care bill of rights under MS § 144A.44 at least thirty (30) days before terminating services to an Enrollee.

(2) If a home health care agency determines it is unable to continue providing services to an Enrollee because of any action under MS § 256B.064, the agency must notify the MCO, the Enrollee, the Enrollee's responsible party if applicable, and the STATE thirty (30) days prior to terminating services to the Enrollee. The MCO and home care agency must cooperate in supporting the Enrollee in transitioning to another home care provider of the Enrollee's choice within the MCO's network .

(3) In the event of a sanction of a home health care agency , a suspension of participation, or a termination of participation of a home health care agency under § 256B.064 or from the MCO, the MCO must inform the Office of Ombudsman for Managed Care for all Enrollees with care plans with the home health care agency. The MCO must contact Enrollees to ensure that the Enrollees are continuing to receive needed care, and that the Enrollees have been given choice of provider (within the MCO's network) if they transfer to another home care provider.

6.1.15 Health Care Home. Enrollees with complex or chronic health conditions may access services through a Health Care Home that meets the certification criteria listed in Minnesota Rules, parts 4764.0010 to 4764.0070.

6.1.16 Hospice Services. Hospice services include services provided by a Medicare certified hospice agency or, when a Medicare certified hospice agency is not available, services that are equivalent to those provided in a Medicare certified hospice agency. For purposes of this section, "equivalent" means that the Enrollee:

(A) Will be provided with a hospice election process that is similar to the hospice election process used by a Medicare certified hospice agency; and

(B) Will be provided with the same choice and amount of services that would be available through a Medicare certified hospice agency.

6.1.17 Inpatient Hospital Services. Coverage for inpatient hospital services shall not exceed the actual semi-private room rate, unless a private room is determined to be Medically Necessary by the MCO.

6.1.18 Interpreter Services. The MCO shall provide sign and spoken language interpreter services that assist Enrollees in obtaining their program's covered health services, to the extent that interpreter services are available to the MCO or its subcontractor when services are delivered. The MCO shall, to the extent possible, make all reasonable efforts to see that interpreter services are provided in a culturally sensitive manner. The intent of the limitation, above, is that the MCO should not delay the delivery of a necessary health care service, even if through all diligent efforts no interpreter is available. This does not relieve the MCO from using all diligent efforts to make interpreter services available.

(A) Coverage for face-to-face oral language interpreter services shall be provided only if the oral language interpreter used by the MCO is listed in the registry or roster established under Minnesota Statutes, § 144.058.

(B) The MCO is not required to provide an interpreter for activities of daily living in residential facilities, but is responsible to provide an interpreter for medical services provided by the MCO outside of the Nursing Facility per diem in Institutional facilities under this Contract.

6.1.19 Laboratory, Diagnostic and Radiological Services.

6.1.20 Medical Emergency, Post-Stabilization Care, and Urgent Care Services. Pursuant to 42 CFR § 438.114, Medical Emergency, Post-Stabilization Care and Urgent Care services must be available 24 hours per day, seven days per week, including a 24-hour per day number for Enrollees to call in case of a Medical Emergency. Except for Critical Access Hospitals, visits to a hospital emergency room that are not an emergency, Post-Stabilization Care, or Urgent Care may not be reimbursed as emergency or services. However, the MCO may reimburse such services as outpatient clinic services and may reimburse for a triage at a triage rate when only triage services are provided. The MCO shall not require an Enrollee to receive a Medical Emergency or Post-Stabilization Care Service within the MCO's network, as specified in section 6.20.1. For Medical Emergency services the MCO shall not:

(A) Require Service Authorization as a condition of providing a Medical Emergency service;

(B) Limit what constitutes a Medical Emergency condition based upon lists of diagnoses or symptoms;

(C) Refuse to cover Medical Emergency services based upon the emergency room Provider, hospital, or fiscal agent not notifying the MCO of an Enrollee's screening and treatment within ten (10) calendar days of the Enrollee requiring Emergency Services.

(D) Hold the Enrollee liable for payment concerning the screening and treatment necessary to diagnose and stabilize the condition; or

(E) Prohibit the treating Provider from determining when the Enrollee is sufficiently stabilized for transfer or discharge. The determination of the treating Provider is binding on the MCO for coverage and payment purposes.

6.1.21 Medical Equipment and Supplies. Medical equipment and supplies includes durable and non-durable medical equipment and supplies that provide a necessary adjunct to direct treatment of the recipient's condition. Supplies and equipment may also include devices, controls, or appliances, which enable the client to increase his or her ability to perform activities of daily living, or to perceive, control, or interact with the environment or communicate with others. This also includes ancillary supplies necessary for the appropriate use of such equipment. All safeguards and provider standards apply.

(A) Covered medical supplies, equipment, and appliances suitable for use in the home are those that are:

(1) Medically necessary;

(2) Ordered by a physician;

(3) Documented in a plan of care that is reviewed and revised as medically necessary by the physician at least once a year; and

(4) Provided to the recipient at the recipient's own place of residence that is a place other than a nursing facility, or intermediate care facility for the developmentally disabled (ICF/DD, formerly known as (ICF/MR).

(5) Medical equipment that is not covered in the facility per diem rate, but must be modified for the recipient, or the item is necessary for the continuous care and exclusive use of the recipient to meet the Enrollee's unusual medical need according to the written order of a physician, will be separately reimbursed by the MCO.

(6) Medical equipment includes replacement of lost, stolen or irreparably damaged hearing aids for an Enrollee who is twenty-one (21) years of age or older, but may be limited to two replacements in a five year period.

6.1.22 Medical Transportation Services. Also see section 6.4 below for Common Carrier Transportation Services. Medical transportation services include:

(A) Ambulance services required for Medical Emergency care, as defined in Minnesota Statutes, § 144E.001, subd. 2. MCOs shall require that providers bill ambulance

services according to Medicare Criteria. Nonemergency ambulance services shall not be paid as emergencies, pursuant to Minnesota Statutes 256B.0625, subd. 17a.; and

(B) Special transportation services for Enrollees who are physically or mentally incapable of transport by taxicab or bus.

6.1.23 Mental Health Services. Mental Health Services shall be provided by qualified Mental Health Professionals. In approving and providing mental health services, the MCO shall use a definition of Medical Necessity that is no more restrictive than the definition of Medical Necessity found in Minnesota Statutes, § 62Q.53 or described in section 2.80. Mental health services must be provided in accordance with Minnesota Rules, Part 9505.0323 (Medical Assistance payment for outpatient mental health services). Mental health services should be directed at rehabilitation of the client in the least restrictive clinically appropriate setting. For adult Mental Health Services, these services include:

(A) Diagnostic assessment, psychological testing, and an explanation of findings to rule out or establish the appropriate Mental Illness (MI) diagnosis in order to develop the individual treatment plan. A psychiatric assessment must include the direct assessment of the Enrollee. The MCO will require behavioral health providers performing diagnostic assessments to:

(1) Screen all adult clients upon initial access of behavioral health services for the presence of co-occurring mental illness and substance use disorder using a screening tool of the Providers' choice, but must meet the following criteria:

(a) Reading grade level of no more than 9th grade;

(b) Easily administered and scored by a non-clinician;

(c) Tested in a general population at the national level;

(d) Demonstrated reliability and validity;

(e) Documented sensitivity of at least seventy percent (70%) and overall accuracy of at least seventy percent (70%); and

(f) Predicts a range of diagnosable major mental illnesses such as affective disorders, anxiety disorders, personality disorders, and psychoses, if a mental illness screening tool; predicts alcohol disorders and drug disorders, especially dependence, if a substance use screening tool; and both of the above, if a combined screening tool.

(2) Preferred criteria for screening tools, but not required, include:

(a) Short duration of screening process taking no more than ten (10) minutes or having ten (10) or fewer items per scale;

(b) Widely used with adults; and

(c) Tool can be used in either interview or self-report format.

(3) The State recommends the following tools:

(a) "In the mental health service for detecting substance use:" Section 3 (Substance use Disorder Screener) of the Global Assessment of Individual Needs-Short Screener (GAIN-SS) or the CAGE-AID; or

(b) "In the chemical health service for detecting mental health issues;" Sections 1 and 2 (Internalizing Disorder and Externalizing Disorder Screeners) of the Global Assessment of Individual Needs-short Screener (GAIN-SS) or the K 6.

(B) Crisis assessment and intervention provided in an emergency room or Urgent Care setting (phone and walk-in).

(C) Residential and non-residential crisis response and stabilization services as authorized by Minnesota Statutes, § 256B.0624.

(D) Intensive Rehabilitative Mental Health Services provided during a short-term stay in an intensive residential therapy setting (IRTS) as authorized by Minnesota Statutes, § 256B.0622.

(E) Assertive Community Treatment (ACT) that is consistent with DHS established standards and protocols. See DHS Bulletin #08-53-01.

(F) Adult Rehabilitative Mental Health Services (ARMHS) as authorized by Minnesota Statutes, § 256B.0623. The MCO may participate in revising standards and guidelines for Adult Rehabilitative Mental Health Services (ARMHS), Intensive Residential Treatment (IRTS) and Assertive Community Treatment (ACT) in order to establish consistent standards and guidelines for behavioral health Providers.

(G) Day treatment.

(H) Partial hospitalization.

(I) For IRTS, ACT, ARMHS, Day Treatment and Partial Hospitalization services identified in paragraphs (D) through (H) above, the MCO shall require its providers to use the Level of Care Utilization System (LOCUS) or another level of care tool recognized nationally with prior approval by the STATE. When determining eligibility and making referrals for these services, the LOCUS must be used in conjunction with a completed diagnostic assessment and functional assessment that reflects the Enrollee's current mental health status.

(J) Individual, family, and group therapy and multiple family group psychotherapy, including counseling related to adjustment to physical disabilities or chronic illness.

(K) Inpatient and outpatient treatment.

(L) Assessment of Enrollees whose health care seeking behavior and/or mental functioning suggests underlying mental health problems.

(M) Neuropsychological assessment.

(N) Neuropsychological rehabilitation and/or cognitive remediation training for Enrollees with a diagnosed neurological disorder that can benefit from cognitive rehabilitation services.

(O) Medication management.

(P) Travel time for mental health Providers as specified in Minnesota Statutes, § 256B.0625, subd. 43, who provide community-based mental health services covered by the MCO in the community at a place other than their usual place of work.

(Q) Mental health services that are otherwise covered by Medical Assistance as direct face-to-face services may be provided via two-way interactive video. The telemedicine method must be medically appropriate to the condition and needs of the Enrollee. The interactive video equipment must comply with Medicare standards in effect at the time the service is provided.

(R) Consultation provided by a psychiatrist via telephone, e-mail, facsimile, or other means of communication, to Primary Care Providers. The consultation must be documented in the patient record maintained by the Primary Care Provider. Consultation provided without the Enrollee being present is subject to federal limitations and data privacy provisions and must have the Enrollee's prior consent.

(S) Mental health outpatient treatment benefits consistent with DHS guidelines and protocols for dialectical behavior therapy for Enrollees diagnosed with severe symptoms and significant dysfunction consistent with the current DSM criteria for a Borderline Personality Disorder. MCO may participate in a workgroup with DHS to establish standards and guidelines for DBT.

(T) For Enrollees with bipolar disorder or schizophrenia, the STATE recommends use of the "Minnesota 10 x 10" program/tool that coordinates primary care physicians and other health care providers to ensure that annual health screenings are offered, including chronic disease for example heart disease and diabetes

(U) Adult Mental Health Targeted Case Management (AMH-TCM). The MCO shall make available to enrollees MH-TCM services that comply with Minnesota Rules, Parts 9520.0900 to 9520.0926 (Rule 79) that establish standards and procedures for providing case management services to adults with serious and persistent mental illness (SPMI) as authorized by Minnesota Statutes, §§ 245.461 to 245.486.

(1) The MCO may offer substitute models of mental health targeted case management services to enrollees who meet SPMI criteria with the consent of the individual, if the substitute model includes all four activities that comprise the CMS definition for targeted case management services, including:

(a) Comprehensive assessment of the Enrollee to determine the need for any medical, educational, social or other services. The LOCUS is not required in determining eligibility for Adult MH-TCM. However it is required as part of Adult MH-TCM services to complete the LOCUS as it relates to the responsibilities of the case manager in assessment, planning, referral and monitoring of all MH services;

i) Development of a specific care plan that:

ii) Is based on the information collected through the assessment;

iii) Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;

iv) Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and

v) Identifies a course of action to respond to the assessed needs of the eligible individual.

(b) Referral and related activities to help the Enrollee obtain needed services including activities that help link an individual with:

i) Medical, social, educational providers; or

ii) Other programs and services capable of providing needed services, such as making referrals to providers, and scheduling appointments for the individual.

(c) Monitoring and follow-up activities, including necessary Enrollee contact to ensure the care plan is implemented, and adequately addresses the Enrollee's needs. These activities and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:

i) Services are being furnished in accordance with the individual's care plan;

ii) Services in the care plan are adequate; and

iii) If there are changes in the needs or status of the individual, necessary adjustments must be made to the care plan and to service arrangements with providers.

(V) MH-TCM Quality. All MH-TCM services must meet the following quality standards:

(1) Assure adequate access to MH-TCM for all eligible Enrollees pursuant to Minnesota Rules parts 9520.0900 to 9520.0903.

(a) The MCO agrees to work with the STATE to provide adequate access to AMH-TCM. This includes limiting the case manager average caseload as specified in Minnesota Rules, part 9520.0903, subp. 2, in order to attend to the outcomes specified for case management services as specified in Minnesota Rules, Part 9520.0905.

(b) The STATE acknowledges that MH-TCM Providers may provide services to Enrollees for multiple health plans and fee-for-service Medicaid, and agrees to monitor caseload ratios and provide feedback to the MCOs regarding the caseload ratios of all contracted case management Providers.

(2) Provide face-to-face contact with the Enrollee at least once per month, or as appropriate to Enrollee need pursuant to Minnesota Rules 9520.0914, subp. 2. B.

(3) Case Managers for AMH-TCM services must meet the qualifications and supervision requirements listed in Minnesota Statutes, § 245.462, subds. 4 and 4(a), and Minnesota Rules, Part 9520.0912.

(W) The MCO Provider must have a working knowledge of physical, mental health, educational and social service resources that are available in order to assist the enrollee with accessing the most appropriate treatment in the least restrictive setting as determined by clinical need.

(X) Court Ordered Treatment. The following procedures apply to mental health services that are court-ordered.

(1) The MCO must provide all court-ordered mental health services pursuant to Minnesota Statutes, § 62Q.535, subds. 1 and 2, and § 253B.045, subd. 6, which are also covered services under this contract. The services must have been ordered by a court of competent jurisdiction and based upon a mental health evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist. The MCO shall assume financial liability for the evaluation that includes diagnosis and an individual treatment plan, if the evaluation has been performed by one of the Participating Providers.

(2) The court-ordered mental health services shall not be subject to a separate Medical Necessity determination by the MCO. However, the MCO may make a motion for modification of the court-ordered plan of care, including a request for a new evaluation, according to the rules of procedure for modification of the court's order.

(3) The MCO's liability for an ongoing mental health inpatient hospital stay at a regional treatment center (RTC) shall end when the medical director of the center or facility, or his or her designee, no longer certifies that the Enrollee is in need of continued treatment at a hospital level of care, and the MCO agrees that the Enrollee

no longer meets Medical Necessity criteria for continued treatment at a hospital level of care.

(4) The MCO must provide a twenty-four (24)-hour telephone number answered in-person that a Local Agency may call to get an expeditious response to situations involving the MCO's Enrollees where court ordered treatment and disability certification are involved.

(Y) Civil Commitment.

(1) The MCO shall:

(a) Work with hospitals in the MCO's network to develop procedures for prompt notification by the hospital to the MCO upon admission of an Enrollee for psychiatric inpatient services;

(b) Work with county pre-petition screening teams to develop procedures for notification within seventy-two (72) hours by the pre-petition screening team to the MCO when an Enrollee is the subject of a pre-petition screening investigation;

(c) Provide expedited determination of eligibility for MH-TCM for MCO enrollees who are referred to the health plan as potentially eligible for MH-TCM;

(d) Assign mental health case management as court ordered services for enrollees who are committed, or for Enrollees whose commitment has been stayed or continued;

(2) The Mental Health Targeted Case Manager shall:

(a) Work with hospitals, pre-petition screening teams, family members or representatives, and current Providers, to assess the Enrollee and develop an individual care plan that includes diversion planning and least restrictive alternatives consistent with the Commitment Act. This may include testifying in court, and preparing and providing requested documentation to the court;

(b) Report to the court within the court-required timelines regarding the Enrollee's Care Plan status and recommendations for continued commitment, including, as needed, requests to the court for revocation of a provisional discharge;

(c) Provide input only for pre-petition screening, court-appointed independent examiners, substitute decision-makers, or court reports for Enrollees who remain in the facility to which they were committed;

(d) Provide AMH-TCM coverage which includes discharge planning for up to one hundred and eighty (180) days prior to an Enrollee's discharge from an Inpatient Hospitalization in a manner that works with, but does not duplicate, the facility's discharge planning services; and

(e) Ensure continuity of health care and Case Management coverage for Enrollees in transition due to change in benefits or change in residence.

6.1.24 Nursing Facility (NF) Services. See section 4.26 for SNF/NF Benefit.

6.1.25 Outpatient Hospital Services. Outpatient hospital services include emergency care.

6.1.26 Personal Care Assistance (PCA) Services. As specified in section 6.1.14(A)(3) under Home Care Services.

6.1.27 Physician Services and Telemedicine Consultation. Services and physician supervision as authorized by 42 CFR § 417.416. Physician services include Telemedicine Consultation. Coverage of Telemedicine Consultations is limited to three Telemedicine Consultations per Enrollee per week.

6.1.28 Podiatric Services.

6.1.29 Prescription Drugs and Over-the-Counter Drugs.

(A) Covered prescription and over-the-counter drugs prescribed by a Provider who is licensed to prescribe drugs within the scope of his/her profession, and dispensed by a Provider who is licensed to dispense drugs within the scope of his/her profession, which are contained in the Medical Assistance Drug Formulary or that are the therapeutic equivalent to Medical Assistance formulary drugs, except those drugs covered under the Medicare Prescription Drug program under Medicare Part D for Medicare eligible Enrollees.

(B) For Dual Eligible persons, the MCO may cover drugs from the drug classes listed in United States Code, title 42, § 1396r-8(d)(2), except that drugs listed in United States Code, title 42, § 1396r-8(d)(2)(E), which are covered by Part D, shall not be covered.

(C) Pursuant to Minnesota Statutes, § 256B.0625, Subd13(c), the MCO may allow pharmacies to prescribe over-the-counter drugs.

(D) If the MCO chooses to have a drug formulary or policies which are more restrictive than the STATE's drug formulary or policies, the MCO shall provide any necessary drug at its own cost to Enrollees on behalf of whom the STATE intervenes, following the STATE's review by a pharmacist and physician. If the STATE does such an intervention, it shall also initiate a corrective action plan to the MCO, which the MCO must implement.

(E) Upon request of the STATE, the MCO shall submit a copy of the MCO's drug formularies including the SNPs Medicare Part D formulary. The MCO may fulfill this requirement by making the drug formulary available on the MCO's website and providing the link to the STATE.

(F) The MCO agrees to offer SNP formularies appropriately tailored to the special needs of Dual Eligibles in that the number and types of drugs required to be prior authorized are comparable to that currently required under the STATE's Medicaid program. The STATE may review public information about the MCO SNP Medicare Part D formularies and may discuss problems or concerns with coverage and prior authorization with the MCO.

(G) For MSHO, the MCO agrees to coordinate the provision of both Medicare and Medicaid drug coverage so that coverage is as seamless as possible for the Enrollee. The MCO assures that its Pharmacy Benefit Manager will administer Medicaid drugs according to Medicaid requirements, and that Medicaid drugs are not being confused with Medicare drugs.

(H) The STATE shall notify the MCO of any inadequacies in the MCO's Medicaid formulary and the MCO shall submit a corrective action plan. For the purposes of this section, formulary "inadequacies" means that the MCO's formulary does not contain a therapeutic equivalent for a class of drugs.

(I) In addition, the MCO shall notify the STATE of any changes in its drug formulary within thirty (30) days of the changes, and for deletions shall submit the justification for the change. The MCO shall also submit a copy of any Service Authorization criteria used to limit access of Enrollees to drugs.

(J) The MCO must cover antipsychotic drugs prescribed to treat emotional disturbance or Mental Illness regardless of the MCO's formulary if the prescribing Provider certifies in writing to the MCO that the prescribed drug will best treat the Enrollee's condition, pursuant to Minnesota Statutes, § 62Q.527, subd. 2. The MCO shall not require recertification from the prescribing Provider on prescription refills or renewals, or impose any special payment requirements that the MCO does not apply to other drugs in its drug formulary. If the prescribed drug has been removed from the MCO's formulary due to safety reasons the MCO does not have to provide coverage for the drug.

(K) Subject to conditions specified in Minnesota Statutes, § 62Q.527, subd. 3, the MCO shall allow an Enrollee to continue to receive a prescribed drug to treat a diagnosed Mental Illness or emotional disturbance for up to one year, upon certification by the prescribing Provider that the drug will best treat the Enrollee's condition, and without the MCO imposing special payment requirements. This continuing care benefit is allowed when the MCO changes its drug formulary or when an Enrollee changes MCOs, and must be extended annually if certification is provided to the MCO by the prescribing Provider. The MCO is not required to cover the prescribed drug if it has been removed from the MCO's formulary for safety reasons.

(L) Pursuant to Minnesota Statutes, § 62Q.527, subd. 4, the MCO must promptly grant an exception to its drug formulary when the health care Provider prescribing the drug for an Enrollee indicates to the MCO that:

(1) The formulary drug causes an adverse reaction in the Enrollee;

(2) The formulary drug is contraindicated for the Enrollee; or

(3) The health care Provider demonstrates to the MCO that the prescription drug must be dispensed as written (DAW) to provide maximum medical benefit to the Enrollee.

6.1.30 Medication Therapy Management (MTM) Care Services. Pursuant to Minnesota Statute, § 256B.0625, subd. 13h, and the Pharmacy Web page on Medication Therapy Management Services listed on the STATE's MHCP Enrolled Providers website at http://www.dhs.state.mn MHCP Provider Update PRX-06-02R. MTM services are covered, except for Enrollees receiving drugs covered by Medicare Part D, for whom MTM services are covered by Medicare. An eligible pharmacist within the MCO's network may provide MTM services via two-way interactive video when there are no pharmacists eligible to provide such services within a reasonable geographic distance of the Enrollee.

6.1.31 Electronic Prescribing. The MCO shall comply with Minnesota Statutes, § 62J.497 and the applicable standards specified in the statute for electronic prescribing. The MCO shall also ensure that its providers involved in prescribing, filling prescriptions or paying for prescriptions, including communicating or transmitting formulary or benefit information also conform to the electronic prescribing standards for transmitting prescription or prescription-related information.

6.1.32 Prosthetic and Orthotic Devices. Includes devices and related medical supplies.

6.1.33 Public Health Services. Public health clinic services and public health nursing clinic services as they are described in Chapter 8 of the Provider Manual which is incorporated herein by reference.

6.1.34 Reconstructive Surgery. As described in Minnesota Statutes, § 62A.25, subd. 2, and the Women's Health and Cancer Rights Act of 1998 (WHCRA), 45 CFR § 146.180.

6.1.35 Rehabilitative and Therapeutic Services. Both evaluation and treatment including:

(A) Physical therapy (including specialized maintenance therapy, pursuant to Minnesota Rules, Part 9505.0390);

(B) Speech therapy (including specialized maintenance therapy; pursuant to Minnesota Rules, Part 9505.0390);

(C) Occupational therapy (including specialized maintenance therapy, pursuant to Minnesota Rules, Part 9505.0390);

(D) Audiology; and

(E) Respiratory therapy

6.1.36 Relocation Targeted Case Management.

6.1.37 Second Opinion. MCOs must provide, at MCO expense, a second medical opinion within the MCO network upon Enrollee request pursuant to Minnesota Rules, Part 9500.1462, A.

6.1.38 Skilled Nursing Facility (SNF) Services. See section 4.26 for SNF/NF benefit.

6.1.39 Specialty Care.

6.1.40 Transplants. Covered transplants include: cornea, heart, kidney, liver, lung, pancreas, heart-lung, intestine, intestine-liver, pancreas-kidney, pancreatic islet cell, stem cell, bone marrow and other transplants that are listed in the Provider Manual, covered by Medicare, or recommended by the State's medical review agent. All organ transplants must be performed at transplant centers meeting United Network for Organ Sharing (UNOS) criteria or at Medicare approved organ transplant centers. Stem cell or bone marrow transplant centers must meet the standards established by the Foundation for the Accreditation of Cellular Therapy (FACT).

6.1.41 Tuberculosis Related Services. Tuberculosis related services include Case Management and Direct Observation Therapy (DOT) which consists of direct observation of the intake of drugs prescribed to treat tuberculosis by a nurse or other trained health care Provider. The MCO shall make reasonable efforts to contract with and use the Local Public Health Nursing Agencies as the Provider for direct observation of the intake of drugs prescribed to treat tuberculosis, and referral for nurse case management, except for persons who are Institutionalized. The MCO shall communicate to medical care Providers that all other tuberculosis patients should be referred to the Local Public Health Agency for DOT and nurse case management services.

6.1.42 Vaccines and Immunizations. Covered vaccines and immunizations include, but are not limited to recommendations by the Minnesota Department of Health. Zostavax® for Enrollees ages sixty (60) and over, and Varicella immunization, are covered.

6.1.43 Vision Care Services. Services include vision examinations, eyeglasses, and optician, optometrist and ophthalmologist services. Eyeglasses, sunglasses and contact lenses shall be provided only if prescribed by or through the MCO participating physicians or participating optometrists. The MCO must make available a reasonable selection of eyeglass frames, but is not required to make available an unlimited selection. Replacement of lost, stolen or irreparably damaged eyeglasses, sunglasses, and contact lenses may be covered upon a showing of Medical Necessity and may be limited to the replacement of the same frames.

6.2 Substitute Health Services Permitted. To the extent consistent with Minnesota Statutes, Chapter 256B, the MCO shall have the right, in its discretion, to pay for or provide if such services are, in the judgment of the MCO, medically appropriate and cost-effective.

(A) The MCO shall have a mechanism for timely payment of Substitute Health Services provided in this section, and for consumer directed community support services in section 6.1.11(K)(17).

(B) Substitute Health Services submitted as encounter data will be considered in calculations of MCO costs pursuant to section 4.5.

6.3 Additional Services Permitted. The MCO may provide or arrange to have provided services in addition to the services described in Article 6, as permitted by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services under Title XIX, § 1915 of the Social Security Act, for Enrollees for whom, in the judgment of the MCO's Care Management staff, the provision of such services is Medically Necessary; provided, however, that it is understood that the provision of any such services shall not affect the calculation of capitation rates pursuant to Article 4.

6.4 Common Carrier Transportation Services.

6.4.1 General. In addition to the transportation services specified in section 6.1.22, and except for the services described in section 6.4.2, the MCO shall provide Common Carrier Transportation, including Volunteer Drivers when available, to its Enrollees for the purpose of obtaining covered health care services. Payment for these services is included in the capitation rates in Appendix II for transporting an Enrollee to or from the site of a non-Emergency service covered under this Contract pursuant to Minnesota Statutes, § 256B.691.

6.4.2 Common Carrier Transportation That is Not the Responsibility of the MCO. The Local Agency shall remain responsible for reimbursing the Enrollee for private automobile transportation to non-Emergency Covered Services, and meals and lodging as necessary. The MCO shall not be responsible for providing Common Carrier Transportation in any situation where the Enrollee has access to private automobile transportation (not including Volunteer Drivers) to a non-Emergency service covered under this Contract. The MCO shall not be responsible for providing Common Carrier Transportation when an Enrollee chooses a non-Emergency Primary Care Provider located thirty (30) miles from the Enrollee's home, or when an Enrollee chooses a Specialty Care Provider that is more than sixty (60) miles from the Enrollee's home, unless the MCO approves the travel because the non-Emergency primary or specialty care required is not available within the specified distance from the Enrollee's residence. Providing non-emergency transportation to medical services located outside of Minnesota that has been approved by the MCO is the responsibility of the Local Agency.

6.5 Limitations on MCO Services.

6.5.1 Medical Necessity. Unless otherwise provided in this Contract, the MCO shall be responsible for the provision and cost of health care services as described in Article 6 only when such services are deemed to be Medically Necessary by the MCO. Home and Community Based Services and services mandated by state or federal law are excluded from the MCO's Medical Necessity determination.

6.5.2 Coverage Limited to Program Coverage. Except as otherwise provided under this Contract, or otherwise mandated by state or federal law, all health care services prescribed or recommended by a Participating Physician, dentist, care manager, or other practitioner, or approved by the MCO are limited to services covered under Medical Assistance or Medicare.

6.6 Services Not Covered By This Contract. Although the MCO may provide the following services, the prepaid capitation rate does not include payment for the following services, and therefore the MCO is not required to provide them.

6.6.1 Abortion Services are not covered.

6.6.2 Cosmetic Procedures or Treatment. Cosmetic procedures or treatment are not covered, except that the following services are not considered cosmetic and therefore must be covered: services necessary as the result of injury, illness or disease, or for the treatment or repair of birth anomalies.

6.6.3 Experimental or Investigative Services are not covered.

6.6.4 Federal Institutions. All claims arising from services provided by institutions operated or owned by the federal government, unless the services are approved by the MCO, are not covered.

6.6.5 State and Other Institutions. All claims arising from services provided by a state regional treatment center, a State-owned long term care facility, or an institution for mental disease (IMD) are not covered, unless the services are approved by the MCO, or the services are covered by Medicare, or unless the services are court-ordered pursuant to Minnesota Statutes, §§ 62Q.535 and 253B.045, subd. 6.

6.6.6 Fertility Drugs and Procedures. Fertility Drugs are not covered when specifically used to enhance fertility. The following procedures also are not covered: in vitro fertilization, artificial insemination, and reversal of a voluntary sterilization.

6.6.7 Sex Reassignment Surgery is not covered.

6.6.8 Incidental Services. Services not covered include but are not limited to rental of television, telephone, barber and beauty services and guest services that are not Medically Necessary.

6.6.9 Certain Mental Health Services. Housing associated with Intensive Residential Treatment (IRTS) is not covered.

6.6.10 HIV Case Management Services are not covered

6.6.11 Nursing Facility Per Diem Services. Nursing Facility per diem services are not covered, except as provided for in section 4.26 for 180 day Nursing Facility coverage.

6.6.12 Out of Country Care. Emergency care or other health care services received from Providers located outside the United States and Canada. For the purpose of this section, United States includes the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

6.6.13 Drugs covered under the Medicare Prescription Drug Benefit. Drugs covered under the Medicare Prescription Drug Program are not covered for Enrollees who are eligible for Medicare.

6.6.14 Other. All other exclusions set forth in Minnesota Statutes, § 256B.0625, Minnesota Statutes, § 256B.69, Minnesota Rules, Part 9505.0170 through 9505.0475, and Minnesota Rules, Part 9500.1450 through 9500.1464 are not covered.

6.7 Enrollee Liability.

6.7.1 Copayments. Enrollees may be liable for copayments under section 4.19.

6.7.2 Limitation. Except for section 4.19, the MCO will not bill or hold the Enrollee responsible in any way for any charges or deductibles for Medically Necessary Covered Services or services provided as alternatives to Covered Services as part of the MCO's Care Management Plan, including Medicare cost sharing under section 4.5.5. The MCO shall ensure that its subcontractors also do not bill or hold the Enrollee responsible in any way for any charges or deductibles for such services. The MCO shall further ensure that an Enrollee will be protected against liability for payment under any of the following circumstances:

(A) The MCO does not receive payment from the STATE for the Covered Services;

(B) A health care Provider under contract or other arrangement with the MCO fails to receive payment for Covered Services from the MCO;

(C) Payments for Covered Services furnished under a contract or other arrangement with the MCO are in excess of the amount that an Enrollee would owe if the MCO had directly provided the services;

(D) A non-Participating Provider does not accept the MCO's payment as payment in full; or

(E) For MSHO Enrollees, if a Provider under contract or other arrangement with the MCO charges an Enrollee cost sharing that would exceed the amounts permitted under Medicaid, if the Dually-eligible Enrollee were enrolled only in Medicaid and Original Medicare rather than the MSHO dual-eligible SNP. Provider contracts shall be consistent with 42 CFR § 422.504 (g)(1)(iii) as published in the Federal Register, Vol. 74, No. 7, January 12, 2010, page 1542.

6.8 Penalty for Illegal Remuneration. If the MCO or its subcontractors violate 42 U.S.C. § 1320a-7b(d), the MCO and its subcontractors may be subject to the criminal penalties stated therein.

6.9 No Enrollee Reimbursement. The MCO shall not make payment to an Enrollee in reimbursement for a service provided under this Contract. (See 42 CFR § 447.25).

6.10 Designated Source of Primary Care. The MCO shall have written procedures that ensure each Enrollee has an ongoing source of Primary Care appropriate to his or her needs and a

Provider formally designated as primarily responsible for coordinating the health care services furnished to the Enrollee.

6.11 Fair Access to Care. The MCO agrees that the health care services listed in Article 6 will be available to Enrollees during normal business hours to the same extent available to the general population.

6.12 Access Standards. The MCO shall provide care to Enrollees through the use of an adequate number of hospitals, Nursing Facilities, service locations, service sites, and professional, allied and paramedical personnel for the provision of all Covered Services, pursuant to the following standards:

6.12.1 Primary Care.

(A) Distance/Time: Not more than thirty (30) miles or thirty (30) minutes distance for all Enrollees, or the STATE's Generally Accepted Community Standards.

(B) Adequate Resources: The MCO shall have available appropriate and sufficient personnel, physical resources, and equipment to meet the projected needs of its Enrollees for covered health care services.

(C) Timely Access: The MCO shall arrange for covered health care services, including referrals to Participating and non-Participating Providers, to be accessible to Enrollees on a timely basis in accordance with medically appropriate guidelines and consistent with Generally Accepted Community Standards. The MCO shall also take into account the urgency of the need for services.

(D) Appointment Times: Not to exceed forty-five (45) days from the date of an Enrollee's request for routine and preventive care and twenty-four (24) hours for Urgent Care.

(E) Tracking: The MCO must have a system in place for confidential exchange of Enrollee information with the Primary Care Provider, if a Provider other than the Primary Care Provider delivers health care services to the Enrollee.

6.12.2 Specialty Care.

(A) Transport Time: Not to exceed sixty (60) minutes, or the STATE's Generally Accepted Community Standards.

(B) Appointment/Waiting Time: Appointments for a specialist shall be made in accordance with the time frame appropriate for the needs of the Enrollee, or the Generally Accepted Community Standards.

6.12.3 Emergency Care/Shock Trauma. All Emergency Care must be provided on an immediate basis, at the nearest equipped facility available, regardless of MCO contract affiliation.

6.12.4 Hospitals. Transport time: Not to exceed thirty (30) minutes, or the STATE's Generally Accepted Community Standards.

6.12.5 Dental, Optometry, Lab, and X-Ray Services.

(A) Transport Time: Not to exceed sixty (60) minutes, or the STATE's Generally Accepted Community Standards.

(B) Appointment/Waiting Time: Not to exceed sixty (60) days for regular appointments and forty-eight (48) hours for Urgent Care. For the purposes of this section, regular appointments for dental care means preventive care and/or initial appointments for restorative visits.

6.12.6 Pharmacy Services. Travel Time: Not to exceed sixty (60) minutes, or the STATE's Generally Accepted Community Standards.

6.12.7 Other Services. All other services not specified in this section shall meet the STATE's Generally Accepted Community Standards or other applicable standards.

6.13 Around-the-Clock Access to Care. The MCO shall make available to Enrollees access to Medical Emergency Services, Post-Stabilization Care Services and Urgent Care on a twenty-four (24) hour, seven-day-per-week basis. The MCO must provide a twenty-four (24) hour, seven day per week MCO telephone number that is answered in-person by the MCO or an agent of the MCO; this telephone number must be provided to the STATE. The MCO is not required to have a dedicated telephone line.

6.14 Serving Minority and Special Needs Populations. The MCO must offer appropriate services for the following special needs groups. Services must be available within the MCO or through contractual arrangements with Providers to the extent that the service is a Covered Service pursuant to this Article.

(A) Persons with Serious and Persistent Mental Illness (SPMI). Services for this group include ongoing medications review and monitoring, day treatment, and other community-based ("milieu") alternatives to conventional therapy, and coordination with the Enrollee's case management service Provider to assure appropriate utilization of all needed psychosocial services.

(B) Elderly Persons with a Physical Handicap or Chronic Illness. Services for this group include in-home services and neurological assessments.

(C) Abused Adults, Abusive Individuals. Services include comprehensive assessment, diagnostic services and specialized treatment techniques for victims and perpetrators of maltreatment (physical, sexual, emotional).

(D) Enrollees with Language Barriers. Services include interpreter services, bilingual staff, culturally appropriate assessment and treatment. When an individual is enrolled in MSHO, the enrollment form will indicate whether the Enrollee needs the services of an interpreter and what language he or she speaks. Upon receipt of enrollment

information indicating interpreter services are needed, the MCO shall contact the Enrollee by phone or mail in the appropriate language to inform the Enrollee how to obtain Primary Care services. In addition, whenever an Enrollee requests an interpreter in order to obtain health care services, the MCO must provide the Enrollee with access to an interpreter, pursuant to section 6.1.18.

(E) Cultural and Racial Minorities. Services include culturally appropriate services rendered by Providers with special expertise in the delivery of health care services to the various cultural and racial minority groups.

(F) Enrollees in Need of Gender-Specific Mental Health and/or CD Treatment. The MCO must provide its Enrollees with an opportunity to receive mental health and/or chemical dependency services from a same-sex therapist and the option of participating in an all-male or all-female group therapy program.

(G) Lesbians, Gay Men, Bisexual and Transgender Persons. Services for this group require sensitivity to critical social and family issues unique to these Enrollees.

(H) Hearing Impaired. Services include access to TDD and hearing-impaired interpreter services.

(I) Persons with a Developmental Disability (DD). These services include specialized mental health and rehabilitative services and other appropriate services covered by Medical Assistance should be designed to maintain or increase function and prevent further deterioration or dependency and should be coordinated with available community resources and support systems including the Enrollee's Local Agency DD case management service provider, families, guardians and residential care Providers. Continuity of care should be a major consideration in the treatment planning process. Referrals to specialists and sub-specialists must be made when medically indicated.

(J) American Indians. Services include culturally appropriate services rendered by Providers with special expertise in the delivery of health care services to the various tribes.

6.15 Client Education. The MCO will ensure that Enrollees are advised of the appropriate use of health care and the contributions they can make to the maintenance of their own health.

6.16 Primary Care Provider. The MCO will reasonably provide each Enrollee with a choice of a Primary Care Provider who will supervise and coordinate the Enrollee's care.

6.17 Direct Access to Obstetricians and Gynecologists. Pursuant to Minnesota Statutes, § 62Q.52, the MCO shall provide Enrollees direct access without a referral or Service Authorization to the following obstetric and gynecologic services: annual preventive health examinations and any subsequent obstetric or gynecologic visits determined to be Medically Necessary by the examining obstetrician or gynecologist; and evaluation and necessary treatment for acute gynecologic conditions or emergencies. Direct access shall apply to obstetric and gynecologic Providers within the Enrollee's network, including any Providers with whom the MCO has established referral patterns.

6.18 Geographic Accessibility of Providers. In accordance with Minnesota Statutes, § 62D.124, the MCO must demonstrate that its Provider network is geographically accessible to Enrollees in its Service Area. In determining the MCO's compliance with the access standards, the STATE may consider an exception granted to the MCO by the Minnesota Department of Health for areas where the MCO cannot meet these standards.

6.19 Service Authorization and Utilization Review.

6.19.1 General Exemption for Medicaid Services. The MCO is exempt from STATE Service Authorization and second surgical opinion procedures at Minnesota Rules, Part 9505.5000 through 9505.5105, and from certification for admission requirements at Minnesota Rules, Part 9505.0500 through 9505.0540.

6.19.2 Medical Necessity Standard. The MCO may require Service Authorization for services, except for Medical Emergency services. Service Authorization shall be based on Medical Necessity, pursuant to section 2.80, and, in the case of mental health services, shall also be based on Minnesota Statutes, § 62Q.53, and for CD services, on Minnesota Rules, Parts 9530.6600 through 9530.6655.

6.19.3 Utilization Review. The MCO, and if applicable its subcontractor, must have in place and follow written policies and procedures for utilization review that reflect current standards of medical practice in processing requests for initial or continued Service Authorization of services, and meet the requirements as specified in Minnesota Statutes, § 62M.05 and § 62M.09. The MCO's policies and procedures shall ensure the following:

(A) Consistent application of review criteria for authorization decisions;

(B) Consultation with the requesting Provider when appropriate;

(C) Decisions to deny an authorization request or authorize it in an amount, duration, or scope that is less than requested be made by a Health Care Professional who has appropriate clinical expertise in treating the Enrollee's health condition; and

(D) Notification to the requesting Provider and written notice to the Enrollee of the MCO's decision to deny or limit the request for services in accordance with section 8.3.

6.19.4 Denials Based Solely on Lack of Service Authorization. Pursuant to Minnesota Statutes, § 62D.12, subd. 19, the MCO shall not deny or limit coverage of a service which the Enrollee has received solely on the basis of lack of Service Authorization, to the extent that the service would otherwise have been covered by the MCO had Service Authorization been obtained.

6.20 Out of Network and Transition Services.

6.20.1 Out of Network Services. The MCO shall cover Medically Necessary Out Of Plan or Out of Service Area services received by an Enrollee when one of the following occurs

(A) The Enrollee requires Medical Emergency Services.

(B) The Enrollee requires Post-Stabilization Care Services to maintain, improve or resolve the Enrollee's condition. The MCO shall continue coverage until: 1) an MCO Provider assumes responsibility for the Enrollee's care; 2) the MCO reaches an agreement with the treating Provider concerning the Enrollee's care;3) the MCO has contacted the treating Provider to arrange for a transfer, or 4) the Enrollee is discharged.

(C) The Enrollee is Out of Service Area and requires Urgent Care; or

(D) The Enrollee is Out of Service Area or Out of Plan (consistent with 42 CFR 42 CFR § 438.206(b)(4)) and in need of non-Emergency medical services that are or have been prescribed, recommended, or are currently being provided by a Participating Provider. The MCO may require Service Authorization. When the Enrollee is authorized for Out of Plan care or Out of Service Area care, the MCO shall reimburse the non-Participating Provider for such services pursuant to section 6.20.3.

(E) The Enrollee moves Out of Service Area as defined in section 2.125 of this Contract and this change is entered on MMIS after the Cut-Off Date, and a payment has been or will be made to the MCO for coverage for the Enrollee for that same or next month, the MCO shall reimburse the Medicare or Medical Assistance fee-for-service rate or billed charges, whichever is less, any services provided by non-Participating Providers to the Enrollee during the balance of the month or the month after which the Enrollee has moved for which the MCO received a Capitation Payment from the STATE. The MCO may condition reimbursement of these Out-Of-Plan services on the Enrollee's requesting MCO approval or Service Authorization to receive such services except for Emergency Care.

6.20.2 Transition Services. The MCO is responsible for care in the following situations.

(A) Services Previously Service Authorized. The MCO shall provide Enrollees Medically Necessary Covered Services and EW covered services that an Out of Plan Provider, another MCO, or the STATE had Service Authorized before enrollment in the MCO. The MCO may require the Enrollee to receive the services by an MCO Provider, if such a transfer would not create undue hardship on the Enrollee, and is clinically appropriate. Transition services relating to orthodontia care, mental health services, at-risk pregnancy services, and chemical dependency services are covered as described in the below paragraphs of this section.

(B) Orthodontia Care. The MCO shall provide orthodontia care for child enrollees if 1) an Out of Plan Provider or the STATE has Service Authorized such care, 2) the care falls under an established plan of care, and 3) the Care Plan has a definitive end date. Payment to the prior Provider must be at least equivalent to the STATE Medical Assistance fee-for-service rate for orthodontia care. In the alternative, the MCO may transfer the Enrollee to a MCO Provider, if such a transfer would not create undue hardship on the Enrollee, and is clinically appropriate.

(C) Chemical Dependency (CD) Treatment Services.

(1) The MCO shall assume responsibility for all treatment and treatment-related room and board effective upon the date of the Recipient's enrollment into the MCO. For MSC+, enrollment into the MCO will not be delayed except for those Enrollees currently in an inpatient hospital-based program. The MCO shall provide coverage for services that were authorized by the CCDTF or any other STATE contracted MCO prior to the Recipient's enrollment in the MCO, unless the MCO completes a new Rule 25 assessment or re-assessment, and the assessment identifies a different level of need for services.

(2) For MSHO Duals, enrollment will not be delayed.

(D) Mental Health Services. At the time of initial enrollment, the MCO shall consider the individual Enrollee's prior use of mental health services and develop a transitional plan to assist the Enrollee in changing mental health Providers, should this be necessary, and develop a plan to assure the need for continuity of care for any Enrollee or family who is receiving ongoing mental health services.

(E) Enrollee Change of MHCP. The MCO shall continue coverage if: 1) the Enrollee was enrolled with the MCO in the same county, but covered under another STATE MCO contract; 2) the MCO products do not have the same Participating Providers; and 3) the Enrollee chooses to receive services from the Participating Providers from the prior enrollment with the MCO. The MCO must notify any affected Enrollee of his/her right to choose to remain with their original Participating Providers.

(F) Pharmacy. The MCO shall continue payment of all drugs an Enrollee is taking upon enrollment into the MCO, under a current prescription, except for those drugs covered by Medicare Prescription Drug Program, for Medicare eligible Enrollees, until such time as a transition plan can be established by the MCO, or ninety (90) days, whichever occurs first, for all those Enrollees who have identified themselves to the MCO or who have been identified to the MCO by an appropriate representative as requiring such continuation.

6.20.3 Reimbursement Rate for Out-of-Plan or Out of Service Area Care. When the Enrollee is authorized for Out-of-Plan Care or Out of Service Area care, the MCO shall reimburse the non-Participating Provider for the Out-of-Plan Care or Out of Service Area Care. Pursuant to § 6085 of the Deficit Reduction Act, the MCO may not reimburse more than the comparable Medical Assistance fee-for-service rate for emergency services furnished by non-Participating Providers. For all other services pursuant to Minnesota Rules, Part 9500.1460, subpart 11a, the MCO is not obligated to reimburse the non-Participating Provider more than the comparable Medical Assistance or Medicare fee-for-service rate or its equivalent, unless another rate is required by law.

6.21 Residents of Nursing Facilities. If a medical service eligible for coverage under this Contract has been ordered by a participating physician or dentist for an Enrollee residing in a Nursing Facility, the MCO is responsible for providing the Medically Necessary service and covering the cost of the service required by the physician's or dentist's order.

6.22 Time Frame to Evaluate Requests for Services.

6.22.1 General Request for Services. The MCO must evaluate all requests for services, either by Participating Providers or Enrollees within ten (10) business days of receipt of the request for services. The MCO must communicate its decision on all requests for services to the Enrollee or his or her authorized representative and the appropriate Provider as expeditiously as the Enrollee's health condition requires, but no later than the evaluation determination.

6.22.2 Request for Urgent Services. If the need is Urgent Care Services, or for services appropriate to decrease the possibility of Institutionalization, the MCO must evaluate the request for services and communicate its decision to the Enrollee or authorized representative and the Provider within an expedited time frame appropriate to the type of service and the need for service that has been requested by the Enrollee or requested on the Enrollee's behalf. The MCO shall in no circumstance allow such reviews to exceed seventy-two (72) hours.

6.22.3 Request for Long Term Care Consultation. The MCO must provide for a Long Term Care Consultation within fifteen (15) calendar days of an Enrollee request.

6.22.4 Request for Mental Health and/or Chemical Dependency (CD) Services. The MCO must provide Mental Health and/or CD services in a timely manner. Enrollees requiring CD services or Enrollees needing mental health crisis intervention services should be seen immediately. Other Enrollees in need of mental health and CD services should have an appropriate assessment performed within two (2) weeks.

6.22.5 At Risk of Nursing Facility Placement Services. The MCO shall provide Medically Necessary and cost-effective services to the Enrollee and offer Home and Community-Based Services (through the MCO) that are designed to prevent placement of a NHC Enrollee into a Nursing Facility.

6.23 Services Received at Indian Health Care Providers.

6.23.1 Access American Indian Enrollees, living on or off the reservation, will have direct out-of-network access to Indian Health Care Providers, for services that would otherwise be covered under Minnesota Statutes, § 256B.0625, even if such facilities are not Participating Providers. The MCO shall not require any Service Authorization or impose any condition for an American Indian to access services at such facilities.

6.23.2 Referrals from Indian Health Care Providers.

(A) When a physician in a IHCP facility refers an American Indian Enrollee to a Participating Provider for services covered under this Contract, the MCO shall not require the Enrollee to see a Primary Care Provider prior to the referral.

(B) The Participating Provider to whom the IHCP physician refers the Enrollee may determine that services are not Medically Necessary or not covered.

6.23.3 Home Care Service Assessments. See section 6.1.14(E) for requirements specific to Tribal Community Members and home care assessments.

6.23.4 Copayments for American Indian Enrollees The MCO shall cooperate in assuring that the IHCP and Providers providing Contract Health Services (IHS CHS) through referral from IHS facilities do not charge copayments to American Indians pursuant to section 4.19.1(A)(4).

6.23.5 STATE Payment for IHS and Tribal Facility Services. The STATE shall pay 638 Facilities directly for services provided to American Indian Enrollees under this Contract, including Elderly Waiver services provided by a tribe under contract with the STATE.

(A) Data on American Indian Enrollees. The STATE shall send an electronic report of the American Indians enrolled in the MCO on a monthly basis, as part of the enrollment data, using the most complete and accurate means available to the STATE. The STATE shall provide the MCO with a statement of encounters by Enrollees electronically, on a quarterly basis, by the 15th day of the month following the end of the calendar quarter, which shall describe the date of service, the Enrollee, and the diagnosis code.

(B) Elderly Waiver Reimbursements. The STATE shall obtain reimbursement from the MCO, on an annual basis and through reasonable means, for payments to Indian Health Care Provider facilities for Elderly Waiver services provided to Enrollees that would be covered under this Contract; however, the financial liability of the MCO for these services, in aggregate for all Enrollees who utilized the Indian Health Care Provider facilities during the Contract Year, shall be limited to forty percent (40%) of the aggregate annual capitated payment amount for these American Indian Enrollees.

(C) The STATE shall not obtain reimbursement for any quarter in which the STATE fails to provide the electronic quarterly report of all its paid Elderly Waiver encounters on a timely basis.

(D) Upon receipt of the statement of encounters, if the MCO determines that duplicate Elderly Waiver claims have been submitted to both the STATE and the MCO, the MCO shall provide that claim information to the STATE within sixty (60) days, and the STATE shall, at its discretion: (A) recover the STATE payment to the IHS/638 facility and subtract the amount from the MCO's reimbursement owed to the STATE; or (B) recover a portion of the STATE's payment to the IHS/638 facility that reflects the payment made by the MCO, and adjust the MCO's reimbursement owed to the STATE accordingly.

(E) If a tribe authorizes services covered under the State Plan for Elderly Waiver tribal Enrollees, those State Plan service costs shall not be recovered by the STATE, as they are already taken into consideration and reflected in the current rates paid under this Contract.

6.23.6 Payment for IHCPs That Are Not IHS and 638 Facilities Consistent with section 5006(d) of the American Recovery and Reinvestment Act of 2009, MCO must pay an Urban Indian Organization that is an FQHC (but not a Participating Provider with the MCO) for the provision of covered services to an American Indian Enrollee at a rate equal to the amount of

payment that the entity would pay an FQHC that is a Participating Provider (but is not an IHCP) for such services.

(A) In the case of an IHCP that is not an IHS or 638 Facility nor FQHC, and for IHS Contract Health Services, the MCO must

(1) pay for covered services (at Participating or non-Participating Providers) provided to American Indian Enrollees at a rate equal to the rate negotiated between the MCO and the Provider or,

(2) if such a rate has not been negotiated, the MCO must make payment at a rate that is not less than the level and amount of payment which the MCO would make if the services were furnished by a Participating Provider which is not an IHCP; and

(3) the MCO must make payment at a rate that is not less than the State Plan rate for the service.

6.23.7 Cooperation. The MCO agrees to work cooperatively with the STATE, other MCOs under contract with the STATE, and tribal governments to find mutually agreeable mechanisms to implement this section, including but not limited to a common notification form by which tribal governments may report referrals to the MCO.

6.24 Access to Culturally and Linguistically Competent Providers. To the extent possible, the MCO shall provide Enrollees with access to Providers who are culturally and linguistically competent in the language and culture of the Enrollee. For the purpose of this Contract, cultural and linguistic competence includes Providers who serve Enrollees that are deaf and use sign language or an alternative mode of communication.

(A) Providers. The MCO agrees to work towards increasing the Provider pool of culturally and linguistically competent Providers where there is an identified need, including but not limited to, participating in STATE efforts to increase the Provider pool of culturally and linguistically competent Providers, and participating in the STATE's needs assessment process and related planning effort to expand the pool.

(B) Access. Nothing in this section shall obligate an MCO to contract or continue to contract with a Provider if the MCO has determined that it has sufficient access for Enrollees to culturally and linguistically competent Providers and/or if the Provider does not meet the MCO's participation criteria, including credentialing requirements.

Article. 7 Quality Assessment and Performance Improvement.

7.1 Quality Assessment and Performance Improvement Program. The MCO shall provide a Quality Assessment and Performance Improvement Program consistent with federal requirements under Title XIX of the Social Security Act, 42 CFR Part 438, Subpart D, and as required pursuant to Minnesota Statutes, Chapters 62D, 62M, 62N, 62Q and 256B and related rules, including Minnesota Rules, Part 4685.1105 to 4685.1130, and applicable NCQA "Standards and Guidelines for the Accreditation of Health Plans," as specified in this Contract. For MSHO, the Quality Assessment and Performance Improvement Program must also meet the

quality review requirements for Medicare Advantage contractors specified in Title XVIII, §1852(e) of the Social Security Act (42 U.S.C. § 1395w-22) and the implementing regulations at 42 CFR Part 422.152-158.

The MCO must comply with the applicable requirements of CMS' "*Quality Framework,*" for EW services, as incorporated into the Waiver Quality Assurance Planning Survey submitted to the STATE bi-annually beginning October 15th , and every other year thereafter.

The MCO shall have an ongoing quality assessment and performance improvement program for the services it furnishes to all Enrollees ensuring the delivery of quality health care.

7.1.1 Scope and Standards. The MCO must incorporate into its quality assessment and improvement program the standards as described in 42 CFR § 438, subpart D (Access, Structure and Operations, and Measurement and Improvement). At least annually, the MCO must assess program standards to determine the quality and appropriateness of care and services furnished to all Enrollees. This assessment must include monitoring and evaluation of compliance with STATE and CMS standards and performance measurement.

7.1.2 Information System. The MCO must operate an information system that supports initial and ongoing operations and quality assessment and performance improvement program. The MCO must maintain a health information system that collects, analyzes, integrates, and reports data, and can achieve the following objectives:

(A) Collect data on Enrollee and Provider characteristics, and on services furnished to Enrollees;

(B) Ensure that data received from Providers is accurate and complete by:

(1) Verifying the accuracy and timeliness of reported data;

(2) Screening or editing the data for completeness, logic, and consistency; and

(3) Collecting service information in standardized formats to the extent feasible and appropriate.

(C) Make all collected data available to the STATE and CMS upon request.

7.1.3 Utilization Management The MCO shall adopt a utilization management structure consistent with state and federal regulations and current NCQA "*Standards and Guidelines for the Accreditation of Health Plans*." Pursuant to 42 CFR § 438.240(b)(3), this structure must include an effective mechanism and written description to detect both under- and over-utilization of services.

(A) Ensuring Appropriate Utilization. The MCO shall facilitate the delivery of appropriate care and monitor the impact of its utilization management program to detect and correct potential under- and over-utilization. The MCO shall:

(1) Choose the appropriate number of relevant types of utilization data, including one type related to behavioral health to monitor.

(2) Set thresholds for the selected types of utilization data and annually quantitatively analyze the data against the established thresholds to detect under- and over-utilization.

(3) Examine possible explanations for all data not within thresholds.

(4) Analyze data not within threshold by medical group or practice.

(5) Take action to address identified problems of under- and over-utilization and measure the effectiveness of its interventions.

7.1.4 Special Health Care Needs. The MCO must have effective mechanisms that assess the quality and appropriateness of care furnished to Enrollees with special health care needs. All Enrollees covered by this Contract are considered to meet the STATE's criteria for special needs.

(A) Identification and Assessment. Pursuant to sections 6.1.3 and 6.1.4 of the Contract, the MCO shall perform a comprehensive assessment or screening on all Enrollees and identify any ongoing special conditions of the Enrollee that may require a course of treatment or regular care monitoring.

(B) Care Plans. For Enrollees with special health care needs as determined through assessment, the MCO shall develop and implement a care plan as required by the Contract in sections 6.1.3, 6.1.4, and 6.1.5. The Care Plan must be:

(1) Developed by the Care Coordinator/Case Manager in conjunction with the Enrollee's Primary Care Provider and with Enrollee participation, and in consultation with any specialists caring for the Enrollee.

(2) Approved by the MCO in a timely manner, if approval is required by the MCO.

(C) Access to Specialists. If the assessment determines the need for a course of treatment or regular care monitoring the MCO must have a mechanism in place to allow Enrollees to directly access a specialist as appropriate for the Enrollee's condition and identified needs. The MCO's mechanism may be to use a standing referral or an approved number of visits as appropriate for the Enrollee's condition and identified needs.

(D) Items Required for Review and Evaluation by the STATE. The MCO shall submit to the STATE the following items for review and evaluation by the STATE: the Care Plan, Case Management and Care System audit reports and audit protocols as required in sections 7.9.3 and 9.3.9, and the Waiver Quality Assurance Planning Survey, required in section 7.9.4. The MCO must submit to the STATE the written Care Plan, County Case Management and Care System audit reports and audit protocols by September 15th of each year, and the Waiver Quality Assurance Plan Survey beginning October 15th, 2010, and every other year thereafter. If there are no

changes to a particular report or description, the MCO shall notify the STATE that there are no changes to that item.

7.2 Practice Guidelines. The MCO shall adopt preventive and chronic disease practice guidelines appropriate for Enrollees age sixty-five (65) and older, consistent with accepted geriatric practices.

(A) Adoption of practice guidelines. The MCO shall adopt guidelines that: 1) Are based on valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field; 2) consider the needs of the MCO Enrollees; 3) Are adopted in consultation with contracting Health Care Professionals: and 4) are reviewed and updated periodically as appropriate.

(B) Dissemination of guidelines. The MCO shall ensure that guidelines are disseminated to all affected Providers and, upon request, to Enrollees and Potential Enrollees.

(C) Application of guidelines. The MCO shall ensure that these guidelines are applied to decisions for utilization management, Enrollee education, coverage of services, and other areas to which there is application and consistency with the guidelines.

(D) Audit of Provider Compliance. The MCO shall audit a reasonable sample of its Providers (by physician or clinic) to determine Provider compliance with the practice guidelines the MCO has chosen as high priority to audit, using an appropriate data source. The MCO shall incorporate into, or include as an addendum, the MCO's Annual Quality Assessment and performance improvement program evaluation (as required in Contract section 7.2.4), a written summary that shall include:

(1) How the MCO implemented this subsection 7.2(A) through (D).

(2) A description of all adopted guidelines, source of guidelines, date the guideline was reviewed and/or revised, including which guidelines are in place, and identify those guidelines that are applicable to, and/or modified for Enrollees under this Contract;

(3) The results of the audit,

(4) Improvement strategies and/or corrective action that will be undertaken if appropriate.

(5) If the MCO adds information to this section as an addendum, then the addendum must include an evaluation of parts (1) through (4) above.

7.2.2 Credentialing and Recredentialing Process. The MCO shall adopt a uniform credentialing and recredentialing process and comply with that process consistent with State regulations and current NCQA "*Standards and Guidelines for the Accreditation of Health Plans*." For organizational Providers, including nursing facilities, hospitals, and Medicare

certified home healthcare agencies; the MCO shall adopt a uniform credentialing and recredentialing process and comply with that process consistent with State regulations.

(A) Waiver service Providers and PCPAs are exempt from this requirement.

(B) Selection and Retention of Providers. The MCO must implement written policies and procedures for the selection and retention of Providers.

(C) Process for Credentialing and Recredentialing. The MCO must follow a documented process for credentialing and recredentialing of those Providers who are subject to the credentialing and recredentialing process and have signed contracts or participation agreements with the MCO.

(D) Discrimination Against Providers Serving High-Risk Populations. The MCO is prohibited from discriminating against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

(E) Sanction Review. The MCO shall ensure prior to entering into or renewing an agreement with a Provider, that the Provider:

(1) Has not been sanctioned for fraudulent use of federal or State funds by the U.S. Department of Health and Human Services, pursuant to 42 U.S.C. §1320 a-7(a) or by the STATE; or

(2) Is not debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 (51 F.R. 6370, February 18, 1986) or under guidelines interpreting such order, or

(3) Is not an affiliate of such a Provider.

(4) The MCO shall not knowingly contract with such a Provider.

(F) Restricting Financial Incentive. The MCO may not give any financial incentive to a health care Provider based solely on the number of services denied or referrals not authorized by the Provider, pursuant to Minnesota Statutes, §72A.20, subd. 33 and as required under 42 CFR §417.479 and for MSHO, 42 CFR §422.208.

(G) Provider Discrimination. The MCO shall not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of the Provider's license or certification under applicable State law, solely on the basis of such license or certification. This section shall not be construed to prohibit the MCO from including Providers only to the extent necessary to meet the needs of the MCO's Enrollees or from establishing any measure designated to maintain quality and control costs consistent with the responsibilities of the MCO. If the MCO declines to include individuals or groups of Providers in its network, it must give the affected Providers written notice of the reason for its decision.

(H) Affiliated Provider Access Standards. The MCO shall require all affiliated Providers to meet the access standards required by section 6.12 above, and applicable State and federal laws. The MCO shall monitor, on a periodic or continuous basis, but no less than every twelve (12) months, the Providers' adherence to these standards.

7.2.3 Annual Quality Assurance Work Plan. On or before May 1st of each Contract Year, the MCO shall provide the STATE an annual written work plan that details the MCO's proposed quality assurance and performance improvement projects for the year. This report shall follow the guidelines and specifications contained in Minnesota Rules, Part 4685.1130, subpart 2, and current NCQA "*Standards and Guidelines for the Accreditation of Health Plans*."

(A) If the MCO chooses to substantively amend, modify or update its work plan at any time during the year, it shall provide the STATE with material amendments, modifications or updates in a timely manner.

(B) The work plan must include specific references to activities that are to be conducted during the year and affect the MSHO and MSC+ population.

(C) MSHO MCO/SNPs may combine their Medicare and Medicaid Quality Assurance Work Plans to the extent specifically applicable to the MSHO population and to the extent the combined plan meets the STATE's requirements. If the MSHO Dual Eligible MCO/SNP submits a separate work plan to CMS, the MCO will provide a timely copy to the STATE.

7.2.4 Annual Quality Assessment and Performance Improvement Program Evaluation. The MCO must conduct an annual quality assessment and performance improvement program evaluation consistent with state and federal regulations, including the CMS "*Quality Framework for the Elderly Waiver*" and current NCQA "*Standards and Guidelines for the Accreditation of Health Plans*." This evaluation must review the impact and effectiveness of the MCO's quality assessment and performance improvement program including performance standard measures and MCO's performance improvement projects. The MCO must submit the written evaluation to the STATE by May 1st of each Contract Year.

(A) The evaluation must also include an analysis on the impact and effectiveness of MSHO's Care Coordination activities.

(B) For MSHO MCO/SNPs, this evaluation may be combined with the required Medicare evaluation, provided it is conducted at the Dual Eligible SNP plan level; is applicable to the MSHO population; and meets the above criteria.

7.3 Performance Improvement Projects (PIP). The MCO agrees to operate ongoing PIPs that incorporate the standards and guidelines outlined by CMS with modifications as defined by the STATE. The MCO must conduct PIPs designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction. The MCO must conduct the PIP in accordance with state and federal protocols. Projects must comply with 42 CFR §438.240(b)(1) and (d) and CMS protocol entitled *Conducting Performance Improvement Projects*.

7.3.1 PIP Collaborative. The MCO is encouraged to continue participation in PIP Collaborative initiatives that coordinate PIP topics and designs between SNPs. The MSHO MCO may use their Medicare performance improvement projects to meet Medicaid requirements if they are approved as required, conducted and reported at the Dual Eligible SNP plan level, applicable to the MSHO population enrolled, and all other requirements in section 7.3 above are met. To the extent that additional, different, or separate PIPs are developed and reported to CMS, the MSHO SNP will provide the State with copies of PIP proposals to CMS and PIP reports submitted to CMS within fifteen (15) days of submission.

7.3.2 New Performance Improvement Project Proposal. On or before September 1st of each Contract Year, the MCO must submit to the STATE for review and approval a written description of the PIP the MCO proposes to conduct beginning the first quarter of the next calendar year. The project proposal(s) must be consistent with CMS published protocol entitled "*Protocol for Use in Conducting Medicaid External Quality Review Activities, Conducting Performance Improvement Projects*" and STATE requirements. The new PIP proposal must include steps one through seven of the CMS protocol. This PIP must be targeted to the MCO's senior populations.

7.3.3 Performance Improvement Project Interim Progress Assessment. By December 1st of each Contract Year, the MCO must produce an interim performance improvement project report for each current project.

(A) The interim project report must include any changes to the project(s) protocol steps one through seven and steps eight and ten as appropriate.

(B) If the MCO makes changes to the STATE approved PIP success measures, the MCO shall submit changes to the STATE for approval.

(C) Upon request of the STATE, the MCO shall make available to the STATE, or the STATE's designated review agency, a copy of the reports.

7.3.4 Final Performance Improvement Project. The MCO must submit to the STATE for review and approval, upon completion of each PIP, a final written report by September 1st of the Contract Year. The report must include any changes to protocol steps one through ten as appropriate. Each completed project must have a separate report.

7.3.5 Performance Improvement Project Life Cycle. The project lifecycle must be based upon the project's measurement periodicity, such that there are two measurement periods after the project has been demonstrated to have obtained a statistically significant improvement (p value of 0.05 or less). A p value must only be considered in the event that a sampling methodology is used. Implementation of the project must begin within the first quarter of the year following the September 1st submission date.

7.3.6 Termination of a Performance Improvement Project. In the rare event that a project, after extensive MCO efforts to assess and correct barriers, fails to achieve statistical significance, the MCO may submit a written request to terminate the project. The request must demonstrate; 1) why the project was unable to result in significant improvement, sustained over time; 2) the MCO's efforts to resolve project barriers; and 3) an explanation of why these

barriers were not addressed during the original proposal. The MCO is encouraged to provide information on how the project may have achieved "meaningful improvement" as defined by NCQA in the written termination request. MSHO SNPs will provide timely notice to the STATE of the termination of any Medicare PIP applicable to the enrolled MSHO population.

7.3.7 Performance Improvement Project Categories. The MCO agrees to work with the STATE on developing Performance Improvement Projects for Seniors. PIP topics should address the full spectrum of clinical and nonclinical areas associated with the MCO and not consistently eliminate any particular subset of enrollees or topics when viewed over multiple years.

7.4 Disease Management Program. The MCO shall make available a Disease Management (DM) Program for its Enrollees with diabetes and heart disease. These programs shall be tailored to meet the appropriate clinical needs of Enrollees under this contract. The MCO shall provide information to the State on how the disease management program has been tailored to meet to meet these needs in the annual evaluation, and within thirty (30) days of adoption of any new DM programs applicable to Enrollees under this contract.

(A) DM Program Standards. The MCO's DM Program shall be consistent with current NCQA "*Standards and Guidelines for the Accreditation of Health Plans*" pursuant to the QI Standard for Disease Management.

(B) Waiver of DM Program Requirement. If the MCO is able to demonstrate that a DM Program: 1) is not effective based upon Provider satisfaction, and is unable to achieve meaningful outcomes; or 2) would have a negative financial return on investment, then the MCO may request that the STATE waive this requirement for the remainder of the Contract Year.

7.5 Enrollee Satisfaction Surveys. The STATE shall conduct an annual Enrollee satisfaction survey, and if necessary, the MCO shall cooperate with the entity arranged by the STATE to conduct the survey.

7.5.1 MSC+ Disenrollment. For MSC+ only, Enrollee disenrollment, as measured by an ongoing survey conducted by the STATE or its designee in the manner required in Minnesota Statutes, Chapter 62J. The MCO shall cooperate with the STATE or its designee in collection activities as directed by the STATE. If the MCO or any of its contracted Care Systems conduct an Enrollee disenrollment survey that involves MSHO Enrollees, the MCO must provide the STATE with a copy of the survey results in a timely manner.

7.5.2 Consumer Survey. The MCO agrees to work with the STATE, as necessary, for the STATE's survey of Elderly Waiver consumers. The STATE will consult with the MCO on the survey tool.

7.5.3 Additional Satisfaction Surveys. If the MCO or any of its contracted Care Systems conduct an Enrollee satisfaction survey that involves MSC+ or MSHO Enrollees, including the Medicare Consumer Assessment of Health Plan Satisfaction (CAHPS), the MCO must provide the STATE with a copy of the survey results in a timely manner.

7.6 External Quality Review Organization (EQRO). The MCO shall cooperate with the entity as arranged for by the STATE in an annual independent, external review of the quality of services furnished under this Contract, as required under 42 U.S.C. §1396a(a)(30), and 42 CFR Part 438, subpart E; such cooperation shall include, but is not limited to 1) meeting with the entity and responding to questions, 2) providing requested medical records and other data in the requested format; and 3) providing copies of MCO policies and procedures, and other records, reports and/or data necessary for the external review.

7.6.1 Nonduplication of Mandatory External Quality Review (EQR) Activities. To avoid duplication, the STATE may use information collected from Medicare or private accreditation reviews in place of a Medicaid review by the STATE, its agent, or EQRO, when the following required terms are met:

(A) Complies with federal requirements (42 CFR §438.360);

(B) CMS or accrediting standards are comparable to standards established by the STATE and identified in the STATE's Quality Strategy;

(C) MCOs must have received an NCQA accreditation rating of excellent, commendable, or accredited; and

(D) All Medicare or accrediting reports, findings or results related to the services under this Contract are provided to the STATE.

7.6.2 Exemption from EQR. The MCO may request from the STATE an exemption to the EQR, if the MCO meets federal requirements (42 CFR §438.362) and is approved by the STATE and CMS.

7.6.3 Review of EQRO Annual Technical Report Prior to Publication. The STATE shall allow the MCO to review a final draft copy of the EQRO Annual Technical Report prior to the date of publication. The MCO shall provide the STATE any written comments about the report, including comments on its scientific soundness or statistical validity, within thirty (30) days of receipt of the final draft report. The STATE shall include a summary of the MCO's written comments in the final publication of the report, and may limit the MCO's comments to the report's scientific soundness and/or statistical validity.

7.6.4 EQRO Recommendation for Compliance. Pursuant to 42 CFR §438.364(a)(5), the MCO shall effectively address recommendations for improving the quality of health care services made by EQRO in the Annual Technical Report for obligations under this Contract.

7.7 Delegation of Quality Improvement Program Activities. The MCO shall meet the requirements for delegation for any delegated activities related to quality improvement. Reviews of Care Systems shall be conducted according to the annual Care System review described in section 9.3.9.

7.8 Annual Performance Measures.

(A) The MCO will provide the STATE the following within thirty (30) days of submission to NCQA: 1) HEDIS report submitted to CMS for MSHO in an Excel spreadsheet format; and 2) upon request, the documentation submitted to CMS for the MSHO Structure and Process Measures.

(B) The MCO will provide the STATE the following within thirty (30) days of receipt from CMS: the summarized results of the MSHO Structure and Process Measures reported by NCQA.

7.9 Care Coordination and Case Management Documentation.

7.9.1 MCO Collaboration. The MCO shall collaborate with the STATE and other MCOs to promote Care Coordination and Case Management efforts and measure its effectiveness through an intervention on a mutually agreed upon topic by the STATE, the MCO and the other MCOs.

7.9.2 MCO Cooperation. The MCO will cooperate with any research or evaluation of Care Coordination and/or Case Management conducted by the STATE, CMS or their contractors.

7.9.3 Care Plan Audits. The MCO shall audit a sample of Care Plans for EW Enrollees. The sample must follow appropriate sampling methodology. The MCO must use a protocol submitted to and approved by the STATE that follows the Care Planning audit data abstraction protocol developed by the Care Plan audit work group. This protocol incorporates requirements for EW services and Case Management as appropriate for the Enrollee. Audit results must be submitted to the STATE along with any Care System and/or Care Plan audits as required under section 9.3.9, by September 15th of each year. MDH will audit a sample of care plans for EW Enrollees from each MCO during its triennial compliance audit.

7.9.4 Waiver Quality Assurance Plan Survey. The MCO will submit the Waiver Quality Assurance Plan Survey, using the tool designated by the STATE, by October 15th, and every other year thereafter.

7.10 Enrollment Data by Care System. Upon request, the MCO shall submit to the STATE enrollment data for each delegated Care System by Rate Cell Category and Care System within thirty (30) days of the request.

7.11 Cooperation with Independent Assessment. The MCO will cooperate with any independent assessment of the MSHO program or of the MSC+ 1915(b)(c) waivers conducted by the STATE, its contractors, or CMS.

7.12 Inspection. The MCO shall provide that the STATE, or its agents may evaluate through inspection or other means, the quality, appropriateness, and timeliness of services or administrative procedures performed under this Contract.

7.13 Workgroup Participation. The MCO is encouraged to appoint representatives to participate in the STATE's workgroups as follows:

(A) Care Coordination; and

(B) Clinical Practice and Performance Measurement. This group will provide input on geriatric clinical practice that includes implementing practice models based on Medical Home concepts, identifying best clinical practices and related performance measurement, integration of new Medicare SNP measures and protocol requirements and ongoing implementation of the Comprehensive Elder Health Evaluation (CEHE) incentive.

(C) Quality Technical Committee covering EQR activities, surveys, Quality Strategy, and

(D) The collaborative quality improvement committee, covering measurement alignment, collaborative and priority initiatives

7.14 Financial Performance Incentives.

7.14.1 Compliance and Limits. Incentives, if any, must comply with the federal managed care incentive arrangement requirements pursuant to 42 CFR § 438.6(c)(1)(iv); (2)(i); (4)(ii) and (iv); (5)(iii) and (iv) and the State Medicaid Manual (SMM) 2089.3, and to the extent that funds are available.

7.14.2 Federal Limit. The total of all payments paid to the MCO under the contract, including any incentives paid under this section, shall not exceed one hundred and five percent (105%) of the Capitation Payments, pursuant to 42 CFR § 438.6(c)(5)(iii), as applicable to each group of Rate Cells covered under the incentive arrangement. If the incentive applies to the entire population covered under the Contract, the limit will apply in aggregate.

7.14.3 Collaboration. MCOs are encouraged to join with other MCOs in collaborative initiatives to expand these preventive services.

7.14.4 Critical Access Dental Payment.

(A) The MCO shall participate in a dental access initiative whereby the MCO agrees to provide increased reimbursement to designated dentists for services for Medical Assistance in accordance with the following:

(1) Designation of Critical Access Dental Providers. The STATE shall provide to the MCO a list of designated dental Providers for the Critical Access dental payment quarterly at the end of February, May, August and November.

(2) Quarterly Reporting of Dental Payments to Designated Critical Access Dental Providers. The MCO shall provide for each quarter no later than the 15th of the month following the end of the quarter the total payment amount paid to the specific designated Critical Access dental Provider, in a format specified by the STATE. For each Provider listed, the MCO shall report payments for the major programs Medical Assistance and MinnesotaCare separately. The report must be certified in accordance with section 9.17.

(3) Critical Access Dental Payments to Designated Critical Access Dental Providers.

(a) The STATE shall calculate the Critical Access dental payment for each designated Provider identified in the MCO's quarterly report, and provide to the MCO a payment report that will identify the amount of critical access dental payment to be paid to each designated Provider.

(b) For Medical Assistance, this amount shall be thirty percent (30%) more than the amount that was reported by the MCO on its quarterly report, consistent with Minnesota Statutes, § 256B, subd. 4.

(c) The STATE will issue a gross payment adjustment to the MCO that will be the sum of the Critical Access dental payment amounts for the Providers identified in the quarterly report. The MCO shall distribute the Critical Access dental payments as specified in the STATE's payment schedule.

(d) In the event that a designated dental provider provides notice to the STATE that a payment by the MCO is incorrect, the MCO remains responsible for the payment after verification of the correct payment.

7.14.5 Annual Comprehensive Elder Health Evaluation Clinical Incentive Measure. All MCOs participating in MSHO and MSC+ will participate in the Annual Comprehensive Elder Health Evaluation (CEHE) Clinical Incentive Program, a provider-based financial incentive program to facilitate an annual comprehensive preventive geriatric care evaluation for Enrollees whereby MCOs pass incentive payments to Providers completing specific services in accordance with the program. MCOs will continue to work in cooperation with STATE's elder care guidelines and measurement work group to develop selected screening, referral, and follow-up practice guidelines and related measurement and incentive methodologies. The CEHE measurement and incentive methodology for implementation is as follows:

(A) For each annual CEHE visit per Enrollee billed with CPT code 99387 (new patient) or 99397 (existing patient), the MCO will receive $15 and the Provider clinic will receive $15, or

(B) For each annual CEHE visit per Enrollee billed with CPT code 99387 (new patient) or 99397 (existing patient) with F-codes for Influenza (1030F) and Pneumococcal (1022F) immunizations status assessment, plus F-codes for visual functional status assessed (1055F), the presence of urinary incontinence assessed (1090F), and mental status assessed (2014F), the MCO will receive $25 and the Provider clinic will receive $40.

(C) The CEHE incentive will be calculated by the STATE using relevant encounter data for the period of the Contract Year. The encounter data for the purpose of calculating the annual CEHE incentive must received by the STATE no later than May 31 of the year following the Contract Year. The STATE may request verification of provider payments.

7.14.6 Pay for Performance. The MCO shall cooperate with the STATE to develop and implement a pay-for-performance model for chronic disease care.

(A) The STATE, as a member of the guiding coalition for the Minnesota Bridges to Excellence (BTE) health care quality initiative, has contracted with the Buyers Health Care Action Group (BHCAG) to implement the pay-for-performance BTE program. All private payers and the STATE participating in the pay-for-performance program contribute incentive payments based on the payer's proportionate share of enrollees served by the clinics or medical groups.

(B) BHCAG calculates the incentive payment annually between May 1 and September 1, and provides a report to the MCOs and the State. As a participant in the program, the STATE pays the incentive reward payments to the MCO based on criteria established by BHCAG. The MCOs pay to BHCAG the same incentive reward payment. BHCAG then distributes the appropriate payment to the eligible clinics or medical groups based on their performance level of providing optimal chronic disease care.

(C) In order to receive the annual pay-for-performance reward, the MCO contracted clinic or medical group must have achieved optimal chronic disease care for a designated percentage of its patients, as determined by the BHCAG. The pay-for-performance projects are limited to:

(1) Diabetes Care, and

(2) Coronary/Vascular Disease Care.

7.15 Minnesota Community Measurement. The STATE will work with MDH and the marketplace of purchasers and Providers on the development and application of the MN Community Measurement programs supporting MHCP. The MCOs shall retain and apply the race and ethnicity data supplied by the STATE when needed for MNCM programs supporting MHCP.

7.16 Medicare Medication Therapy Management Programs. The MSHO SNP will provide the STATE with an update of its current Medicare Medication Therapy Management programs and protocols upon request of the STATE each Contract Year.

Article. 8 The Grievance System: Grievances, Notices of Action (DTR) Appeals, and State Fair Hearings.

8.1 General Requirements.

8.1.1 Components of Grievance System. The MCO must have a Grievance System in place that includes a Grievance process, an Appeal process, and access to the State Fair Hearing system. For MSHO this system must include a Medicare process for Medicare covered services and a Medicaid process, and MSHO Enrollees shall have the right to choose which or both processes to pursue. The overall system must:

(A) Assure compliance with Medicare and Medicaid requirements; and

(B) Preserve MSHO Enrollees' access to all appropriate levels of Medicare and Medicaid appeals; and

(C) To the extent possible, integrate both processes to make the system easier to navigate for the MSHO Enrollee.

8.1.2 Timeframes for Disposition. The MCO must dispose of each Grievance and resolve each Appeal, and provide notice as expeditiously as the Enrollee's health condition requires, but no later than timeframes set forth in this Article. For MSHO, in instances where the MCO's integrated system described in section Article. 8 creates timeline conflicts, the MCO must apply the timeline that benefits the Enrollee to the greatest extent.

8.1.3 Legal Requirements. The Grievance and Appeals System must meet requirements of Minnesota Statutes, § § 62M.06, 256.045, subd. 3a; (excluding the reference to Minnesota Statutes §62D.11) 42 CFR § 438, Subpart F. For MSHO, as a Medicare integrated product, the Grievance and Appeals system must also meet the requirements of 42 CFR § 422, Subpart M.

8.1.4 STATE Approval Required. The MCO's Grievance System is subject to approval by the STATE. This requires that:

(A) Any proposed changes to the Grievance System must be approved by the STATE prior to implementation.

(B) The MCO must send written notice to Enrollees of significant changes to the Grievance System at least thirty (30) days prior to implementation.

(C) The MCO must provide information specified in 42 CFR § 438.10(g)(1) about the Grievance System to Providers and subcontractors at the time they enter into a contract.

(D) Within sixty (60) days after the execution of a contract with a Provider, (e.g. hospitals, individual Providers, and clinics), the MCO must inform the Provider of the programs under this contract, and specifically provide an explanation of the Notice of Rights and Responsibilities, and Grievance, Appeal and State Fair Hearing rights of Enrollees and Providers under this Contract.

8.1.5 Response to Investigation. Pursuant to Minnesota Statutes, § 256B.69, 3a, the MCO must respond directly to county advocates, established under Minnesota Statutes, § 256B.69, subd. 21, and the STATE ombudsman, established under Minnesota Statutes, § 256B.69, subd. 20, regarding service delivery.

8.2 MCO Grievance Process Requirements

8.2.1 Filing Requirements. The Enrollee, or the Provider acting on behalf of the Enrollee with the Enrollee's written consent, may file a Grievance within ninety (90) days of a matter involving an Enrollee's dissatisfaction about any matter other than an MCO "Action;" Examples include the quality of care or services provided, rudeness of a provider or employee, or failure to respect the enrollee's rights. A Grievance may be filed orally or in writing.

8.2.2 Timeframe for Resolution of Grievances.

(A) Oral Grievances must be resolved within ten (10) days of receipt.

(B) Written Grievances must be resolved within thirty (30) days of receipt.

(C) Oral Grievances may be resolved through oral communication, but the MCO must send the Enrollee a written decision for written Grievances.

8.2.3 Timeframe for Extension of Grievance Resolution. The MCO may extend the timeframe for resolution of a Grievance by an additional fourteen (14) days if the Enrollee or the Provider requests the extension, or if the MCO justifies a need for additional information, including how the extension is in the Enrollee's best interest. The MCO must provide written notice to the Enrollee of the reason for the decision to extend the timeframe if the MCO determines that an extension is necessary. The MCO must issue a notice of resolution no later than the date the extension expires. The STATE may review the MCO's justification upon request.

8.2.4 Handling of Grievances.

(A) The MCO must mail a written acknowledgment to the Enrollee or Provider acting on behalf of the Enrollee, within ten (10) days of receiving a written Grievance, and may combine it with the MCO's notice of resolution if a decision is made within the ten (10) days.

(B) The MCO must maintain a log of all Grievances, oral and written.

(C) The MCO must not require submission of a written Grievance as a condition of the MCO taking on the Grievance.

(D) The MCO must give Enrollees any reasonable assistance in completing forms and taking other procedural steps, including but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

(E) The individual making a decision on a Grievance shall not have been involved in any previous level of review or decision-making.

(F) If the MCO is deciding a Grievance regarding the denial of an expedited resolution of an Appeal or one that involves clinical issues, the individual making the decision must be a Health Care Professional with appropriate clinical expertise in treating the Enrollee's condition or disease. The MCO shall make a determination in accordance with the timeframe for an expedited Appeal.

8.2.5 Notice of Grievance Disposition

(A) Oral grievances may be resolved through oral communication. If the disposition, as determined by the Enrollee, is partially or wholly adverse to the Enrollee, or the oral grievance is not resolved to the satisfaction of the Enrollee, the MCO must inform the

enrollee that the grievance may be submitted in writing. The MCO must also offer to provide the enrollee with any assistance needed to submit a written grievance, including an offer to complete the Grievance form, and promptly mail the completed form to the enrollee for his/her signature pursuant to Minnesota Statutes § 62Q.69, subd. 2. In addition, the MCO must inform the enrollee of options for further assistance through the Managed Care Ombudsman and/or review by the Minnesota Department of Health.

(B) When a grievance is filed in writing, the MCO must notify the enrollee in writing of its disposition. The written notice must include the results of the MCO investigation, MCO actions relative to the grievance, and options for further review through the Managed Care Ombudsman, and the Minnesota Department of Health if the enrollee is not satisfied with the disposition.

8.3 Denial, Termination, or Reduction (DTR) Notice of Action to Enrollees. If the MCO denies, reduces or terminates services or claims that are: 1) requested by an Enrollee; 2) ordered by a Participating Provider; 3) ordered by an approved, non-Participating Provider; 4) ordered by a care manager; or 5) ordered by a court, the MCO must send a DTR notice to the Enrollee that meets the requirements of this section.

8.3.1 General DTR Requirements.

(A) The DTR must meet the language requirements of 42 CFR § 438.10(c). The DTR must also:

(1) Be understandable to a person who reads at the 7th grade reading level;

(2) Be available in alternative formats as required by section 3.2.2(B).

(3) Be approved in writing by the STATE, pursuant to section 3.2.

(4) Maintain confidentiality for Family Planning Services, (i.e. ensure that all information related to Family Planning is provided only to the Enrollee, in a confidential manner).

(5) Be sent to the Enrollee. The MCO may have its subcontractor send the DTR to the Enrollee only if MCO has received prior written approval by the STATE. The MCO must submit in advance for STATE approval any DTR notification and member rights form that will be used by subcontractor.

(B) Content of the DTR. The DTR must include:

(1) The Action that the MCO has taken or intends to take;

(2) The type of service or claim that is being denied, terminated, or reduced;

(3) A clear detailed description in plain language of the reasons for the Action;

(4) The specific federal or state regulations that support or require the Action, whichever applies. Nothing in this paragraph prevents the MCO from providing additional specific information;

(5) The date the DTR was issued;

(6) The effective date of the Action if it results in a reduction or termination of ongoing or previously authorized services;

(7) The date the MCO receives the request for Service Authorization if the Action is for a denial, limited authorization, termination or reduction of a requested services;

(8) The first date of service, if the Action is for denial, in whole or in part, of payment for a service;

(9) The STATE's language block with an MCO phone number that the Enrollees may call to receive help in translation of the notice;

(10) A phone number at the MCO where Enrollees may call to obtain information about the DTR; and

(11) The Notice of Member Rights that must include but is not limited to:

(a) The Enrollee's right (or Provider on behalf of Enrollee with the Enrollee's written consent) to file an Appeal with the MCO;

(b) The requirements and timelines for filing an MCO Appeal pursuant to 42 CFR § 438.402;

(c) The Enrollee's right to file a request for a State Fair Hearing without first exhausting MCO's Appeal procedures, or up to thirty (30) days after the MCO's final determination of the Appeal;

(d) The process the Enrollee must follow in order to exercise these rights;

(e) The circumstances under which expedited resolution is available and how to request it for an Appeal or State Fair Hearing;

(f) The Enrollee's right to continuation of benefits upon request within the time frame allowed, how to request that benefits be continued, and under what circumstances the Enrollee may be billed for these services if the Enrollee files an Appeal at the MCO or requests a State Fair Hearing;

(g) The right to seek an expert medical opinion from an external organization in cases of Medical Necessity at the STATE's expense, for consideration at State Fair Hearings;

(h) A "PCA Notice of Member Rights" if the denial, termination or reduction is for PCA services. In the event that both PCA and other services are addressed in one Action, the Enrollee is entitled to both Notices of Member Rights.

(C) Notice to Provider. The MCO must also notify the Provider of the Action. For denial of payment, notice may be in the form of an Explanation of Benefits (EOB), Explanation of Payments, or Remittance Advice. The MCO must also notify the Provider of the right to Appeal a DTR pursuant to section 8.4, and provide an explanation of the Appeal process. This notification may be through Provider contracts, Provider manuals, or through other forms of direct communication such as Provider newsletters.

(D) Notice to Enrollee of Right to Quality Improvement Organization Review for MSHO. The MCO shall ensure that the MSHO Enrollee is notified of the right to request an immediate Quality Improvement Organization (QIO) review if the MSHO Enrollee believes she/he is being prematurely discharged from the hospital pursuant to 42 CFR §§ 422.620 and 422.622. This requirement is limited to hospital discharges and supersedes the otherwise required STATE DTR notice requirement specified in section 8.3.1of this Contract.

(E) Medicare Rights. The MCO shall ensure that the MSHO Enrollees receive timely notification of termination of Medicare services provided by a skilled nursing facility, home health agency or comprehensive outpatient rehabilitation facility in accordance with 42 CFR § 422.624. The MSHO Enrollee shall also have the right to appeal such termination to an Independent Review Entity (IRE) under 42 CFR § 422.626. This provision supersedes the otherwise required STATE DTR notice under section 8.3.1 of this contract.

8.3.2 Timing of the DTR Notice.

(A) Previously Authorized Services. For previously authorized services, the MCO must mail the Notice to the Enrollee and the attending health care provider at least ten (10) days before the date of the proposed Action in accordance with 42 CFR § 438.404(c)(1). The following criteria must also be met:

(1) The ongoing medical service must have been ordered by a participating or authorized non-Participating Provider who is a treating physician, osteopath, dentist, mental health professional, or chiropractor.

(2) The service must be eligible for payment according to Minnesota Statutes, § 256B.0625 and Minnesota Rules, Part 9505.0170 through 9505.0475.

(3) All procedural requirements regarding prior authorization must have been met.

(B) Denials of Payment. For denial of payment, the MCO must mail the DTR notice to the Enrollee at the time of any Action affecting the claim.

(C) Standard Authorizations. For standard authorization decisions that deny or limit services, the MCO must provide the notice:

(1) As expeditiously as the Enrollee's health condition requires,

(2) To the attending Health Care Professional and hospital by telephone within one working day after making the determination;

(3) To the Provider, Enrollee and hospital, in writing, and which must include the process to initiate an appeal, within ten (10) business days following receipt of the request for the service, unless the MCO receives an extension of the resolution period pursuant to section 8.3.28.3.2(E).

(D) Expedited Authorization. For expedited Service Authorizations, the MCO must provide the authorization as expeditiously as the Enrollee's health condition requires, not to exceed seventy-two (72) hours of receipt of the request for the service. Expedited Service Authorizations are for cases where the Provider indicates or the MCO determines that following the standard timeframe could seriously jeopardize the Enrollee's life or health, or ability to attain , maintain or regain maximum function.

(E) Extensions of Time. The MCO may extend the timeframe by an additional fourteen (14) days for resolution of a standard authorization if the Enrollee or the Provider requests the extension, or if the MCO justifies a need for additional information and how the extension is in the Enrollee's interest. The MCO must provide written notice to the Enrollee of the reason for the decision to extend the timeframe, and the Enrollee's right to file a Grievance if he or she disagrees with the MCO's decision to extend. The MCO must issue a determination no later than the date the extension expires. The STATE may review the MCO's justification upon request.

(F) Delay in Authorizations. For Service Authorizations not reached within the timeframe specified in 42 CFR § 438.210(d)(1), the MCO must provide a notice of denial on the date the timeframe expires.

8.3.3 Continuation of Benefits Pending Decision.

(A) If an Enrollee files an Appeal with the MCO before the date of the Action proposed on a DTR and requests continuation of benefits within the time allowed, the MCO, in accordance with 42 CFR § 438.420(b), may not reduce or terminate the service until ten (10) days after a written decision is issued in response to that Appeal, unless the Enrollee withdraws the Appeal; or if the Enrollee has requested a State Fair Hearing with a continuation of benefits, until the State Fair Hearing decision is reached.

(B) The continuation of benefits is not required if the Provider who orders the service is not an MCO Participating Provider or authorized non-Participating Provider.

(C) For MSHO, the MCO shall not continue the service if the service is a Medicare-only covered service per Title XVIII of the Social Security Act.

(D) The termination of Consumer Directed Community Support (CDCS) services to Elderly Waiver participants is subject to a STATE Fair Hearing and Notice requirements. However, CDCS services do not continue during the STATE Fair Hearing process. If the Enrollee is still eligible for Elderly Waiver Services, the DTR Notice to the Enrollee must include the non-CDCS waiver services that the MCO authorizes as a replacement for the terminated CDCS services.

8.4 MCO Appeals Process Requirements.

8.4.1 Filing Requirements. The Enrollee or the Provider acting on behalf of the Enrollee with the Enrollee's written consent may file an Appeal within ninety (90) days of the Notice of Action, or for any other Action taken by the MCO as it is defined in 42 CFR § 438.400(b). In addition, attending Health Care Professionals may appeal utilization review decisions at the MCO level without the written signed consent of the Enrollee in accordance with Minnesota Statutes, § 62M.06. An Appeal may be filed orally or in writing. The initial filing determines the timeframe for resolution. For MSHO, if the Enrollee chooses to file an Appeal through the Medicare process under 42 CFR § 422.582, the Enrollee must file an Appeal within sixty (60) days unless the Enrollee shows good cause. Nothing shall prevent an MSHO Enrollee from pursuing both the Medicare and Medicaid process simultaneously. If the Appeal is filed orally the MCO must assist the Enrollee, or Provider filing on behalf of the Enrollee, in completing a written signed Appeal. Once the oral Appeal is reduced to a writing by the MCO, and pending the Enrollee's signature, the MCO must:

(A) Resolve the Appeal in favor of the enrollee, regardless of receipt of a signature, or

(B) If no signed Appeal is received within thirty (30) days, the MCO may resolve the Appeal as if a signed appeal were received.

8.4.2 Medicare Requests for Hearing for MSHO. The MSHO Enrollee may choose the Medicare process of the MCO's system for Medicare covered services as required in section 8.1.1. The MCO must follow 42 CFR § § 422.600 through 616, which includes Enrollee access to review by an independent review entity, Administrative Law Judge, Medicare Appeals Council and Judicial Review.

8.4.3 Timeframe for Resolution of Standard Appeals. The MCO must resolve each Appeal as expeditiously as Enrollee's health requires, not to exceed thirty (30) days after receipt of the Appeal.

8.4.4 Timeframe for Resolution of Expedited Appeals.

(A) The MCO must resolve and provide written notice of resolution for both oral and written Appeals as expeditiously as the Enrollee's health condition requires, but not to exceed seventy-two (72) hours after receipt of the Appeal. The MCO shall also notify the enrollee and attending health care professional by telephone of its determination as mandated by Minnesota Statutes, § 62M.06, subd. 2(b).

(B) If the MCO denies a request for expedited Appeal, the MCO shall transfer the denied request to the standard Appeal process, preserving the first filing date of the

expedited Appeal. The MCO must notify the Enrollee of that decision orally within twenty-four (24) hours of the request and follow up with a written notice within two days.

(C) When a decision not to certify a health care service is made prior to or during an ongoing service, and the attending health care professional believes that an expedited appeal is warranted, the MCO must ensure that the enrollee and the attending health care professional have an opportunity to appeal the determination over the telephone. In such an appeal, the MCO must ensure reasonable access to its consulting physician as authorized by Minnesota Statutes § 62M.06, subd.2(a).

8.4.5 Timeframe for Extension of Resolution of Appeals. An extension of the timeframes of resolution of Appeals of fourteen (14) days is available for Appeals if the Enrollee requests the extension, or the MCO justifies both the need for more information and that an extension is in the Enrollee's interest. The MCO must provide written notice to the Enrollee of the reason for the decision to extend the timeframe if the MCO determines that an extension is necessary. The MCO must issue a determination no later than the date the extension expires. The STATE may review the MCO's justification.

8.4.6 Handling of Appeals.

(A) All oral inquiries challenging or disputing a DTR Notice of Action or any Action as defined in 42 CFR § 438.400(b) shall be treated as an oral Appeal and shall follow the requirements of section 8.4.

(B) The MCO must send a written acknowledgment within ten (10) days of receiving the request for an Appeal and may combine it with the MCO's notice of resolution if a decision is made within the ten (10) days.

(C) The MCO must give Enrollees any reasonable assistance required in completing forms and taking other procedural steps, including but not limited to providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.

(D) The MCO must ensure that the individual making the decision was not involved in any previous level of review or decision-making.

(E) If the MCO is deciding an Appeal regarding denial of a service based on lack of Medical Necessity, the MCO must ensure that the individual making the decision is a Health Care Professional with appropriate clinical expertise in treating the Enrollee's condition or disease, as provided for in Minnesota Statutes, §§ 62M.06, 62M.09 and 42 CFR § 438.406(a)(3)(ii).

(F) The MCO must provide the Enrollee with a reasonable opportunity to present evidence and allegations of fact or law, in person, by telephone as well as in writing. For expedited Appeal resolutions, the MCO must inform the Enrollee of the limited time available to present evidence in support of the expedited Appeal.

(G) The MCO must provide the Enrollee, and his or her representative an opportunity, before and during the Appeals process, to examine the Enrollee's case file including medical records and any other documents and records considered during the Appeal process.

(H) The MCO must include as parties to the Appeal the Enrollee, his or her representative, or the legal representative of a deceased Enrollee's estate.

(I) The MCO must not take punitive action against a Provider who requests an expedited resolution or supports an Enrollee's Appeal.

8.4.7 Subsequent Appeals. If an Enrollee Appeals a decision from a previous Appeal on the same issue, and the MCO decides to hear it, for purposes of the timeframes for resolution this will be considered a new Appeal.

8.4.8 Notice of Resolution of Appeal.

(A) The MCO must provide a written notice of resolution for all Appeals, and must include in the text of the notice: 1) the results of the resolution process and date it was completed, and; 2) the Enrollee's right to request a State Fair Hearing if the resolution was not wholly favorable to the Enrollee. The MCO must include with the notice a copy of the STATE's Notice of Rights and/or PCA Notice of Rights.

(B) For Appeals of Utilization Management (UM) decisions, the written notice of resolution shall be sent to the Enrollee and the attending health care professional.

(C) The MCO must notify the enrollee and attending health care professional by telephone of its determination on an expedited appeal as expeditiously as the enrollee's medical condition requires, but no later than seventy-two (72) hours after receiving the expedited Appeal.

(D) If an Enrollee or Attending Health Care Professional is unsuccessful in an appeal of the UM determination, the MCO must provide: 1) a complete summary of the review findings, 2) qualifications of the reviewer, 3) the relationship between the Enrollee's diagnosis and the review criteria used, including the specific rationale for the reviewer's decision, consistent with Minnesota Statutes, § 62M.06 subd. 3(e) and § 72A.285.

8.4.9 Reversed Appeal Resolutions. If a decision by an MCO is reversed by the Appeal process, the MCO:

(A) Must comply with the Appeal decision promptly and as expeditiously as Enrollee's health condition requires;

(B) Must pay for any services the Enrollee already received that are the subject of the Appeal.

8.4.10 Upheld Appeal Resolutions. If the final resolution of the appeal is adverse to the Enrollee, that is if the MCO decision is upheld, the MCO may recover the cost of the services

furnished to the Enrollee while the appeal was pending, to the extent that the services were the subject of the appeal, pursuant to 42 CFR 438.420(d).

8.4.11 Additional Levels of Resolution. This article does not prohibit an MCO from offering additional levels of internal resolution mechanisms so long as the MCO complies with the minimum requirements set forth herein.

8.5 Maintenance of Grievance and Appeal Records. The MCO must maintain and make available upon request by the STATE its records of all Grievances, DTRs, Appeals and State Fair Hearings.

8.6 Reporting of Grievances to the STATE. The MCO must submit to the STATE quarterly electronic report of all oral and written Grievances that meets the following requirements:

(A) Is a comma-delimited text file, with data elements specified by the STATE and per STATE specifications, including identifying oral and written grievances separately in order to track both types of filed grievances;

(B) Grievance data is submitted through the Online Grievance/DTR/Appeals Reporting Web Application (ORWA), via MN-ITS;

(C) Is due on or before the 30th day of the month following the end of the quarter, for all oral and written Grievances resolved in the previous quarter. If the 30th day of the month falls on a weekend or holiday, the report is due to the STATE on the following business day.

8.7 Reporting of DTRs to the STATE. The MCO must submit to the STATE a quarterly DTR report, that meets the following requirements:

(A) In ASCII format, with data elements specified by the STATE, including the PMI number and major program of each Enrollee.

(B) DTR data is submitted through the Online Grievance/DTR/Appeals Reporting Web Application (ORWA), via MN-ITS;

(C) Is due on or before the 30th day of the month following the end of the quarter, for all DTRs resolved in the previous quarter. If the 30th day of the month falls on a weekend or holiday, the report is due to the STATE on the following business day.

8.8 Report of Appeals to the STATE. The MCO must submit to the STATE a quarterly electronic report of all oral and written Appeals that meets the following requirements:

(A) Is a comma-delimited text file, with data elements specified by the STATE and per STATE specifications, including identifying oral and written appeals separately in order to track both types of filed appeals;

(B) Appeal data is submitted through the Online Grievance/DTR/Appeals Reporting Web Application (ORWA), via MN-ITS; and

(C) Is due on or before the 30th day of the month following the end of the quarter, for all oral and written Appeals resolved in the previous quarter. If the 30th day of the month falls on a weekend or holiday, the report is due to the STATE on the following business day.

8.9 Submission of Part D Grievances and Appeals. The MSHO MCO will send to the STATE a copy of its Part D Grievance and Appeals summary report for MSHO Duals within thirty (30) days of its availability.

8.10 State Fair Hearings.

8.10.1 Matters Heard by State Fair Hearing Referee. Pursuant to Minnesota Statutes, § 256.045, the State Fair Hearing Referees may review any Action by the MCO, as Action is defined in 42 CFR § 438.400(b) and section 2.3 of this Contract.

8.10.2 Standard Hearing Decisions.

(A) The Enrollee, or the Provider acting on behalf of the Enrollee with the Enrollee's written consent, may file a request for a State Fair Hearing within thirty (30) days of the Notice of Action or Appeal decision, and within ninety (90) days, if there is good cause for the delay pursuant to Minnesota Statutes, § 256.045.

(B) The STATE must take final administrative action on any request for a State Fair Hearing within ninety (90) days of the following, whichever is earlier:

(1) The date the Enrollee filed an Appeal of the same issue with the MCO, excluding the days it subsequently took for the Enrollee to file the request for a State Fair Hearing with the STATE; or

(2) The date the request for a State Fair Hearing was filed.

(C) The MCO must cooperate with the STATE in determining the date the Enrollee filed an Appeal with the MCO, including but not limited to:

(1) The MCO shall name a specific contact for the State Fair Hearing Office to contact for information about: a) an Appeal of the same issue filed at the MCO; b) the date the Appeal was filed; and c) the date of resolution of the Appeal.

(2) The MCO shall respond with the following information about an Appeal within one working day of receiving the request from the State Fair Hearing Office: a) whether an Appeal was filed with an MCO; b) the date the Appeal was filed; c) the resolution of the Appeal; and d) the date it was resolved.

(3) The MCO shall notify the STATE and the State Fair Hearing Office of changes to the name or phone number of the contact within one working day of any change.

8.10.3 Costs of State Fair Hearing. The MCO shall provide reimbursement to the Enrollee for transportation, Child care, photocopying, medical assessment outside the MCO's network, witness fee, and other necessary and reasonable costs incurred by the Enrollee or former Enrollee in connection with a request for State Fair Hearing. Necessary and reasonable costs shall not include the Enrollee's legal fees and costs, or other consulting fees and costs incurred by or on behalf of the Enrollee.

8.10.4 Expedited Hearing Decisions.

(A) The STATE must take final action within three (3) working days of receipt of the file from the MCO on a request for an expedited State Fair Hearing, or a request from the Enrollee which meets the criteria of 42 CFR § 438.410(a).

(B) The MCO must send the file to the State Fair Hearing Office as expeditiously as the Enrollee's health requires, and not to exceed one working day.

8.10.5 Continuation of Benefits Pending Resolution of State Fair Hearing.

(A) If the Enrollee files a written request for a State Fair Hearing with the STATE, and requests continuation of benefits within the time allowed, pursuant to Minnesota Statutes, § 256.045, subd. 3a, before the date of the proposed Action in either the MCO's Notice or Appeal decision, the MCO, in accordance with 42 CFR § 438.420(b), may not reduce or terminate the service until the STATE issues a written decision in the State Fair Hearing, or the Enrollee withdraws the request for a State Fair Hearing.

(B) An Enrollee whose PCA services will be reduced or terminated due to the requirements of Minnesota Statutes § 256B.0659 may request continued services pending appeal or State Fair Hearing within the time period allowed to request an appeal, or State Fair Hearing.

(C) In the case of a reduction or termination of ongoing services, services must be continued, pending outcome of all Appeal hearings if: (1) there is an existing order for services by the treating and Participating Provider; or (2) the treating and Participating Provider orders discontinuation of services and another Participating Provider orders the service, but only if that Provider is authorized by his/her contract with the MCO to order such services. The notice required by section 8.3.1 shall include this right.

8.10.6 Compliance with State Fair Hearing Resolutions.

(A) Compliance with Decisions. The MCO must comply with the decision in the State Fair Hearing promptly and as expeditiously as Enrollee's health condition requires.

(B) MCO's Responsibility for Payment of Services. If the MCO's Action is not sustained by the State Fair Hearing decision, the MCO must promptly pay for any services the Enrollee received that are the subject of the State Fair Hearing.

(C) Enrollee's Responsibility for Payment of Services. If the MCO's Action is sustained by the State Fair Hearing decision, the MCO may institute procedures to recover the cost of medical services furnished solely by reason of section 8.3.3.

8.10.7 Representation and Defense of MCO Determinations. The MCO agrees that it is the responsibility of the MCO to represent and defend all MCO determinations at the State Fair Hearing including compliance with the access to files and appeal summary requirements of Minnesota Statutes, §256.0451, subd 2., and subd. 3, and at any subsequent judicial reviews involving that determination. The MCO must receive the advice and consent of the STATE before appealing any subsequent judicial decisions adverse to the Commissioner's Order. The MCO agrees that the STATE shall provide necessary information, but that the STATE shall not assume any costs associated with such representation. The STATE shall notify the MCO in a timely manner of any State Fair Hearings that involve the MCO.

8.10.8 External Review Participation. In the course of a State Fair Hearing an Enrollee may request an expert medical opinion be arranged by the external review entity pursuant to Minnesota Statutes, § 62Q.73, subd. 2. The MCO must participate in the external review process in accordance with this section and must comply with the process as specified in Minnesota Statutes, § 62Q.73, subd. 6(a).

8.10.9 Judicial Review. If the Enrollee disagrees with the determination of the STATE resulting from the State Fair Hearing, the Enrollee may seek judicial review in the district court of the county of service.

8.10.10 Second Opinions

(A) State Fair Hearings. At the request of a State Fair Hearing referee, the MCO shall provide for a second medical opinion from the MCO and shall comply with any order of the STATE pursuant to Minnesota Statutes, § 256B.69, subdivision 11, and Minnesota Rules, Part 9500.1462 C.

(B) Mental Health. The MCO shall provide for a second medical opinion for mental health conditions pursuant to Minnesota Statutes, § 62D.103.

(C) Chemical Dependency. The MCO shall provide for a second opinion for chemical dependency services as provided for in Minnesota Statutes, § 62D.103 and Minnesota Rules, Part 9530.6655. To the extent these laws are in conflict, the MCO shall apply Minnesota Rules, Part 9530.6655 to Enrollees under this Contract. The MCO shall inform the Enrollee in writing of the Enrollee's right to make a written request for a second assessment at the time the Enrollee is assessed for a program placement.

8.11 Sanctions for Enrollee Misconduct. The MCO shall place an Enrollee in the Restricted Recipient Program for the conduct described in Minnesota Rules, Part 9505.2165.

8.11.1 Notice to Affected Enrollees. The MCO must notify Enrollees in writing if the Enrollee is to be placed in the Restricted Recipient Program. The notice must be sent at least thirty (30) days prior to placement. The notice to the Enrollee must state:

(A) Placement in the Restricted Recipient Program will not result in a reduction of services or loss of eligibility or disenrollment from the MCO;

(B) The factual basis of the allegations against the Enrollee;

(C) The right to dispute the MCO's factual allegations;

(D) The right to request an Appeal with the MCO and request a State Fair Hearing, and the right to request a State Fair Hearing without first exhausting the MCO's Grievance and Appeal procedures; and

(E) Enrollee rights listed in the "Member Rights for Placement in the Restricted Recipient Program" document.

8.11.2 Enrollee's Right to Appeal. An Enrollee may Appeal or request a State Fair Hearing for placement in the Restricted Recipient Program. If the Enrollee Appeals or requests a State Fair Hearing prior to the date of the proposed placement, the MCO may not impose the placement until the Appeal or State Fair Hearing is resolved in the MCO's favor. If the Enrollee does not Appeal within thirty (30) days of the date of notice, placement will occur and the designated Providers will be assigned.

8.11.3 Reporting of Restrictions.

(A) Until the MCO has access to enter data directly into MMIS, the MCO must report to the STATE, the names and PMI numbers of all Enrollees placed in the Restricted Recipient Program, the date of placement, placement reason codes, and the names of the designated Providers with their addresses and Provider numbers. This information shall be reported to the STATE within five working days of the Enrollee's placement in the Restricted Recipient Program.

(B) Once the MCO has access to enter data directly into MMIS, the MCO shall enter into MMIS the names and PMI numbers of all Enrollees placed in the Restricted Recipient Program, the date of placement, placement reason codes, and the names of the designated Providers with their addresses and Provider numbers. This information shall be entered into MMIS within five working days of the Enrollee's placement in the Restricted Recipient Program.

8.11.4 Program Administration. The MCO will administer the Restricted Recipient Program consistent with Restricted Recipient Program criteria and process developed jointly with the MCOs and Minnesota Rules, Parts 9505.2160 through 9505.2245. The Restricted Recipient Program criteria and process is posted on the STATE's public website.

Article. 9 Required Provisions.

9.1 Compliance with Federal, State and Local Law. The MCO and its subcontractors shall comply with all applicable federal and state statutes and regulations, as well as local ordinances and rules now in effect and hereinafter adopted, including but not limited to Minnesota Statutes, §§ 62J.695 through 62J.76 (Patient Protection Act), Minnesota Statutes,

§ 62Q.47 (mental health parity), Minnesota Statutes, § 62Q.53 (mental health Medical Necessity), Minnesota Statutes, §§ 62Q.56 and 62Q.58 (Continuity of Care and Care Coordination) and Minnesota Statutes, § 62Q.19 (essential community providers).

9.1.1 Licensing and Certification For Non-County Based Purchasing Entities. MCO warrants that it is qualified to do business in the State and is not prohibited by its articles of incorporation, bylaws or the law of the state under which it is incorporated from performing the services under this Contract. MCO further warrants that MCO has obtained any and all necessary permits, licenses, or certificates to conduct business in the State. The MCO shall be properly licensed or certified for the performance of any services pursuant to this Contract. Loss of the appropriate certificate of authority for health maintenance organization (HMO) or community integrated service network (CISN), under Minnesota Statutes, Chapters 62D and 62N respectively, shall be cause for termination of this Contract pursuant to section 5.2.3. In the event any license is canceled, revoked, suspended or expires during the term of this Contract, the MCO agrees to so inform the STATE immediately.

9.1.2 HMO and CISN Requirements For County Based Purchasing Entities. The MCO shall comply with state statutes and regulations applicable to health maintenance organizations (HMO)s or community integrated service networks (CISNs), including: (A) Minnesota Statutes, § 62A.0411 (48-hour hospital stay for maternity patients); (B) Minnesota Statutes, §§ 62J.695 to 62J.76 (Patient Protection Act); and (C) Minnesota Statutes, § 62D.03, 4(a)-(d), (h)-(i), (k), (m)-(n), (p), (r)-(s) & (u), 62D.041, subd. 3 & 9, 62D.06-.08, 62D.11, 62D.123, 62M.04-12, 62N.28, 62N. 29, 62N.31 & 72A.201, and Minnesota Rules 4685.0300, subparts 2(A) & (B), 4685.1010, 4685.1115, 4685.1120, 4685.1900 & 4685.3300, subpart 9 (HMO and CISN requirements to the extent the Commissioner of Health has interpreted them to apply to county-based purchasers).

9.2 MCO Solvency Standards.

(A) If the MCO is a not a Federally Qualified HMO, the MCO must provide written assurance to the STATE by April 30th of the Contract Year, and any time thereafter, if there is significant change in the MCO or the Contract, that its provision against the risk of insolvency is adequate to ensure that its Enrollees will not be liable for the MCO's debts if it becomes insolvent.

(B) All MCOs must meet the solvency standards established by the State for Health Maintenance Organization (HMO) or be licensed or certified by the State as a risk-bearing entity.

9.3 Subcontractors.

9.3.1 Written Agreement. All subcontracts must be in writing and must include a specific description of payment arrangements. All subcontracts are subject to STATE and CMS review and approval, upon request by the STATE and/or CMS. Payment arrangements must be available for review upon request by the STATE and/or CMS. All contracts must include:

(A) Disclosure of Ownership Information. In order to assure compliance with 42 CFR § 438.610, the MCO before entering into a contract must request the following information. The required information must include:

(1) The name and address of each Person with an Ownership or Control Interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more;

(2) A statement as to whether any Person with an Ownership or Control Interest as identified in (B)(1) is related to any other Person with an Ownership or Control Interest as spouse, parent, child, or sibling; and

(3) The name of any other organization in which a Person with an Ownership or Control Interest in the disclosing entity also has an ownership or control interest.

(4) For purposes of section 9.3, subcontractor means an individual, agency, or organization to which a disclosing entity has contracted, or is a person with an employment, consulting or other arrangement with the MCO for the provision of items and services that are significant and material to the MCO's obligations under its contract with the STATE.

(B) MCO Disclosure Assurance. The MCO must be able to submit to the STATE, on September 1st of Contract Year a letter of assurance stating that the disclosure of ownership information has been requested of all subcontractors, and reviewed by MCO prior to MCO and subcontractor contract renewal.

9.3.2 Providers Without Numbers. The MCO shall submit to the STATE, in a format provided by the STATE, a form for each Provider who does not already have a STATE Provider number (UMPI) or NPI, pursuant to section 3.4.1(K).

9.3.3 Proof of Subcontractor Status. The MCO must submit, upon STATE request, proof of subcontractor status.

9.3.4 Provision of MSHO Information. The MCO shall inform and educate its Primary Care Providers and/or its Care Systems about the integrated Medicare and Medicaid benefits available under MSHO and shall communicate the MCO's efforts upon request by the STATE.

9.3.5 Subcontractors Audit. The MCO shall require that all subcontractors shall provide CMS, the Comptroller General or designees, and the STATE with the right to inspect, evaluate, and audit any pertinent books, financial records, documents, papers, and records of any subcontractor involving financial transactions related to this Contract. The right under this section to information for any particular contract period will exist for a period equivalent to that specified in section 9.4.5 of this Contract.

9.3.6 Compliance with Federal Law. All contracts and subcontracts shall comply with 42 CFR § § 422.503 and 504 for MSHO, for Medicare, and for all MCOs, 42 CFR § 434.6(b) for Medical Assistance services, and 42 CFR § 438.6(l) for those requirements that are appropriate to the service or activity delegated under the subcontract.

9.3.7 Health Care Services. Notwithstanding section 9.3.8, the MCO may contract with Providers of health care services to provide services to Enrollees of the MCO. Subcontracts with other Providers of health care services shall not abrogate or alter the MCO's primary responsibility for performance under this Contract.

9.3.8 Subcontractual Delegation. The MCO oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor. The MCO shall:

(A) Prior to any delegation, evaluate the prospective subcontractor's ability to perform the activities to be delegated.

(B) Have a written agreement that: (1) specifies the activities and report responsibilities delegated to the subcontractor; and (2) provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

(C) Monitor at least annually the subcontractor's performance through a formal review process that results in a written report.

(D) Upon request by the STATE, provide a copy of the formal delegation review process for approval.

(E) By January 15th of each Contract Year submit to the STATE an annual schedule identifying subcontractors, delegated functions and responsibilities, and when their performance will be reviewed.

(F) Take corrective action with the subcontractor if deficiencies or areas for improvement are identified, and notify the STATE in writing the reasons for and the actions taken for correction.

(G) The MCO must provide to the STATE upon request a copy of the annual subcontractor performance report. The STATE agrees to return any copies of any submitted subcontractor performance report at the close of its review. The STATE may at its discretion choose to review this on site.

9.3.9 Annual Reviews of Care System Subcontractors, County Care Coordination and Case Management Systems. The MCO shall conduct a review of each MSHO Care System, MSHO County Care Coordination Systems, and MSC+ Case Management System the MCO owns or with which the MCO has a subcontract for Enrollees covered under this Contract. Written audit reports of each Care System, County Care Coordination and County Case Management System must be submitted to the STATE by September 15th of each Contract Year in accordance with section 7.1.4(D).

(A) Annual reviews and written reports must include a description of the organizational, service delivery, and case management structures, and the risk sharing arrangement between the MCO and each Care System, County Care Coordination System or Case Management System. In addition, annual reviews must include the process used by the MCO to conduct the review, any deficiencies and/or concerns raised during the review, and any corrective actions taken by either the MCO or by the Care System, County Care

Coordination System or Case Management System to address deficiencies and/or concerns raised during the review. Annual reviews and written reports must include but are not limited to Care Plan audits as specified under section 7.9.3. The review must address the Care System's County Care Coordination System or Case Management System's compliance with subcontract requirements such as those described in the STATE's "Protocol for Annual Reviews of Care System Subcontractors" attached hereto as Appendix III.

(B) The MCO/SNP will work with the STATE and other MCO/SNPs on methods for coordinating County Care Coordination System and MSC+ Case Management System reviews among MCO/SNPs and across counties including development of joint review protocols and summary reporting formats. Such protocols must consider applicable components described in the STATE's "Protocol for Annual Reviews of Care System Subcontractors" attached hereto as Appendix III and the Waiver Quality Assurance Plan Survey referenced in section 7.9.4. MCO/SNPs may use a joint contractor to conduct such reviews, while meeting applicable HIPAA requirements.

(C) The MCO will work with the State and other MCOs to develop a standard audit tool for oversight of Elderly Waiver network functions delegated to counties. The workgroup will consider schedules for Care Coordination and Case Management System reviews that can vary based on performance.

9.3.10 FQHCs and RHCs Contracting Requirements. If the MCO negotiates a Provider agreement or subcontract with a federally qualified health center (FQHC) as defined in § 1905(l)(2)(B) of the Social Security Act, 42 U.S.C. § 1396d(l)(2)(B), or a rural health clinic (RHC) as defined in 42 CFR § 440.20, the negotiated payment rates must be comparable to the rates negotiated with other subcontractors who provide similar health services. The STATE may require the MCO to contract with an FQHC or Rural Health Clinic (RHC) that has been designated under Minnesota Statutes, § 62Q.19 as an essential community Provider. The MCO is not required to pay any settle-up payments in addition to the negotiated payment rate.

9.3.11 Nonprofit Community Health Clinics, Community Mental Health Centers, and Community Health Service Agencies Contracting Requirements. The MCO shall contract with nonprofit community health clinics (community health clinic), as defined in Minnesota Statutes, Chapter 145A, including all FQHCs that are also nonprofit community health clinics, community mental health centers, or Community Health Service Agencies (community health boards), as defined in Minnesota Statutes, § 256B.0625, subd. 30, to provide services to Enrollees who choose to receive services from the clinic or agency, if the clinic or agency agrees to payment rates that are competitive with rates paid to other MCO Providers for the same or similar services, pursuant to Minnesota Statutes, § 256B.69, subd. 22. The MCO may reasonably require a community clinic, community mental health center, or Community Health Service Agency to comply with the same or similar contract terms that the MCO requires of the MCO's other Participating Providers, except that the MCO cannot exclude coverage for a Covered Service provided by a clinic or agency in a subcontract with a clinic or agency. Upon request of the MCO, the STATE will provide the MCO with a list of all nonprofit community clinics, community mental health centers, and Community Health Service Agencies within the Service Area.

9.3.12 Essential Community Providers (ECPs). The MCO shall offer to contract with any designated Essential Community Provider, as described in a listing provided by the STATE, and located within its Service Area, pursuant to Minnesota Statutes, § 62Q.19. The MCO must offer to contract with all ECPs in their service area for medical services. The MCO may contract, but is not required to do so, for non-medical services the ECP is certified to provide.

9.3.13 Enrollees Held Harmless.

(A) Except for Medical Assistance copayments pursuant to section 4.19, and Waiver Obligations, the MCO shall ensure that the Enrollee is not held responsible for any fees associated with the Enrollee's medical care received from the MCO subcontractor or an Out-of-Plan Provider with whom the MCO has negotiated a rate for providing the Enrollee services covered under this Contract.

(B) The MCO shall ensure, through its Provider contracts, that Providers notify Enrollees in writing of Enrollee liability for non-covered services and prior to performance of the service, receive written authorization from the Enrollee for the non-covered service.

(C) Where an Enrollee receives Medical Emergency Services, Post-Stabilization Care Services or Urgent Care Out of Service Area or Out of Plan, the MCO shall pay the Out of Service Area or Out of Plan Provider on the condition that the Provider hold the Enrollee harmless for any financial liability.

(D) The MCO shall ensure that Enrollees receiving services at hospitals or ambulatory surgical centers are not held liable for any service provided for an authorized procedure (e.g. anesthesiologist/radiologist).

9.3.14 Exclusions of Individuals and Entities.

(A) The MCO must search the Medicare Exclusion Database (MED) or the OIG List of Excluded Individuals/Entities (LEIE) database monthly, and require all subcontractors to search the MED or the LEIE for any Providers, agents, Persons with an Ownership or Control Interest and Managing Employees to verify that these persons:

(1) Are not excluded from participation in Medicaid under Sections 1128 or 1128A of the Social Security Act.

(2) Have not been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or programs under title XX of the Social Security Act.

(B) The MCO must require subcontractors to assure to the MCO that no agreements exist with an excluded entity or individual for the provision of items or services related to the MCO's obligation under this contract.

(C) The MCO shall require all subcontractors to report to the MCO within five (5) days any information regarding individuals or entities specified in (A) above, who have been

convicted of a criminal offense related to the involvement in any program established under Medicare, Medicaid, the Title XX services program, or that have been excluded from participation in Medicaid under § § 1128 or 1128A of the Social Security Act.

(D) The MCO shall report this information to the STATE within seven (7) days of the date the MCO receives the information.

(E) The MCO must also promptly notify the STATE of any action taken on a subcontract under this section, consistent with 42 CFR § 1002.3 (b)(3).

(F) In addition to complying with the provisions of section 9.3.15, the MCO shall not enter into any subcontract that is prohibited, in whole or in part, under § 4707(a) of the Balanced Budget Act of 1997 or under Minnesota Statutes, § 62J.71.

9.3.15 Financial Incentives. The MCO may not give any financial incentive to a health care Provider based solely on the number of services denied, limited or discontinued, or referrals not authorized by the Provider, pursuant to Minnesota Statutes, §72A.20, subd. 33 and as required under 42 CFR § 422.208 and § 438.210.

9.3.16 Medical Necessity Definition. The MCO shall include in all subcontracts for the delivery of services under this Contract a requirement that the subcontractor follow the definition of Medical Necessity in section 2.80, and in subcontracts for the delivery of mental health services that the subcontractor additionally follow the Medical Necessity definition found in Minnesota Statutes, § 62Q.53. Subcontracts shall include the definition found in section 2.80, and the definition found in Minnesota Statutes, § 62Q.53 where applicable.

9.3.17 Provider Payment. The MCO agrees to pay health care Providers on a timely basis consistent with the claims payment procedure described in § 1902(a)(37)(a) of the Social Security Act (42 U.S.C. § 1396(a)), and 42 CFR Parts 447.45 and 447.46.

9.3.18 Complaint Reporting. The MCO shall require:

(A) Participating Primary Care Providers to report quality of care complaints pursuant to Minnesota Rules, Part 4685.1110, subpart 9 (A), and

(B) Care Systems to report any complaints relating to MSHO Enrollees to the MCO on a quarterly basis.

9.3.19 Patient Safety. The MCO, in all future or renewing Provider contracts, shall encourage its Participating Providers that are hospitals to: 1) report through Leapfrog, a national patient safety initiative, and 2) develop and implement patient safety policies to systematically reduce medical errors. Such policies may include systems for reporting errors, and systems analysis to discover and implement error-reducing technologies.

9.3.20 Nursing Facility Subcontracting.

(A) The MCO may develop contracts and negotiate rates with Nursing Facilities. The MCO must include in its payment arrangements for Nursing Facility services provisions

that require the Nursing Facilities to cooperate with STATE procedures in the collection of Spenddowns.

(B) If the MCO authorizes Nursing Facility care in a NF where the MCO does not have a contracted rate, the MCO shall pay the NF the appropriate Medicaid or, for MSHO, Medicare rate. For MSHO, in non-contracting facilities, the MCO shall be responsible for determining if the NF day meets Medicare or Medicaid requirements based on current Medicare and Medicaid coverage criteria. For Medicaid leave days, fee-for-service pays qualified Nursing Facilities sixty percent (60)% of the applicable case mix payment rate. The MCO shall pay non-contracted facilities whose Nursing Facility occupancy leave rates would otherwise qualify for payment under fee-for-services at this level.

9.3.21 Elderly Waiver Provider Subcontracting.

(A) MCO's Network for EW Services. The MCO may develop contracts and negotiate rates with Elderly Waiver Providers as subcontractors. The MCO must implement a plan for oversight of Elderly Waiver Providers, including mechanisms for verification that Elderly Waiver Providers meet the EW Provider requirements. The oversight plan must include procedures for ongoing monitoring of Elderly Waiver Providers and services, and the MCO must notify the STATE of this plan.

(1) This oversight process may need to be modified upon the phase-in of a centralized process for annual Department of Human Services contracting and enrollment of one or more Elderly Waiver service provider types. Such phase-in will begin no sooner than July 1, 2011. The MCO Consultation Work Group will be consulted for additional details of this implementation.

(B) County Networks for EW Services. The MCO may develop an agreement with a willing county or counties to utilize the Elderly Waiver Providers approved and contracted by each county. The MCO must provide notice in writing to the county's EW Providers that the MCO is accessing the EW services through the existing county contract, and must provide written information needed for the provider to deliver and bill for EW services at the contracted rates. The MCO may have additional requirements in their agreements with the county or counties related to provider network management. Under this agreement, the MCO will work with the county to utilize county rates or develop alternatives to those rates. If the agreement does not include a plan for oversight of Elderly Waiver Providers, including mechanisms for verification that Elderly Waiver Providers meet Elderly Waiver Provider requirements and procedures for ongoing monitoring of Elderly Waiver Providers and services, the MCO must implement an oversight plan that includes such mechanisms and must notify the state of this plan.

(1) Arrangements with counties or tribes made under this paragraph may need to be modified upon the phase in of a centralized process for annual Department of Human Services contracting and enrollment of one or more Elderly Waiver service provider

types beginning no sooner than July 1, 2011. The MCO Consultation Work Group will be consulted for additional details of this implementation.

(2) Counties and tribes have been advised that their contracts with Elderly Waiver Providers must remain in place through December 31, 2011, or until such time as the Provider re-enrolls with the state during 2011.

(C) Network Requirements. Nothing in this section shall preclude MCOs from paying Elderly Waiver Providers on a non-participating basis when the MCO determines that is necessary. The MCO must notify the STATE of its plan for oversight of EW services administered by Elderly Waiver Providers who are paid on a non-participating basis. This plan must include mechanisms for verification that Elderly Waiver providers meet Elderly Waiver Provider requirements and procedures for on-going monitoring of Elderly Waiver Providers and services. The MCO must use the rates or rate methodology established by the local agency, or may use the annual rate limits published by the STATE.

(1) This oversight process may need to be modified upon the phase-in of a centralized process for annual Department of Human Services contracting and enrollment of one or more Elderly Waiver service provider types. Such phase-in will begin no sooner than July 1, 2011. The MCO Consultation Work Group will be consulted for additional details of this implementation.

(D) Waiver Obligations. The MCO must include in its payment arrangements for Elderly Waiver Providers, mechanisms that require the Provider to cooperate with the MCO's process for Provider collection of Waiver Obligations.

(E) GRH and Foster Care. Where counties require that MCOs have a formal agreement with a Provider in order to access group residential housing funding, or to license adult foster care settings, the MCO must provide evidence of a contract with the waiver provider to the county.

(F) Customized Living Subcontracting.

(1) Rates paid to Customized Living providers by the MCO for Medical Assistance covered services cannot exceed the maximum service limit rates as published in DHS bulletin 10-25-04, or as indicated in replacement bulletins.

(2) The MCO must provide for Customized Living Services within the parameters required by the STATE. The payment agreement between the MCO and the Customized Living provider must delineate the component services included in the enrollee's Customized Living plan. The MCO must ensure there is documented need within the parameters established by the STATE for all services authorized. The payment rate must be based on the amount of component services. Component rates must not exceed payment rates for comparable EW or State Plan rates established by the STATE.

(3) Rate-Setting Tool. DHS has issued a Customized Living Planning and Rate-Setting Tool (CL Tool) that the MCO may use to meet these requirements.

(a) If the MCO chooses to use the CL Tool, the MCO will work with the STATE on a process to ensure that CL Tool worksheets are shared electronically between the MCO and the STATE so that the CL Tool and all component rates may be evaluated; or

(b) The MCO may choose to use the CL Tool and to establish its own component rates.

9.3.22 Provider and Enrollee Communications. The MCO may not prohibit, or otherwise restrict, a Health Care Professional acting within the lawful scope of practice from advising or advocating on behalf of an Enrollee, with respect to the following:

(A) The Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(B) Any information the Enrollee needs in order to decide among all relevant treatment options;

(C) The risks, benefits, and consequences of treatment or non-treatment; or

(D) The Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

9.3.23 Relationships with Providers for MSHO. Pursuant to 42 CFR Part 422, subpart E, the MCO shall comply with all applicable Provider requirements for MSHO in that section, including, but not limited to: Provider certification requirements; anti-discrimination requirements; Provider participation and consultation requirements; the prohibition on interference with Provider advice; limits on Provider indemnification; rules governing payments to Providers; Medicare cost sharing; and limits on Physician Incentive Plans.

9.3.24 Automatic Termination of Subcontract Clause. The following provision is required to be included in all contracts and/or subcontracts entered into by the MCO, with the exception of contracts for the purchase of items and equipment, including leases of real property which exceed the term of this contract, unless CMS agrees to its omission.

(A) Failure of the MCO to include the clause in such a contract and/or subcontract without the written agreement of CMS to its omission, shall make the related costs incurred after the effective date of the non-renewal or termination, unallowable. The clause is as follows:

(B) "In the event the Medicare contract between CMS and the MCO is terminated or non-renewed, the contract between the STATE and the _____ (name of MCO) shall be terminated unless CMS and the STATE agree to the contrary. Such

termination shall be carried out in accordance with the termination requirement stated in 42 CFR § § 422.506 and 422.512."

9.3.25 Business Continuity Plan (BCP). By December 1st of the Contract Year, the MCO shall ensure that its subcontractors that provide Priority Services have in place a written Business Continuity Plan (BCP) that complies with the requirements of Article 20.

9.4 Maintenance, Inspection and Retention of Records.

9.4.1 Quality, Appropriateness and Timeliness of Services. The MCO shall provide that the STATE and CMS or their agents may evaluate through inspection of other means the quality, appropriateness, and timeliness of services performed under this Contract.

9.4.2 Facilities Evaluation. The MCO shall provide that the STATE and CMS may evaluate, through inspection or other means, the facilities of the MCO when there is reasonable evidence of some need for that inspection.

9.4.3 Enrollment and Disenrollment Records Evaluation. The MCO must provide that the STATE and CMS may evaluate, through inspection or other means, the enrollment and disenrollment records when there is reasonable evidence of need for such inspection.

9.4.4 Independent Audit. The MCO shall provide that the STATE, CMS or the Comptroller General, or their designees, may audit or inspect any books, documents, financial records, papers and records of the MCO and its subcontractors or transferees that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the Contract.

9.4.5 Timelines. The MCO must provide that the STATE and CMS's right to inspect, evaluate and audit shall extend through ten (10) years from the date of the final settlement for any Contract Year unless: (A) the STATE or CMS determines there is a special need to retain a particular record or records for a longer period of time and the STATE or CMS notify the MCO at least thirty (30) days prior to the normal record disposition date; (B) there has been a termination, dispute, Fraud, or similar default by the MCO, in which case the record retention may be extended to ten (10) years from the date of any resulting final settlement; or (C) the STATE or CMS determined that there is a reasonable possibility of Fraud and the record may be reopened at any time. Records to be retained include, but are not limited to, medical, claims, care management, and Service Authorization records.

9.4.6 Record Maintenance. The MCO agrees to maintain such records and prepare such reports and statistical data as may be deemed reasonably necessary by the STATE and CMS. It is further agreed that all records must be made available to authorized representatives of the STATE and CMS during normal business hours and at such times, places, and in such manner as authorized representatives may reasonably request for the purposes of audit, inspection, examination, and for research as specifically authorized by the STATE to the MCO in fulfillment of the STATE or federal requirements. It is understood and agreed that the MCO shall be afforded reasonable notice of a request by an authorized representative of the STATE or CMS to examine records maintained by the MCO or its agents, unless otherwise provided by law.

9.4.7 Record Retention by MCO. The MCO agrees to maintain and make available to the STATE and CMS all records related to Enrollees enrolled pursuant to this Contract for a period of ten (10) years after the termination date of this Contract. Records to be retained include, but are not limited to, medical, claims, Care Management, and Service Authorization records.

9.5 Settlement upon Termination. Upon termination of the Contract, or at such time as Enrollee Recipients terminate enrollment in MSHO and in the MCO, and prior to final settlement, the MCO shall, upon request by the STATE, provide to the STATE copies of all information that may be necessary to determine responsibility for outstanding claims of Providers, and to ensure that all outstanding claims are settled promptly.

9.6 Trade Secret Information. The STATE agrees to protect from dissemination information submitted by the MCO to the STATE that the MCO can justify as trade secret information, pursuant to Minnesota Statutes, § 13.37, subd. 1(b). Protected information may be Marketing plans and materials, rates paid to Providers, Medicare bid information or any other information. The MCO must identify information as trade secret prior to or at the time of its submission for the STATE to consider classifying it as non-public. If information identified by the MCO as trade secret is subject to a data practices request or otherwise subject to publication, and if the STATE determines that the MCO's trade secret identification is colorable, the STATE shall provide the MCO an opportunity to justify in writing that the information meets the requirements of Minnesota Statutes, § 13.37. Trade secret information may be shared with CMS. The STATE must notify CMS that such information is considered trade secret. Pursuant to Minnesota Rules, Part 9500.1459, rates paid to the MCO, the STATE's rate methodology, and this Contract are not trade secrets.

9.7 Date of Issue of Enrollee Material. The MCO shall submit to the STATE, upon request, written confirmation of the dates on which the MCO issues all new Enrollee materials required by section 3.2.6. The MCO must notify the STATE and provide a brief explanation in writing within two (2) working days if the MCO cannot comply with the time frame specified in section 3.2.6.

9.8 Reporting of Time-Sensitive Data. The STATE may collect data or contract with external vendors for studies, including but not limited to, data validation, service validation, and quality improvement.

9.8.1 Notice. The STATE will give the MCO at least forty-five (45) days notice. The notice will include the time-sensitive nature of the data, and data specifications for the required data.

9.8.2 Data Specification Issues. The MCO must notify the STATE within one week of any issues concerning the data specifications.

(A) Timely Submission. If the MCO is not able to submit all required data by the deadline, the MCO may request a delay. The STATE shall not grant a delay if such delay would result in the STATE's inability to evaluate the MCO's performance or data in the contracted study.

(B) Requirements. The MCO must submit accurate and complete data within the time periods that meet the data specifications.

9.9 Ownership of Copyright. If any copyrightable material is developed in the course of or under this contract, the STATE and the U.S. Department of Health and Human Services shall have a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use, the work for government purposes.

9.10 Liability. The STATE and MCO agree that, to the extent provided for in state law, each shall be responsible for the loss, damage or injury arising from its own negligence in performing this Contract.

9.11 Severability. If any provision or paragraph of this Contract is found to be legally invalid or unenforceable, such provision or paragraph shall be deemed to have been stricken from this Contract and the remainder of this Contract shall be deemed to be in full force and effect.

9.12 Workers' Compensation. In accordance with the provisions of Minnesota Statutes, §176.182, the MCO shall provide acceptable evidence of compliance with the workers' compensation insurance coverage requirement of Minnesota Statutes, § 176.181, subd 2.

9.13 Affirmative Action. The MCO certifies that it has received a certificate of compliance from the Commissioner of Human Rights pursuant to Minnesota Statutes, § 363A.36. County administered MCOs are exempt from this statute.

9.14 Voter Registration. The MCO certifies that it will comply with Minnesota Statutes, § 201.162.

9.15 Fraud and Abuse Requirements.

9.15.1 Integrity Program.

(A) Administrative and Management Procedures. The MCO shall have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against Fraud, Abuse and Improper Payments. The arrangements or procedures shall include the following:

(1) Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable Federal and STATE standards;

(2) The designation of a compliance officer and a compliance committee that are accountable to senior management of the MCO;

(3) Effective training and education for the compliance officer and the MCO's employees;

(4) Effective lines of communication between the compliance officer and the MCO's employees;

(5) Enforcement of standards through well-publicized disciplinary guidelines;

(6) Provision for internal monitoring and auditing, including monitoring and auditing of subcontracted services to detect Fraud, Abuse and Improper Payments;

(7) Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to this Contract;

(8) Provision for profiling Provider services and Enrollee utilization that identifies aberrant behavior and/or outliers;

(9) Policies and procedures that safeguard against unnecessary or inappropriate use of services and against excess payments for services;

(10) Policies and procedures that safeguard against failure by subcontractors or Participating Providers to render Medically Necessary items or services that are required to be provided to an Enrollee covered under this Contract; and

(11) Provision for identifying, investigating, and taking corrective action against fraudulent and abusive practices by Providers, subcontractors, and Enrollees, or MCO employees, officers and agents.

(12) A method to verify whether services under this Contract, paid for by the MCO, were actually furnished to the Enrollees as required in 42 CFR § 455.1(a)(2). The MCO shall utilize direct methods for verifying the provision of any covered services to Enrollees. MCOs are not precluded from using a variety of direct methods to verify services, especially with provider types that have been identified by the STATE or the MCO as high risk for program integrity issues including transportation, PCAs, medical supply, and interpreters. The MCO's direct methods and results shall be included in the Annual Integrity Program Report under section 9.15.1(D). .

(a) Direct methods include:

i) Confirming clinic visits or linking authorization and payment of transportation and interpreter services to clinic visits;

ii) Expansion of HEDIS and PIP chart review contracts to require notification to the MCO of any discrepancy in charts against paid claims;

iii) Individual notices to Enrollees within 45 days of the payment of claims, in the form of an Explanation of Medical Benefits (EOMB) consistent with Minnesota Statutes, § 62J.581. EOMB notices must not include any confidential services and must not be sent to the Enrollee if the only service furnished was confidential. Notices should be provided to a sample group of at least 10% of Enrollees who received services from the provider type being verified. Notices must include a statement that the notice is not a bill. Notices

must include the MCO's phone number that Enrollees can call to ask questions or obtain information about the services identified on the notice;

iv) Care manager or care coordinator follow up with Enrollees to confirm services and notification to MCO when services were not delivered,

v) Clinic authorization of a patient incentive that confirms a completed office visit;

vi) Specific service confirmation questionnaires; or

vii) Post-payment review of provider documentation of services for a sample of claims.

(b) Indirect methods such as DTRs, hotlines, billing monitoring, or customer satisfaction surveys are important program integrity practices and methods but they are not sufficient to verify services.

(B) Documentation. The MCO shall document all activities and corrective actions taken under its integrity program.

(C) Compliance Officer. The MCO shall identify to the STATE the compliance officer who is responsible for implementation of the integrity program.

(D) Annual Integrity Program Report. The MCO shall report annually to the STATE in writing, by August 31st of each Contract Year, detailing the MCO's integrity program, including investigative activity, corrective actions, Fraud and Abuse prevention efforts, and results according to guidelines provided by the STATE. The report must detail implementation of the requirements of section 9.15.1(A), and must specifically describe the activities it has undertaken to safeguard against fraud, as required by section 9.15.4.

(E) Violation Report Process. The MCO shall establish and adhere to a process for reporting to the STATE, CMS and/or the Office of Inspector General for the U.S. Department of Health and Human Services, credible information of violations of law by the STATE, the MCO, Participating Providers, subcontractors, or Enrollees, for a determination as to whether criminal, civil, or administrative action may be appropriate. If the MCO has reason to believe that an Enrollee has defrauded the Medicaid program, the MCO shall refer the case to an appropriate law enforcement agency as mandated in 42 CFR § 455.15(b).

(F) Quarterly Reporting of Actions Terminating Provider Participation. The MCO shall report quarterly to the STATE the name, specialty, and address (in a form approved by the STATE) of each Provider whose participation status, the MCO has taken action to terminate or not renew during the previous quarter.

9.15.2 Fraud and Abuse by MCO, its Subcontractors, and/or Participating Providers.

(A) The MCO's officers understand that this Contract involves the receipt by the MCO of state and federal funds, and that they are, therefore, subject to criminal prosecution and/or civil or administrative actions for any intentional false statements or other fraudulent conduct related to their obligations under this Contract.

(B) The MCO and its subcontractors shall, upon the request of the Minnesota Medicaid Fraud Control Unit (MFCU) of the Minnesota Attorney General's Office, make available to MFCU all administrative, financial, medical, and any other records that relate to the delivery of items or services under this Contract. The MCO shall allow the MFCU access to these records during normal business hours, except under special circumstances when after hours admissions shall be allowed. Such special circumstances shall be determined by the MFCU.

(C) The MCO shall report to the STATE and the MFCU any suspected Fraud and/or Abuse by Providers within twenty-four (24) hours after the MCO knows or has reason to believe of such suspected Fraud and/or Abuse. The MCO shall cooperate fully in any investigation of the suspected Fraud and/or Abuse by the STATE and MFCU and in any subsequent legal action that may result from those investigations.

9.15.3 Fraud and Abuse by Recipient. The MCO shall report to the STATE any suspected Fraud and/or patterns of Abuse by Recipients.

9.15.4 Fraud and Abuse by PCA Providers.

(A) The STATE has determined that enrollment of individual PCA Providers in the fee-for-service system will allow the STATE to safeguard against unnecessary or inappropriate use of PCA services and against excess payments. The MCO shall ensure that PCA Providers have a background study completed prior to providing any PCA services.

(B) The MCO may work with the STATE to utilize the STATE's licensing system for these purposes, but any other process utilized by the MCO must review using the same standards as the STATE's licensing system.

(C) The MCO shall require that PCPAs submit claims to the MCO using one date of service per claim line, per PCA.

9.15.5 False Claims.

(A) If the MCO receives or makes Medicaid payments totaling five million dollars ($5,000,000) or more within a Federal fiscal year (October 1st to September 30th), the MCO must establish, implement, and disseminate written policies and procedures to all employees including management, contractors and agents that includes detailed information pertaining to the False Claims Act (federal and state) and other provisions named in § 1902(a)(68)(A) of the Social Security Act. These policies must include detailed provisions regarding the MCO's procedures for detecting and preventing fraud, waste, and abuse. The MCO shall certify to the STATE by February 1st of the Contract Year that it has complied with this requirement for the previous Contract Year, using as

its certification the DHS Deficit Reduction Act (DRA) Assurance Statement posted on the Managed Care website.

(B) In addition, the MCO must include in its written policies and procedures (and in employee handbook(s) if any, specific discussions of the following:

(1) The False Claims Act, 31 U.S.C. §§ 3729 through 3733;

(2) Administrative remedies for false claims and false statements established under 31 U.S.C. §§ 3801, et seq.;

(3) The Minnesota False Claims Act, Minnesota Statutes, § 15C.02, and any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) The rights of employees to be protected as whistle-blowers, including the employer restrictions listed in Minnesota Statutes, § 15C.14; and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

9.16 Conflicts of Interest. Pursuant to 42 CFR § 438.58, and Minnesota Statutes, § 256B.0914, the MCO shall have in effect conflict of interest rules at least as effective as those in 41 U.S.C. § 423.

9.17 Data Certifications. As a condition for receiving payment the MCO shall certify its data and documents that are utilized by the STATE in determining payments made to the MCO.

9.17.1 Data Submitted to the STATE. The MCO shall provide to the STATE a certification that accompanies its submission of the data indicated below. The MCO may submit a separate written Data Certification, due by the 5th day of the following month for any submissions in the previous month, which identifies each and every data submission, unless otherwise specified in the Contract, the date it was submitted, and certifies all data submitted. The following data must be certified:

(A) Encounter data;

(B) Data associated with the reporting requirements of the managed care withhold;

(C) Data submissions as requested by the STATE for the development of rates;

(D) Health care expenditures.

(E) Dental payment report for Critical Access Dental Designated Providers, as specified in section 7.14.4; and

(F) Any other data or document determined by the STATE to be necessary to comply with 42 CFR § 438.604.

9.17.2 Financial Filing with MDH. The MCO shall either certify to the STATE that its annual statutory financial filing with the Minnesota Department of Health (MDH) represents only costs related to services covered under the STATE Plan, Home and Community Based Services (HCBS) Waiver Services, including the MCO's administrative costs. The MCO must certify and report the dollar value of each service that is a non-State Plan service. The MCO must provide this certification no later than May 1st of the Contract Year.

9.17.3 Requirements. Each certification shall meet the following requirements:

(A) Include an attestation as to the accuracy, completeness and truthfulness of the data or documents being submitted.

(B) Provide that the attestation is based upon the best knowledge, information and belief of the one certifying on behalf of the MCO.

(C) Be certified by either the MCO's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual with authority to sign for and who reports to either the MCO's CEO or CFO.

(D) Certification must be submitted concurrently with the data, or pursuant to section 9.17.1.

9.18 Exclusions and Convicted Persons

(A) The MCO shall not pay for any items or services furnished, ordered or prescribed by excluded individuals or entities pursuant to 42 CFR § 1001.1901.

(B) (A) The MCO shall not include in their business entity a director, officer, partner or Person with an Ownership or Control Interest who is excluded from participation in Medicaid under §§ 1128 or 1128A of the Social Security Act. This includes entities owned or controlled by a sanctioned person pursuant to 42 CFR § 1001.1001.

(C) The MCO shall not make an employment, consulting or other agreement with an individual or entity for the provision of items or services that are significant and material to the MCO's obligations under its contract with the STATE where the individual or entity is excluded from participation in Medicaid under §§ 1128 or 1128A of the Social Security Act. Significant and material services include, but are not limited to health care, utilization review, medical social work, or administrative services.

(D) The MCO shall not have any agents, Managing Employee, or Persons with an Ownership or Control Interests who have been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program, in accordance with 42 CFR 455.106.

(E) The MCO shall report to the STATE, within ten (10) working days of receipt of the following:

(1) Any information regarding excluded or convicted individuals or entities, including those in paragraph (D) above; and

(2) Any occurrence of an excluded, convicted, or unlicensed entity or individual who applies to participate as a Provider.

(F) The MCO shall promptly notify the STATE of any administrative action it takes to limit participation of a Provider in the Medicaid program as mandated by 42 CFR § 1002.3(b)(3).

9.18.2 Compliance with Public Health Services Act for MSHO. The MCO shall comply with:

(A) § 1318(a) and (c) of the Public Health Services Act, 42 U.S.C. § 300e-17(a)(2), that pertain to disclosure of certain financial information;

(B) § 1301(c)(1) and (c)(8) of the Public Health Services Act, that relate to fiscal, administrative and management requirements and liability arrangements to protect all members of the organization; and to notify the STATE and CMS sixty (60) days prior to any changes in its insolvency arrangements; and

(C) The reporting requirements in 42 CFR § 422.516(a) that pertain to the monitoring of an organization's continued compliance.

9.19 Receipt of Federal Funds. The MCO will receive federal payments and is therefore subject to laws which are applicable to individuals and entities receiving federal funds. The MCO shall inform all related entities, contractors and/or subcontractors that payments they receive are, in whole or in part, from federal funds.

9.20 Formal Presentations. The MCO shall provide to the STATE copies of any formal presentation by the MCO or its Administrative Services Organization, including reports, statistical or analytical materials, papers, articles, professional publications, speeches, or testimony (except testimony before the Minnesota Legislature), that is based on information obtained through the administration of this Contract.

Article. 10 Assignment. The MCO shall neither assign nor transfer any rights or obligations under this Contract without the prior written consent of the STATE.

Article. 11 Third Party Liability and Coordination of Benefits

11.1 Agent of the STATE. Pursuant to 42 CFR 433, subpart D and Minnesota Statutes, § 256B.042, subd. 2, § 256B.056, subd. 6, § 256.015, subd. 1, and § 256B.37, subd. 1, the STATE hereby authorizes the MCO as its agent to obtain third party and Medicare reimbursement by any lawful means including asserting subrogation interest, filing liens, asserting independent claims, and to coordinate benefits, for MCO Enrollees.

11.2 Third Party Recoveries. The MCO must take reasonable measures to determine the legal liability of third parties to pay for services furnished to MCO Enrollees. To the extent

permitted by state and federal law, the MCO shall use Cost Avoidance and/or Post Payment Recovery Processes, as defined in Article 2 of this Contract, to ensure that primary payments from the liable third party are utilized to offset medical expenses.

(A) Known Third Parties. The STATE shall include information about known third party resources on the electronic enrollment data given to the MCO twice a month.

(B) Additional Resources. The MCO shall report to the STATE any additional third party resources available to an Enrollee discovered by the MCO on a form provided by the STATE, within ten (10) business days of verification of such information. The MCO shall report any known change to health insurance information in the same manner.

(C) Cost Benefit. The MCO's efforts to determine liability and use Cost Avoidance Procedures or Post Payment Recovery processes shall not require that the MCO spend more on an individual claim basis than could be recovered through those efforts.

(D) Retention of Recoveries. The MCO is entitled to retain any amounts recovered through its efforts, provided that:

(1) Total payments received do not exceed the total amount of the MCO's financial liability for those services provided by the MCO to the Enrollee;

(2) STATE FFS and reinsurance benefits have not duplicated this recovery; and

(3) Such recovery is not prohibited by federal or state law.

(E) Return of Payments. The MCO may require its capitated Providers to return any third party payments to the MCO.

(F) Unsuccessful Effort. If the MCO is unsuccessful in its efforts to obtain necessary cooperation from an Enrollee to identify potential third-party resources after sixty (60) days of such efforts, the MCO may inform the STATE in a format to be determined by the STATE that efforts have been unsuccessful.

11.3 Coordination of Benefits.

11.3.1 Coordination of Benefits. For Enrollees who have private health or long term care coverage, the MCO must coordinate benefits in accordance with Minnesota Rules, Part 9505.0070 and Minnesota Statutes, §62A.046. Coordination of benefits includes paying any applicable co-payments or deductibles on behalf of an Enrollee, except for Medical Assistance copayments pursuant to section 4.19. For Enrollees who are also eligible for Medicare, coordination of benefits includes paying any applicable copayments, coinsurance or deductibles on behalf of an Enrollee, up to the Medicare allowed amount.

11.3.2 Cost Avoidance.

(A) The MCO shall Cost Avoid all claims or services that are subject to third-party payment to the extent permitted by state and federal law, and may deny a service to an Enrollee if the MCO is assured that a third party (i.e., other insurer) will provide the service. The MCO must determine whether it is more cost-effective to provide the service or pay the co-pays, coinsurance and deductibles to a Non-Participating Provider. If the MCO refers an Enrollee to a third-party insurer for a service that the MCO covers, and the third-party insurer requires payment in advance of all co-payments, coinsurance and deductibles, the MCO shall make such payments in advance or at the time such payments are required.

11.3.3 Post-Payment Recoveries.

(A) Post-Payment Recoveries to be Pursued by the MCO. The MCO shall recover funds Post Payment in cases where the MCO was not aware of third-party coverage at the time services were rendered or paid for, or the MCO was not able to Cost Avoid (payment was not available at the time the claim was filed). The MCO shall identify all potentially liable third parties and pursue reimbursement from them. Potentially liable third party coverage sources include, but are not limited to,

(1) Uninsured/Under insured motorist insurance,

(2) First and third party liability insurance,

(3) Awards as a result of a tort action,

(4) Workers' compensation,

(5) Medical payments insurance for accidents (otherwise known as "med pay" provisions or benefits of policy),

(6) Long Term Care Insurance, and

(7) Indemnity/accident insurance.

(B) The MCO shall develop procedures to identify trauma diagnoses and investigate potential liability.

(C) Recoveries Not to be Pursued by the MCO. The MCO shall not pursue reimbursement under estate recovery or medical support recovery provisions. This applies to recoveries of medical expenses paid for an Enrollee when the following subsequent recovery actions are taken by a Local Agency or the STATE: 1) Medical Assistance lien or estate recovery; 2) Special Needs or Pooled Trusts; or 3) annuities.

11.4 Reporting of Recoveries.

11.4.1 Report on Encounters. The MCO shall report on the encounter claim all third party liability payments as required in section 3.4.1.

11.4.2 Quarterly Report.

(A) The MCO shall, on a quarterly basis, also disclose to the STATE all Cost Avoided and recovered amounts made from private insurance carriers and other responsible third parties, using a format provided by the STATE. This report is due by the 20th of the month following the end of the quarter.

(B) For MSC+, Medicare cost avoidance and recovery amounts must include fee-for-service (Original) Medicare.

(C) For MSHO, the MCO shall also report an estimate of Medicare payment, however, the MCO may base the estimate on the methodology used for submitting bids to CMS to derive the amount.

11.5 Causes of Action. If the MCO becomes aware of a cause of action to recover medical costs for which the MCO has paid under this Contract, the MCO shall file a lien, assert a claim or a subrogation interest in the cause of action. The MCO shall follow the STATE's policy guidelines in settlement of any claim.

11.6 Determination of Compliance. The STATE may determine whether the MCO is in compliance with the requirements in this Article by inspecting source documents for (1) appropriateness of recovery attempt; (2) timeliness of billing; (3) accounting for third party payments; (4) settlement of claims; and (5) other monitoring deemed necessary by the STATE.

Article. 12 Governing Law, Jurisdiction and Venue. This Contract, and amendments and supplements thereto, will be governed by the laws of the State of Minnesota. Venue for all legal proceedings arising out of this contract, or breach thereof, will be in the state or federal court with competent jurisdiction in Ramsey County, Minnesota.

Article. 13 Compliance with State and Federal Laws. The MCO shall comply with all applicable state and federal laws and regulations in the performance of its obligations under this Contract. Any revisions to applicable provisions of federal or state law and implementing regulations, and policy issuances and instructions, except as otherwise specified in this Contract, apply as of their effective date. If any terms of this Agreement are determined to be inconsistent with rule or law, the applicable rule or law provision shall govern.

In the performance of obligations under this Contract, the MCO agrees to comply with provisions of the following laws:

13.1 Constitutions. The Constitutions of the United States and the State of Minnesota.

13.2 Prohibitions Against Discrimination.

(A) Title VI of the Civil Rights Act of 1964 and pertinent regulations at 45 CFR § 80.

(B) Executive Order 11246 (30 FR 12319), Equal Employment Opportunity, dated September 24, 1965; "Equal Employment Opportunity," as amended by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment

Opportunity," and as supplemented by regulations at 41 CFR Part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity Department of Labor," as applicable.

(C) Section 504 of the Rehabilitation Act of 1973 and pertinent regulations at 45 CFR § 84.

(D) Section 508 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794d).

(E) Age Discrimination Act of 1975 and pertinent regulations at 45 CFR Part 91.

(F) Minnesota Statutes, §363A.36.

(G) Title IX of the Education Amendments of 1972.

(H) The MCO shall cooperate with the STATE's Medicare Revenue Enhancement Program (MREP) to ensure that Skilled Nursing Facility days are covered pursuant to Medicare guidelines. Cooperation includes but is not limited to filing Requests for Redetermination for which DHS must be allowed up to one hundred and twenty (120) days from the date of denial.

(I) The Americans with Disabilities Act. 1990, 42 U.S.C. §12101, et seq., and regulations promulgated pursuant to it. The MCO also shall comply with 28 CFR §35.130(d), which requires the administration of services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

(J) Any other laws, regulations, or orders that prohibit discrimination on grounds of race, sex, color, age, religion, health status, physical disability, sexual orientation, national origin, or public assistance status.

13.3 State Laws. Minnesota Statutes, § 256B.69 et seq.; Minnesota Rules, Parts 9500.1450 to 9500.1464; Minnesota Statutes, § 256D.03; Minnesota Statutes, § 256L.01 et. seq.; and Minnesota Rules, Parts 9506.0010 to 9506.0400.

13.4 Medicaid Laws. Title XIX of the Social Security Act (42 U.S.C. § 1396 et. seq.), applicable provisions of 42 CFR Part 431.200 et. seq. and 42 CFR Part 438; waivers or variances approved by CMS; the Rehabilitation Act of 1973.

13.5 Environmental Requirements. The MCO shall comply with all applicable standards, order or requirements issued under section 306 of the Clean Air Act (42 USC §1857(h)), section 508 of the Clean Water Act (33 USC § 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Part 15).

13.5.1 Energy Efficiency Requirements. The MCO shall recognize mandatory standards and policies relating to energy efficiency which are contained in the State energy conservation plan issued in compliance with the Energy Policy and Conservation Act (PL. 94-163, 89 Stat, 871), as applicable.

13.6 Anti-Kickback Provisions. The MCO shall be in compliance with the Copeland "Anti-Kickback" Act, 18 U.S.C. § 874, as supplemented by Department of Labor regulations, 29 CFR Part 3, "Contractors and Subcontractors on Public Building or Public Work financed in whole or in part by Loans or Grants from the United States," as applicable.

13.7 Davis-Bacon Act. The MCO shall be in compliance with the Davis-Bacon Act, as amended (40 U.S.C. §§ 276a to 276a-7), as supplemented by Department of Labor regulations (29 CFR Part 5), as applicable.

13.8 Contract Work Laws. The MCO shall be in compliance with the Contract Work Hours and Safety Standards Act (40 U.S.C. §§ 327-330), as supplemented by Department of Labor regulations (29 CFR Part 5), as applicable.

13.9 Regulations about Inventions. As applicable, the MCO will provide for the rights of the Federal Government and the recipient in any resulting invention in accordance with 37 CFR Part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any further implementing regulations issued by HHS.

13.10 Prohibition on Weapons. MCO agrees to comply with all terms of the Minnesota Department of Human Services' policy prohibiting carrying or possessing weapons wherever and whenever MCO is performing services within the scope of this contract. Any violations of this policy by MCO or MCO's employees may be grounds for immediate suspension or termination of the contract.

Article. 14 Information Privacy and Security. The MCO will comply with the following requirements regarding Protected Information.

14.1 HIPAA Compliance. The MCO and the STATE shall be in compliance with the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), any rules promulgated thereunder, and the Health Care Administrative Simplification Act of 1994, Minnesota Statutes, § 62J.50 et. seq., including but not limited to, compliance with 45 CFR Parts 160 and 162, Health Insurance Reform: Standards for Electronic Transactions, except as provided in section 3.4.1. The MCO shall be in compliance with these requirements consistent with the applicable effective dates contained in state or federal law.

14.2 Business Associate and Trading Partner. The STATE makes available and/or transfers to the MCO certain information in connection with the provision of services provided by the MCO on behalf of the STATE and in making available and transferring certain information discloses to the MCO certain Protected Health Information (PHI) as defined in 45 CFR § 164.501.

> (A) PHI. PHI is considered "private data on individuals" (as defined in Minnesota Statutes, § 13.02, subd. 12) and must be afforded special treatment and protection. PHI is subject to regulatory protection under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), implementing regulations at 45 CFR Parts 160

and 164, the Standards for Security of Protected Health Information and Privacy of Identifiable Health Information (hereinafter Privacy Regulation).

(B) Covered Entity. Both the STATE and MCOs are a "Covered Entity" as the term is defined in the Privacy Regulation; and because the MCO receives PHI from the STATE, it is also a "Business Associate" of the STATE as the term is defined in the Privacy Regulation. Pursuant to the Privacy Regulation, Business Associates of Covered Entities must agree in writing to certain mandatory provisions regarding the use and disclosure of PHI.

(C) Trading Partner. The MCO exchanges electronically transmitted PHI with the STATE, and is a "Trading Partner" in accordance with the Privacy Regulation. Pursuant to the Privacy Regulation, Trading Partners must comply with the requirements of the Privacy Regulation as it relates to conducting standard transactions. The purpose of this section is to assure and document that the parties comply with the requirements of the Privacy Regulation, including, but not limited to, the Business Associate contract requirements at 45 CFR Part 164 and the Administrative requirements for transaction standards between Trading Partners specified at 45 CFR Part 162

(D) Definitions. Unless otherwise provided for in this Contract, capitalized terms in this section have the same meaning as set forth in the Privacy Regulation.

14.3 Duties Relating to Protection of Information.

14.3.1 Proper Handling of Information. MCO shall be responsible for ensuring proper handling and safeguarding by its workforce members (as defined in the Privacy Regulation), subcontractors, Business Associates, and authorized agents of protected information collected, created, used, maintained, or disclosed on behalf of STATE. This responsibility includes ensuring that workforce members and agents comply with and are properly trained regarding, as applicable, the laws listed in section 14.1.

14.3.2 Minimum necessary access to information. MCO shall comply with the "minimum necessary" access and disclosure rule set forth in the HIPAA and the MGDPA. The collection, creation, use, maintenance, and disclosure by MCO shall be limited to "that necessary for the administration and management of programs specifically authorized by the legislature or local governing body or mandated by the federal government." See, respectively, 45 CFR §§ 164.502(b) and 164.514(d), and Minn. Stat. § 13.05 subd. 3.

14.3.3 Part of Welfare System. MCO will be considered part of the "welfare system," as defined in Minnesota Statutes § 13.46, subd. 1, and agrees to be bound by applicable state and federal laws governing the security and privacy of information.

14.3.4 Additional Privacy and Security Safeguards. MCO shall comply with the requirements set forth below regarding "Use of Information."

14.4 Use of Information.

(A) MCO shall:

(1) Not use or further disclose Protected Information created, collected, received, stored, used, maintained or disseminated in the course or performance of this Agreement other than as permitted or required by this Agreement or as required by law, either during the period of this agreement or hereafter.

(2) Use appropriate safeguards to prevent use or disclosure of the protected information by its workforce members, subcontractors and agents other than as provided for by this Agreement. This includes, but is not limited to, having implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentially, integrity, and availability of any protected information that it creates, receives, maintains, or transmits on behalf of STATE.

(3) Report to STATE's privacy official any Privacy Incident or Security Incident of which it becomes aware. The MCO shall comply with any corrective actions required by the STATE as a result of the Privacy Incident or Security Incident. Such corrective action may include, but is not limited to:

(a) Conducting an internal investigation of the incident;

(b) Providing the STATE a report summarizing the MCO's internal review and investigative findings of the incident;

(c) Providing notice of a breach, consistent with HIPAA regulations to Enrollee(s) whose protected information was, or is reasonably believed to have been, accessed; and

(4) Providing updates to the STATE regarding any confirmed or suspected incidents, or lack thereof, involving misuse of the unauthorized data.

(5) Consistent with this Agreement, ensure that any agents (including contractors and subcontractors), analysts, and others to whom it provides Protected Information, agree in writing to be bound by the same restrictions and conditions that apply to it with respect to such information.

(6) Document such disclosures of PHI and information related to such disclosures as would be required for STATE to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

(7) Mitigate, to the extent practicable, any harmful effects known to it of a use, disclosure, or breach of security with respect to Protected Information by it not permitted or required by this Agreement.

(8) Make available PHI in accordance with 45 CFR § 164.524 and Minnesota Statutes, § 13.04, subd. 3, within ten (10) days of the date of the request, excluding Saturdays, Sundays and legal holidays, of receipt of a written request by the STATE.

(9) Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526 within fifteen (15) days of receipt of written request by the STATE.

(10) Make its internal practices, books, records, policies, procedures, and documentation relating to the use, disclosure, and/or security of PHI available to the STATE and/or the Secretary of the United States Department of Health and Human Services (HHS) for purposes of determining compliance with the Privacy Rule and Security Standards, subject to attorney-client and other applicable legal privileges.

(11) Comply with any and all other applicable provisions of the HIPAA Privacy Rule and Security Standards, including future amendments thereto.

(12) Document such disclosures of PHI and information related to such disclosures as would be required for the MCO or the STATE to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

(13) Either: a) provide to STATE information required to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528 within fifteen (15) days of receipt of written request by the STATE; or b) upon the STATE's request, respond directly to the individual requesting an accounting of disclosures from the MCO.

(B) The STATE shall:

(1) Only release information that it is authorized by law or regulation to share with MCO.

(2) Obtain any required consents, authorizations or other permissions that may be necessary for it to share information with MCO.

(3) Promptly notify MCO of limitation(s), restrictions, changes, or revocation of permission by an individual to use or disclose Protected Information, to the extent that such limitation(s), restrictions, changes or revocation may affect MCO's use or disclosure of Protected Information.

(4) Not request MCO to use or disclose Protected Information in any manner that would not be permitted under law if done by STATE.

14.5 Disposition of Data Upon Completion, Expiration, or Agreement Termination. Upon completion, expiration, or termination of this Agreement, MCO will return or destroy all Protected Information that the MCO still maintains received from the STATE or created or received by the MCO for purposes associated with this Agreement. MCO will retain no copies of such Protected Information, provided that if such return or destruction is not feasible, or if MCO is required by the applicable regulation, rule or statutory retention schedule to retain beyond the life of this Agreement, MCO will extend the protections of this Agreement to the Protected Information and refrain from further use or disclosure of such information, except for

those purposes that make return or destruction infeasible, for as long as MCO maintains the information.

14.6 Sanctions. In addition to acknowledging and accepting the terms set forth in this Agreement relating to liability, the parties acknowledge that violation of the laws and protections described above could result in limitations being placed on future access to protected information, in investigation and imposition of sanctions by the U.S. Department of Health and Human Services, Office for Civil Rights, and/or in civil and criminal penalties.

14.7 MCO's Own Purposes. The STATE makes no warranty or representations that compliance by the MCO will be adequate or satisfactory for the MCO's own purposes. The MCO is solely responsible for all decisions it makes regarding the safeguarding of PHI or other Protected Information.

14.8 Privacy Act Compliance. The MCO shall comply with the requirements of the Privacy Act, as implemented by 45 CFR § 5b and 42 CFR § 401(B), as applicable. The MCO must comply with the confidentiality requirements of 42 CFR § 482.24 for medical records and for all other health and enrollment information on Enrollees that is contained in the MCO's records or obtained from CMS or the STATE. The MCO must use and disclose individually identifiable health information in accordance with the privacy requirements in 45 CFR §§ 160 and 164, subparts A and E, to the extent that the requirements are applicable.

14.9 Procedures and Controls. The MCO agrees to establish and maintain procedures and controls so that no information contained in its records or obtained from the STATE or CMS or from others in carrying out the terms of this Contract shall be used by or disclosed by it, its agents, officers, or workforce members except as provided in Minnesota Statutes Chapter 13 and in §1106 of the Social Security Act and implementing regulations.

14.10 Requests for Data. 42 CFR § 431.301 (pursuant to 1902(a)(7) of Title XIX and 42 U.S.C. § 1396a(7)) requires the STATE to ensure that disclosures of data concerning Enrollees and Potential Enrollees be limited to purposes directly connected with the administration of the State Plan, as defined in 42 CFR § 431.302.

14.10.1 Approval. The STATE has not delegated to the MCO the authority to determine whether such disclosures of data are appropriate for any population covered under this MSHO and MSC+ Contract. The MCO must get prior approval from the STATE for disclosures of such data on the Enrollees covered by this Agreement.

14.10.2 MN-HIE. The STATE authorizes the MCO to enter into data sharing or subscriber agreements with Minnesota Health Information Exchange (MN-HIE.)

14.11 Authorized Representatives. The STATE's authorized representative for data privacy and security is the Minnesota Department of Human Service Privacy Official. MCO's responsible authority for complying with data privacy and security is the MCO's Privacy and/or Security Official(s).

14.12 Indemnification. Notwithstanding section 9.10, the MCO agrees to indemnify and save and hold the STATE, its agents and employees harmless from all claims arising out of,

resulting from, or in any manner attributable to any violation by the MCO of any provision of the laws listed in section 2.115 in connection with the performance of the MCO's duties and obligations under this Agreement. This includes, but is not limited to, legal fees and disbursements paid or incurred to enforce the provisions of this Agreement.

Article. 15 Lobbying Disclosure. The MCO certifies that, to the best of its knowledge, understanding, and belief, that:

(A) No Federal Funds Used. No Federal appropriated funds have been paid or will be paid in what the undersigned believes to be a violation of 31 U.S.C. § 1352, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, the modification of any Federal contract, grant, loan, or cooperative agreement, or in any activity designed to influence legislation or appropriations pending before Congress.

(B) Other Funds Used. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer of employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(C) Certification. The undersigned will require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and will require that all sub-recipients certify and disclose accordingly. This certification is a material representation of facts upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by 31 U.S.C., § 1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Article. 16 C.L.I.A. Requirements. All laboratory testing sites providing services under this contract must comply with the Clinical Laboratory Improvement Amendment (C.L.I.A) requirements in 42 CFR § 493. The MCO shall obtain the valid C.L.I.A. certificate numbers from laboratories used by the MCO, and shall ensure that the certificates remain current. The MCO shall make a written report to the STATE of any laboratories it discovers to be non-C.L.I.A. certified.

Article. 17 Advance Directives Compliance. Pursuant to 42 U.S.C. §1396(a)(57) and (58) and 42 CFR §422.128, and 42 CFR §489.100-104, the MCO agrees:

17.1 Enrollee Information. To provide all Enrollees at the time of enrollment a written description of applicable State law on Advance Directives and the following:

(A) Information regarding the Enrollee's right to accept or refuse medical or surgical treatment and to execute a living will, durable power of attorney for health care decisions, or other Advance Directive.

(B) Written policies of the MCO respecting the implementation of the right; and

(C) Updated or revised changes in State law as soon as possible, but no later than ninety (90) days after the effective date of the change.

(D) Information that complaints concerning noncompliance with the Advance Directive requirements may be filed with the State survey and certification agency, pursuant to 42 CFR § 422.128(b)(3), as required in 42 CFR § 438.6(i).

17.2 Providers Documentation. To require MCO's Providers to ensure that it has been documented in the Enrollee's medical records whether or not an Enrollee has executed an Advance Directive.

17.3 Treatment. To not condition treatment or otherwise discriminate on the basis of whether an Enrollee has executed an Advance Directive.

17.4 Compliance with State Laws. To comply with State law, whether statutory or recognized by the courts of the State, on Advance Directives, including Laws of Minnesota 1998, Chapter 399, §38.

17.5 Education. To provide, individually or with others, education for MCO staff, Providers and the community on Advance Directives.

Article. 18 Disclosure.

18.1 Disclosure Requirements. The MCO must consent to any financial, character, and other inquiries by the STATE.

18.1.1 General Disclosure. Upon request by the STATE, the MCO must disclose the following information as indicated in the sections below:

(A) The MCO shall notify the STATE in a timely manner of changes to the MCO's Government Programs staff and management.

(B) The type of organizational structure, a description of the management plan, the general nature of the MCO's business and general nature of the management plan's business.

(C) The MCO's full legal or corporate name and any trade names, aliases, and/or business names currently used.

(D) The jurisdiction of the MCO and date of incorporation, along with any articles of incorporation and by-laws, if applicable, along with state and federal tax returns for the past five years. If the MCO is an organization other than a corporation, the copies of any agreements creating or governing the organization must be submitted.

(E) The date the MCO commenced doing business in Minnesota, and, if the MCO is incorporated outside of Minnesota, a copy of the MCO's certificate of authority to do business in Minnesota.

(F) Whether the MCO is directly or indirectly controlled to any extent or in any manner by another individual or entity; if so, the MCO must disclose the identity of the controlling entity in a description of the nature and extent of control.

(G) Any agreements or understandings that the MCO has entered into regarding ownership or operation of the MCO.

18.1.2 Disclosure of Management/Fiscal Agents. The MCO must disclose the following, if applicable:

(A) A description of the terms and conditions of any contract or agreement between the MCO and the management or fiscal agent.

(B) All corporations, partnerships or other entities providing management of fiscal agent services.

(C) The management or fiscal agent's full legal or corporate name and any trade names currently used. The legal name, aliases, and previous names of management personnel, to the extent known.

(D) The jurisdiction of the management or fiscal agent and date of incorporation, along with any articles of incorporation and by-laws, if applicable, along with state and federal tax returns for the current period and the past six periods. Copies of any agreements creating or governing the organization must be submitted if the management or fiscal agent is an organization other than a corporation.

(E) The date the management or fiscal agent commenced doing business in Minnesota, and if they are incorporated outside of Minnesota, a copy of their certificate of authority to do business in Minnesota.

18.2 Disclosure of, Compliance with, and Reporting of Physician Incentive Plans. The MCO may operate a Physician Incentive Plan, as defined in 42 CFR § 422.208(a), only if the requirements of 42 CFR § 422.208 are met.

18.2.1 Disclosure to the STATE. The MCO must report to the STATE in writing no later than March 31st of each Contract Year, that the MCO is in compliance with the Physician Incentive Plan requirements as set forth in 42 CFR § 422.208. The MCO shall maintain in its files the following information in sufficient detail to enable the STATE or CMS to determine the MCOs compliance with 42 CFR § 422.208 and shall make that information available to the

STATE or CMS upon request. The MCO must take into consideration its contractual relationship with all its subcontractors, including the relationship between its subcontractors and other Providers down to the level of the physician.

(A) The physician/physician group for which risk has been transferred for services not furnished by the physician/physician group, such as referral services.

(B) The type of incentive arrangement such as withhold, bonus or capitation associated with the transfer of risk for the physician/physician group.

(C) The percent of the potential payment to the physician/physician group that is at risk for referrals.

(D) The panel size, and if patients are pooled, the pooling method used to determine if significant financial risk (SFR) exists for the physician/physician group.

(E) If SFR exists, the MCO must provide an assurance that the physician or physician group at SFR has adequate stop-loss protection, including the threshold amounts for individual/professional, institutional, or combination for all services, and the type of coverage (i.e. per member per year or aggregate).

(F) If the MCO has Physician Incentive Plans that place physician/physician groups at SFR for the cost of referral services it must conduct Enrollee surveys and provide a summary of the survey results. Additionally, for MSC+, the STATE shall annually conduct the survey of Enrollees who have disenrolled, and make available the survey results to the MCO.

18.2.2 Disclosure to Enrollees. The MCO must provide the following information in accordance with 42 CFR §422.210 to any Enrollee or Potential Enrollee upon request:

(A) Whether the MCO or its subcontractors use a Physician Incentive Plan that affects the use of referral services.

(B) The type of incentive arrangement(s) used.

(C) Whether stop-loss protection is provided.

(D) If the MCO was required to conduct an Enrollee survey, a summary of the survey results.

Article. 19 Federal Audit Requirements and Debarment Information.

19.1 Single Audit Act. MCO will certify that it will comply with the Single Audit Act, OMB Circular A-128 and OMB Circular A-133, as applicable. The MCO shall obtain a financial and compliance audit made in accordance with the Single Audit Act, OMB Circular A-128 or A-133, as applicable. Failure to comply with these requirements could result in forfeiture of federal funds.

19.2 Debarment, Suspension and Responsibility Certification. Federal Regulation 45 CFR § 92.35 prohibits the STATE from purchasing goods or services with federal money from vendors who have been suspended or debarred by the federal government. Similarly, Minn. Statutes, § 16C.03, subd. 2, provides the Commissioner of Administration with the authority to debar and suspend vendors who seek to contract with the STATE. Vendors may be suspended or debarred when it is determined, through a duly authorized hearing process, that they have abused the public trust in a serious manner.

BY SIGNING THIS CONTRACT, MCO CERTIFIES THAT IT AND ITS PRINCIPALS:

(A) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from transacting business by or with any federal, state or local governmental department or agency; and

(B) Have not within a three-year period preceding this Contract: a) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (federal, state or local) transaction or contract; b) violated any federal or state antitrust statutes; or c) committed embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property; and

(C) Are not presently indicted or otherwise criminally or civilly charged by a governmental entity for: a) commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (federal, state or local) transaction; b) violating any federal or state antitrust statutes; or c) committing embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property; and

(D) Are not aware of any information and possess no knowledge that any subcontractor(s) that will perform work pursuant to this contract are in violation of any of the certifications set forth above.

(E) Shall immediately give written notice to the STATE should MCO come under investigation for allegations of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing: a public (federal, state of local government) transaction; violating any federal or state antitrust statutes; or committing embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property.

Article. 20 Emergency Performance interruption (EPI).

20.1 Business Continuity Plan (BCP). By April 1st of the Contract Year, the MCO shall have in place a written Business Continuity Plan (BCP) to be enacted in the event of an EPI. The BCP must:

(A) Identify an Emergency Preparedness Response Coordinator (EPRC). Include the appointment and identification of an Emergency Preparedness Response Coordinator (EPRC). The EPRC shall serve as the contact for the STATE with regard to emergency

preparedness and response issues and shall provide updates to the STATE as the EPI unfolds. The MCO shall inform the STATE by April 1st of the Contract Year whether there has been any change in the contact information of its appointed EPRC, and must indicate if there are no changes in the notification. If the MCO's EPRC changes at any other time during this agreement, the MCO must immediately notify the STATE.

(B) Outline Activation Procedures. Outline the procedures used for the activation of the BCP upon the occurrence of an EPI.

(C) Ensure Priority Services. Ensure that MCO operations continue to produce and deliver essential products and services, particularly Priority Services obligations, under this contract. This includes, but is not limited to:

(1) Outlining the roles, command structure, decision making processes and emergency action procedures that will be implemented upon the occurrence of an EPI;

(2) Providing alternative operating plans for Priority Services;

(3) Providing procedures to move Enrollees to Fee for Service if the STATE determines such movement is necessary to properly provide service to the Enrollees; and

(4) Providing procedures to allow Enrollees to go to another clinic if their primary care clinic is not functioning.

(D) Include Reversal Process. Include procedures to reverse the process once the external environment permits the MCO to re-enter normal operations.

(E) Be Reviewed, Exercised and Updated. Be reviewed and revised as needed at least annually. The BCP shall also be exercised on a regular basis, typically annually. Exercises are not required to consist of large scale tests of multiple applications, but may instead consist of plan reviews, tabletop exercise and/or unit/component tests. When deciding on what type of exercise to use, the MCO shall balance the benefit of each type of exercise against the criticality of the service, costs (direct and indirect) associated with the exercise, and vulnerability of each service to failure.

(F) Be Available to the STATE. Upon written request, be available to the STATE during normal business hours for review and inspection at the MCO's location.

20.2 EPI Occurrence. If an EPI occurs, the MCO must:

(A) Implement its BCP within two (2) days of such EPI. In the event that the MCO's BCP cannot or is not implemented in this timeframe, the STATE shall have one or more of the following courses of action and remedies:

(1) Require joint management of contract operations between MCO and STATE staff.

(2) Move some or all of the MCO's Enrollees to another MCO.

(3) Bring some or all of the MCO's contractual duties in-house within the STATE.

(4) Immediately terminate the contract for the MCO's failure to provide the BCP services.

(5) Postpone Negotiations. If requested by the STATE, immediately postpone any active or soon to be active negotiations with the STATE for the following year's contract until such time as normal operations can be resumed. If, as a result of the EPI, a contract is not executed for the following year prior to December 15th of the Contract Year, the current contract will be renewed in accordance with Article 5.

(B) Provide Notice to the State. Use best efforts to provide notification to the STATE of any significant closures within the MCO or its network.

(C) Affected Enrollee Access. Allow Enrollees whose Primary Care Provider(s) is significantly affected by the EPI to access other Primary Care Providers or, if found necessary by the STATE, be moved to Fee for Service.

(D) Continuation and Excuse from Services. Continue its duties and obligations under this contract for as long as is practical. If the MCO believes that, despite the implementation of its BCP, it can no longer provide any or all of the Priority Services, the MCO must provide the STATE prompt written notices of such belief and request the STATE excuse it from those services. The notice and request must include specific details as to: (a) what services the MCO is requesting to be excused from providing; and (b) what circumstances prevent the MCO from providing the services.Burden for Excuse. If the MCO asserts that it can no longer provide any or all of the Priority Services as a result of the EPI, the MCO shall have the burden of proving that:

(2) Reasonable steps were taken (under the circumstances) to minimize delay or damages caused by foreseeable events;

(3) That all non-excused obligations will be substantially fulfilled; and

(4) That the STATE was timely notified of the likelihood or actual occurrence which would justify such an assertion, so that other prudent precautions could be contemplated. Failure by the MCO to prove any of these points may result in penalties for contract breach in accordance with Article 5.

(E) Relief from Breach. The MCO's liability for breach under Article 5 of this contract will only be relieved for services excused in writing by the STATE. The STATE will not unreasonably withhold excuse from services for which the MCO has followed the procedures and met the burdens of this section.

(F) Return to Normal Operations. The MCO may suspend the performance of excused services under this Agreement until any disruption resulting from the EPI has been resolved. However, the MCO shall make every effort to eliminate any obstacles

resulting from the EPI so as to minimize to the greatest extent possible its adverse effects. Once the disruptions from the EPI are resolved to the point that the MCO can reasonably resume normal performance on one or more of the excused services, the MCO shall reverse the BCP process and resume normal operations for those services, and provide notice to the STATE of the same.

Article. 21 Modifications. Any material alteration, modification or variation in the terms of this contract shall be reduced to writing as an amendment hereto, signed by the parties, and attached hereto.

Article. 22 Survival. Notwithstanding the termination of this Contract for any reason, sections 3.4 and 9.4 (reporting and access to records), section 4.20 (Medicaid Managed Care Withhold.), sections 4.22 and 4.23 (payment error), section 7.14 (Financial Performance Incentives.) and section 14.5 (Information Privacy and Security, including Indemnification) shall survive the termination of this Contract.

Article. 23 Entire Agreement. The parties understand and agree that the entire agreement of the parties is contained herein and that this Contract supersedes all oral agreements and negotiations between the parties relating to this subject matter. All appendices, guidances, reference books including companion guides, technical specifications and webpages referred to in this Contract are incorporated or attached and deemed to be part of the Contract.

Article. 24 Amendments. Any amendments to this Contract shall be in writing, signed by all parties, and attached hereto.

Signature page follows.

IN WITNESS WHEREOF, the parties hereto have executed this Contract. This Contract is hereby accepted and considered binding in accordance with the terms outlined in the preceding statements.

STATE OF MINNESOTA **DEPARTMENT OF HUMAN SERVICES**		**(MCO)**
		(Two corporate officers must execute)
By:		By:
Name: Brian Osberg		Print Name:
Title: Medicaid Director		Title:
Date:		Date
		and
		By:
		Print Name:
		Title:
		Date

List of Appendices:

Appendix I: Service Areas

Appendix II: Rates

Appendix III: Protocol For Annual Review of Care System Subcontracts and Care Plans

Appendix IV: Long Term Care Elderly Waiver Risk Adjusted Payment System

Correction note: Due to a Department of Human Services requirement to eliminate the use of the term "mental retardation" which was used primarily in describing "intermediate care facility for the mentally retarded," this model contract document was corrected March 8, 2011. The term "mental retardation" was replaced by "developmentally disabled."

APPENDIX III: PROTOCOL FOR ANNUAL REVIEW OF CARE SYSTEM SUBCONTRACTS AND CARE PLANS

The Minnesota Department of Human Services (DHS) requires managed care organizations (MCOs) participating in the Minnesota Senior Health Options (MSHO) program to conduct an annual review of any care system with which they have a subcontract. To assist health plans in conducting these reviews, DHS is distributing the following Guidelines. MCOs should think of these Guidelines as a tool. They can be added to or modified to meet the plans needs or to better reflect the relationship between the plan and the care system. The Guidelines are not intended as a method for regulating care systems.

As part of an annual care system review, an MCO should request the care system to provide them with the following information:

1) 2-3 case studies
2) Provider communication process or tool
3) Institutional and community-based care management models, care coordinator to member ratio, process used to determine who to case manage, and risk assessment methods or tools.
4) Utilization reports, patterns identified and interventions taken, and outcomes measured.
5) As part of an annual review, a health plan should consider reviewing the following information and/or policies:
6) Medical Records
7) Policy and Procedures for the following:

Tracking and institutional status
Completion of screening documents
Tracking rate cell changes
Pre-admission screening
Authorization of enhanced services
Care management decisions
Providing culturally appropriate care
Tracking 180 days of NF liability
Spousal impoverishment referrals
Evaluating requests for services
Transfer to or from another care system
Compliance with marketing procedures
Completion and processing of referrals
Obtaining medical records
Coordination for MH/SA care
Coordination for dental care
Member complaints
Member confidentiality
Suspected fraud and abuse reporting
Advance Directives
Education and enrollment process

a) Copies and results of any member and provider satisfaction surveys conducted

b) Copies of all standard correspondence with members

c) Marketing materials, if any

d) UM reports

e) Copies of monthly financial reports

f)