MINNESOTA DEPARTMENT OF HUMAN SERVICE
CONTRACT FOR MEDICAL ASSISTANCE, GENERAL ASSISTANCE AND MINNESOTACARE MEDICAL CARE SERVICES

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MINNESOTA DEPARTMENT OF HUMAN SERVICES
CONTRACT FOR MEDICAL CARE SERVICES FOR FAMILIES AND CHILDREN

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 _________________, Managed Care Organization (MCO) (hereinafter MCO);

WHEREAS, the STATE and the MCO have agreed to renew the Contract numbered _______, for the period of January 1, 2007 through December 31, 2007;

WHEREAS, 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, sections 256B.69 and 256B.692; for the MinnesotaCare Program, Minnesota Statutes Chapter 256L; and for the General Assistance Medical Care Program, Minnesota Statutes, section 256D.03; and may request waivers for the Medical Assistance program pursuant to Section 1115 of the Social Security Act, 42 U.S.C. § 1315 et seq.; and,

WHEREAS, this contract represents the Prepaid Medical Assistance/Prepaid General Assistance Medical Care and MinnesotaCare programs for persons eligible for Medical Assistance under the age of 65, and all eligible persons in General Assistance Medical Care (GAMC) and MinnesotaCare.

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

Article 1. Overview. This Agreement applies to the health benefits the MCO shall provide through the Prepaid Medical Assistance, Prepaid General Assistance Medical Care and MinnesotaCare programs for persons eligible for Medical Assistance under the age of 65, and all eligible persons in General Assistance Medical Care (GAMC) and MinnesotaCare. The Medical Assistance, General Assistance Medical Care and MinnesotaCare Medical Care programs are public health benefits programs intended to provide Enrollees with access to cost-effective health care options.

All articles of this Contract apply to all programs, unless otherwise noted.

Article 2. Definitions. Whenever used in this Agreement, 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.

Section 2.1. ***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.

Section 2.2. ***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, under Section 3.1.2.F., to obtain services outside the network.

Section 2.3. ***Adjudicate*** means the point at which a claim has reached its final disposition of paid or denied.

Section 2.4. ***Adult*** means an individual 21 years of age or older.

Section 2.5. ***American Indian*** means those persons for whom services may be provided pursuant to 25 CFR 900.6.

Section 2.6. ***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 or an Enrollee's written request for review of a Grievance.

Section 2.7. ***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.

Section 2.8. ***Capitation Payment*** means a payment the STATE makes periodically to the MCO for each Enrollee covered under the Contract for the provision of medical services as defined in Article 6 regardless of whether the Enrollee receives these services during the period covered by the payment.

Section 2.9. ***Care Management for all Enrollees*** means the overall method of providing on-going health care in which the MCO manages the provision of primary health services with additional appropriate services provided to an Enrollee. See Section 6.1.3.

Section 2.10. ***Child*** means, for MinnesotaCare, an individual under 21 years of age, including the unborn Child of a Pregnant Woman, an emancipated minor, and the emancipated minor's spouse (if under 21) pursuant to Minnesota Statutes, section 256L.01, subdivision 1a. ***Child*** means, for Medical Assistance and GAMC, an individual under 21 years of age pursuant to Minnesota Statutes, section 256B.055, subdivision 9.

Section 2.11. ***Clean Claim*** means, pursuant to 42 CFR 447.45 and 447.46, and Minnesota Statutes, section 62Q.75, 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.

Section 2.12. ***Clinical Trials*** means those trials that: 1) have been subjected to independent peer-review of the rationale and methodology; 2) 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 3) whose results will be reported upon completion of the trial regardless of their positive or negative nature.

Section 2.13. ***CMS*** (formerly Health Care Financing Administration (HCFA)) means Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

Section 2.14. ***Common Carrier Transportation*** means the transport of an Enrollee by a bus, taxicab, or other commercial carrier or by private automobile.

Section 2.15. ***Community Health Services Agency*** means a "local health agency" or a public or private nonprofit organization that enters into a contract with the Minnesota Commissioner of Health pursuant to Minnesota Statutes, sections 145.891 through 145.897.

Section 2.16. ***Cost Avoidance Procedure*** means the process by which a Provider obtains payment from the identified third party resource before billing the MCO.

Section 2.17. ***Covered Service*** means a health care service as defined in Minnesota Statutes, section 256B.0625, and Minnesota Rules, Parts 9505.0170 through 9505.0475, and that was provided in accordance with the MCO's Service Delivery Plan and the MCO Certificate of Coverage, as approved by the STATE.

Section 2.18. ***Cut-Off Date*** means the last day on which enrollment information may be entered in MMIS in order to be effective the first day of the following month.

Section 2.19. ***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 that: 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.

Section 2.20. ***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.

Section 2.21. ***EPSDT (or C&TC)*** means the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) Program required under 42 CFR 441.50, known in Minnesota as the

Child and Teen Checkups (C&TC) Program, that provides comprehensive health services for Medical Assistance-eligible Children under age 21.

Section 2.22. ***Education Begin Date*** means the date on which the MCO will be presented by the Local Agency as an initial enrollment option to PMAP and PGAMC Recipients.

Section 2.23. ***Enrollee*** means a Medical Assistance, GAMC, or MinnesotaCare eligible person 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 representative 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.

Section 2.24. ***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.

Section 2.25. ***Family Planning Service*** means a family planning supply (related prescribed 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.

Section 2.26. ***Federally Qualified HMO*** means an HMO that CMS has determined is a qualified HMO under section 1310(d) of the Public Health Service (PHS) Act.

Section 2.27. ***Fraud*** means the definition set out in Minnesota Rules, Part 9505.2165, subpart 4.

Section 2.28. ***General Assistance Medical Care or GAMC*** means the state medical program authorized under Minnesota Statutes, section 256D.03.

Section 2.29. ***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.

Section 2.30. ***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.

Section 2.31. ***Grievance System*** means the overall system that includes Grievances and Appeals handled at the MCO and access to the State Fair Hearing process.

Section 2.32. ***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.

Section 2.33. ***Home Care Services*** includes nursing services, private duty nursing services, home health aide services, personal care assistant services, nursing supervision of personal care services, physical therapy, occupational therapy, speech therapy, respiratory therapy, durable medical equipment, and supplies.

Section 2.34. ***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.

Section 2.35. ***Inpatient Hospitalization*** includes inpatient medical, mental health and chemical dependency services, excluding free-standing residential chemical dependency facilities.

Section 2.36. ***Local Agency*** means a county or multi-county agency that is authorized under Minnesota Statutes, sections 393.01, subdivision 7, and 393.07, subdivision 2, as the agency responsible for determining Recipient eligibility for the Medical Assistance and GAMC programs. Local Agency also means a federally recognized American Indian tribe's social service, human service, and/or health services agency.

Section 2.37. ***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.

Section 2.38. ***Marketing*** means any communication from a 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 reenroll in the MCO's product(s) under this Contract.

Section 2.39. ***Marketing Materials*** means materials that:

Section 2.39.1. Are produced in any medium, by or on behalf of an MCO; and

Section 2.39.2. Can reasonably be interpreted as intended to influence individuals to enroll or reenroll in the MCO's product(s) under this Contract.

Section 2.40. ***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 30 miles or 30 minutes; or 2) a change which results in the discontinuation of a Primary Care Provider who is responsible for Primary Care for 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 that involves a termination of a sole source service Provider 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.

Section 2.41. ***Medical Assistance*** means the federal/state Medicaid program authorized under Title XIX of the federal Social Security Act and Minnesota Statutes, Chapter 256B.

Section 2.42. ***Medical Assistance Drug Formulary*** means prescription or over-the-counter drugs covered under the Medical Assistance program as determined by the Commissioner of Human Services pursuant to Minnesota Statutes, section 256B.0625, subdivision 13.

Section 2.43. ***Medical Assistance Family and Children*** means a category of PMAP Enrollees used as a factor to determine the Rate Cell of an individual Enrollee.

Section 2.44. ***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.

Section 2.45. ***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.

Section 2.46. ***Medical Support*** means cash contributions by a Child's Parent for all or a portion of the Child's ongoing medical expenses in accordance with a court order or judgment, pursuant to Minnesota Statutes, section 518.171.

Section 2.47. ***Medically Necessary or Medical Necessity*** means, 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:

1) in response to a life threatening condition or pain; or

2) to treat an injury, illness or infection; or

3) to treat a condition that could result in physical or mental disability; or

4) to care for the mother and child through the maternity period; or

5) to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition; or

6) as a preventive health service defined under Minnesota Rules, Part 9505.0355.

Section 2.48. ***Medicare Prescription Drug Program (Part D Drug Benefit)*** means the prescription drug benefit for Medicare beneficiaries, pursuant to Title I of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173.

Section 2.49. ***Metro Area*** means the following seven Minnesota counties: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington.

Section 2.50. ***MinnesotaCare*** means the program authorized in Minnesota Statutes, Chapter 256L, to promote access to appropriate covered health services to assure healthy Children and Adults.

Section 2.51. ***MinnesotaCare Enrollee*** means a non-Pregnant Adult who meets MinnesotaCare eligibility requirements, has paid the required Premium (active) and is eligible to receive the MinnesotaCare health care service described in Section 6.3.2. of this Contract.

Section 2.52 ***MinnesotaCare Limited Benefit Set (MLB)*** means the program authorized in Minnesota Statutes, section 256L.035 that offers limited benefits for certain single adults and households without children. Enrollees of this program receive the health care services described in Section 6.3.3. of this Contract.

Section 2.53. ***MinnesotaCare/Medical Assistance Enrollee*** means a Child or Pregnant Woman who meets MinnesotaCare/Medical Assistance eligibility requirements, has paid the required Premium (active) and is eligible to receive the MinnesotaCare/Medical Assistance health care services described in Section 6.3.1. of this Contract.

Section 2.54. ***MMIS*** means the Medicaid Management Information System.

Section 2.55 ***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.

Section 2.56. ***Notice of Action*** includes a Denial, Termination, or Reduction of Service Notice (DTR) and notice of any other Action taken by the MCO as it is defined in 42 CFR 438.400(b).

Section 2.57. ***Out of Service Area*** refers to healthcare provided to an Enrollee by non-Participating Providers outside of the geographical area served by the MCO.

Section 2.58. ***Out of Plan*** refers to healthcare provided to an Enrollee by non-Participating Providers within the geographic area served by the MCO.

Section 2.59. ***Parent*** means, for MinnesotaCare, the legal guardian or birth, step, or adoptive mother or father of a Child.

Section 2.60. ***Participating Provider*** means a Provider who is employed by or under contract with the MCO to provide health services to Enrollees.

Section 2.61. ***Party in Interest*** means:

A. Any person who is:

1) a director, officer, partner, or employee responsible for management or administration of an MCO;

2) directly or indirectly the beneficial owner of more than 5% of the equity of an MCO;

3) the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5% of an MCO; or

4) in the case of an MCO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law.

B. Any organization in which a person described in paragraph (A):

1) is director, officer or partner;

2) had directly or indirectly a beneficial interest of more than 5% of the equity of the MCO; or

3) has a mortgage, deed of trust, note or other interest valuing more than 5% of the assets of the MCO.

C. Any person directly or indirectly controlling, controlled by, or under common control with an MCO.

D. Any spouse, child, or parent of an individual described in paragraphs (A), (B), or (C).

Section 2.62. ***Person Master Index (PMI)*** means the STATE identification number assigned to an individual Recipient.

Section 2.63. ***Person with an Ownership or Control Interest*** means a person or corporation that: 1) owns, directly or indirectly, 5% or more of the MCO's capital or stock or receives 5% or more of its profits; 2) has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the MCO or by its property or assets, and that interest is equal to or exceeds 5% of the total property and assets of the MCO; or 3) is an officer or director of the MCO (if it is organized as a corporation) or is a partner in the MCO (if it is organized as a partnership).

Section 2.64. ***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 417.479 (c).

Section 2.65. ***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.

Section 2.6. ***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 (1) 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 one hour; or 5) the MCO and treating Provider are unable to reach agreement regarding the Enrollee's care. The MCO must meet one of the criteria specified in Section 6.24.1.B. of the Contract to end its financial responsibility for Post-Stabilization Care Services.

Section 2.67. ***Potential Enrollee*** means a Medical Assistance, GAMC or MinnesotaCare eligible person who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an Enrollee of a specific MCO.

Section 2.68. ***Pregnant Woman*** means a basis of eligibility for Medical Assistance, as defined in 42 CFR Part 435 and implemented under State law that is used as a factor to determine the Rate Cell of an Enrollee.

Section 2.69. ***Premium Payment*** means, for MinnesotaCare, the payment made by a MinnesotaCare applicant or Enrollee and received by the STATE as required under Minnesota Statutes, section 256L.06 and Minnesota Rules, Part 9506.0040.

Section 2.70. ***Prepaid General Assistance Medical Care Program, or PGAMC*** means the program authorized under Minnesota Statutes, section 256D.03.

Section 2.71. ***Prepaid Medical Assistance Program, or PMAP*** means the program authorized under Minnesota Statutes, section 256B.69 and Minnesota Rules, Parts 9500.1450 through 9500.1464.

Section 2.72. ***Primary Care*** means all healthcare services and laboratory services customarily furnished by or through a general practitioner, family practice physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them.

Section 2.73. ***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 485.0100, subpart 12b, under contract with or employed by the MCO.

Section 2.74. ***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.

Section 2.75. ***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, and definitions of Covered Services under the Medical Assistance, GAMC and MinnesotaCare programs.

Section 2.76. ***Quality Care and Rewarding Excellence, or QCare*** means a quality standard program, pursuant to Minnesota Executive Order 06-10, used by the STATE in its health care purchasing policies to reward top performing Providers while reducing health care costs by:

A. implementing quality of care standards;

B. setting aggressive targets for health care Providers;

C. making measures available to the public online; and

D. changing the health care payment system to reward quality rather than quantity.

Section 2.77. ***Qualified Professional*** means a Qualified Professional as defined in Minnesota Statutes, section 256B.0625, subd. 19c.

Section 2.78. ***Rate Cell*** means the category attributed to an Enrollee to determine the monthly prepaid capitation rate that will be paid by the STATE to the MCO for health care 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, and product ID.

Section 2.79. ***Recipient*** means a person who has been determined by the STATE or Local Agency to be eligible for the Medical Assistance or General Assistance Medical Care Program or eligible and active for the MinnesotaCare Program.

Section 2.80. ***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 24 months of eligibility the Recipient/Enrollee must obtain health services from:

    1) a designated Primary Care Provider or Providers located in the Recipient's/Enrollee's local trade area, a hospital, pharmacy, or other designated health service Provider;

    2) an agency licensed by the Minnesota Department of Health according to Minnesota Statutes, Chapter 144A, as a class A or other home care agency or a designated Medicare certified home health agency; and

B. Prohibiting the Recipient/Enrollee from using the personal care assistance choice or consumer directed community support services for a period of 24 months of eligibility.

Section 2.81. ***Rural Area*** means any area other than an urban area as an urban area is defined in 42 CFR 412.62(f)(1)(iii).

Section 2.82. ***Service Area*** means the Counties of Minnesota in which the MCO agrees to offer health coverage under this Contract. See Appendix I - MCO Service Areas.

Section 2.83. ***Service Authorization*** means a managed care Enrollee's request, or a Provider's request on behalf of an Enrollee, for the provision of a medical service, and the MCO's determination of the Medical Necessity for the medical service prior to the delivery or payment of the service.

Section 2.84. ***Spenddown*** means the process by which a person who has income in excess of the Medical Assistance income standard allowed in Minnesota Statutes, section 256B.056, subdivision 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.

Section 2.85. ***STATE*** means the Minnesota Department of Human Services, or its agents, and the Commissioner of Human Services.

Section 2.86. ***State Fair Hearing*** means a hearing filed according to an Enrollee's written request with the STATE pursuant to Minnesota Statutes, section 256.045, related to: 1) the delivery of health services or participation in the MCO; 2) denial (full or partial) of a claim or service; 3) failure to make an initial determination in 30 days; or 4) any other Action or Grievance.

Section 2.87. ***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.

Section 2.88. ***Telemedicine Consultations*** 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.

Section 2.89. ***Transitional MinnesotaCare*** means the Minnesota publicly funded health care program for single adults and households with no children formerly enrolled in GAMC and enrolled in MinnesotaCare pursuant to Minnesota Statutes, sections 256D.03, subd. 3, and 256L.07, subd. 6.

Section 2.90. ***Urgent Care*** means acute, episodic medical services available on a 24-hour basis that are required in order to prevent a serious deterioration of the health of an Enrollee.

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

Section 3.1. ***Eligibility and Enrollment Duties.***

Section 3.1.1. ***Eligibility.***

A. ***Service Area***. Only those eligible persons who are enrolled in Medical Assistance, GAMC and MinnesotaCare residing within the County(ies) of the State of Minnesota identified in Appendix I – MCO 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 Determinations for Medical Assistance and GAMC.*** Eligibility for Medical Assistance and GAMC and eligibility for participation in PMAP and PGAMC will be determined by the Local Agency. All persons who receive Medical Assistance or GAMC and reside in the Service Area will participate in PMAP or PGAMC, except for Recipients who are members of the following Medical Assistance and GAMC populations:

1.) Recipients receiving Medical Assistance due to blindness or disability as determined by the U.S. Social Security Administration or the STATE Medical Review Team, except if 65 years of age or older.

2.) Medical Assistance and GAMC Recipients receiving the Refugee Assistance Program pursuant to 8 U.S.C. § 1522(e).

3.) Medical Assistance and GAMC Recipients who are residents of state institutions, unless the placement has been approved by the MCO. For purposes of this Contract, approval by the MCO would include a placement which is court-ordered within the terms described in Section 6.1.18.C. For purposes of this Section, Ah Gwah Ching Nursing Facility and the Woodhaven Senior Community are not considered state institutions.

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

5.) Individuals who are Qualified Medicare Beneficiaries (Q.M.B.), as defined in Section 1905(p) of the Social Security Act, 42 U.S.C. § 1396d(p), who are not otherwise receiving Medical Assistance.

6.) Individuals who are Service Limited Medicare Beneficiaries (S.L.M.B.), as defined in Section 1905(p) of the Social Security Act, 42 U.S.C. § 1396a(a)(10)(E)(iii) and 1396d(p), and who are not otherwise receiving Medical Assistance.

7.) Non-citizen Recipients who only receive emergency Medical Assistance under Minnesota Statutes, section 256B.06, subdivision 4.

8.) Recipients receiving Medical Assistance or GAMC on a medical Spenddown basis.

9.) Recipients, who at the time of notification of mandatory enrollment in PMAP or PGAMC, 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.

10.) Medical Assistance and GAMC Recipients with private healthcare coverage through a HMO certified under Minnesota Statutes, Chapter 62D. Such Recipients may enroll in PMAP and PGAMC on a voluntary basis if the private HMO is the same as the MCO the person will select under PMAP or PGAMC.

11.) Recipients of GAMC receiving the "GAMC Hospital Only" benefit according to Minnesota Statutes, section 256D.03, subd. 3.

12.) Medical Assistance and GAMC Recipients with cost effective employer-sponsored private healthcare coverage, or who are enrolled in a non-Medicare individual health plan determined to be cost-effective according to Minnesota Statutes, section 256B.69, subd. 4(b)(9).

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

14.) GAMC persons who are eligible for Medicare benefits or who reside in nursing homes.

15.) Women receiving Medical Assistance through the Breast and Cervical Cancer Control Program.

D. The following populations are excluded from mandatory enrollment, but may elect to enroll in PMAP on a voluntary basis:

1.) Adults who are determined to be seriously and persistently mentally ill and eligible to receive Medical Assistance covered targeted case management services pursuant to Minnesota Statutes, section 245.4711.

2.) Children who are determined to be severely emotionally disturbed and eligible to receive Medical Assistance covered targeted case management

services pursuant to Minnesota Statutes, section 245.4881.

3.) Children who are receiving Medical Assistance through adoption assistance according to Minnesota Statutes, section 256B.69, subd. 4(b)(1).

E. ***Eligibility Determinations for MinnesotaCare.*** Eligibility for MinnesotaCare will be determined by the STATE or the Local Agency. All persons who receive MinnesotaCare and reside in the Service Area will participate.

Section 3.1.2. *Enrollment.*

A. ***Nondiscrimination.*** The MCO will accept all eligible Recipients, pursuant to Section 3.1.1., who select or are assigned to the MCO without regard to physical or mental condition, health status, need for health services, 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 or are assigned. Recipients who do not choose an MCO within the allotted time will be assigned to an MCO by the STATE. The STATE may limit the number of Enrollees in the MCO if, in the STATE's judgment, the MCO is unable to demonstrate a capacity to serve additional Enrollees.

C. ***Timing of Enrollment.*** Recipients may enroll with the MCO at any time during the duration of this Contract, subject to the limitations under Article 3.

D. ***Transitional MinnesotaCare.*** The Local Agencies shall enroll single adults and households with no children, formerly enrolled in GAMC, in MinnesotaCare according to Minnesota Statutes, sections 256D.03, subd. 3, and 256L.07, subd. 6. The Local Agencies shall pay any required premiums for these individuals for no less than their first six months of enrollment.

E. ***Period of Enrollment.*** Each 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.

F. ***Single MCO Entity Provider***. If the MCO is a single entity Provider in a Rural Area, the MCO must allow Recipients: 1) to choose from at least two Participating Providers; and 2) to obtain services from any other Provider when the circumstances allow pursuant to 42 CFR 438.52.

G. ***Enrollee Change of MCO.*** Enrollees may change to a different MCO during the open enrollment period, and as required under Minnesota Rules, Part 9500.1453, subparts 5, 7 and 8, and 42 CFR Part 438. Also see Section 3.4.1.C and G.

H. ***Reenrollment.*** In no circumstance shall the MCO randomly assign an Enrollee to a Primary Care Provider upon reenrollment.

I. ***Choice of Health Care Professional***. The MCO must allow an Enrollee to choose his or her health 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).

J. ***Enrollee Change of Primary Care Provider.*** The Enrollee may change to a different Primary Care Provider within the MCO's network every thirty days upon request to the MCO. This Section does not apply to Enrollees who are under administrative sanctions pursuant to Section 8.8.

K. ***Open Enrollment***. The MCO shall enroll any eligible Recipients during any open enrollment period required by the STATE.

L. ***Notice to Student Enrollees.*** MCOs meeting the definition of a closed panel health plan, as defined in Minnesota Statutes, section 62Q.43, subdivision 1, shall at least annually notify full-time student Enrollees under the age of 25 of their right to change their designated clinics or physicians at least once per month. The MCO may require from the student at least 15 days notice of intent to change his or her designated clinic or physician, and as long as the clinic or physician is part of the MCO's statewide clinic or physician network.

M. ***Effective Date of Coverage***. MCO coverage of Enrollees shall commence at the following times:

1.) When enrollment occurs and has been entered on the STATE's MMIS on or before the Cut-Off Date, medical coverage shall commence at midnight, Minnesota time, on the first day of the month following the month in which the enrollment was entered on the STATE MMIS.

2.) 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 the enrollment was entered on the STATE MMIS.

3.) Eligible newborns will be enrolled in the same MCO as the mother for the birth month, unless the newborn meets one of the exclusion reasons listed in Section 3.1.1. If a newborn is enrolled in the MCO on MMIS within 90 days of the birth, the MCO will receive a capitation payment for the birth month and the succeeding months as long as the newborn remains eligible and there is not a request to change to another MCO. If the newborn is not

enrolled in the MCO within 90 days of the birth, the MCO will receive a capitation payment for the birth month only, and will be enrolled in the MCO for the next available month unless a change of MCOs is requested.

4.) MCO coverage of Recipients or Enrollees who are receiving inpatient hospitalization services at the time coverage otherwise would become effective under 1) and 2) above of this Section shall commence:

a.) for a MinnesotaCare or MinnesotaCare/Medical Assistance Enrollee, during initial enrollment into managed care, on the first day after discharge from the hospital, except that eligible newborns may be enrolled in the MCO effective the first day of the month of birth, even if hospitalized.

b.) for Medical Assistance, GAMC and MinnesotaCare or MinnesotaCare/Medical Assistance Enrollees not included in 4(a), on the first day of the month following the month of discharge from the hospital, except for eligible newborns who may be enrolled in the MCO effective the first day of the month of birth, even if hospitalized.

5.) For Enrollees who are in an Inpatient Hospital or a Chemical Dependency (CD) Residential Treatment Facility (Rule 31) (e.g. extended care, halfway house or free-standing residential CD treatment facility) at the time of enrollment in the MCO, the effective date of the enrollment will be delayed until the first day of the month following the Enrollee's discharge from the Inpatient Hospital or CD facility.

N. ***Capability to Receive Electronically.***

1) The MCO shall have the capability to receive enrollment data electronically via a medium prescribed by the STATE. If there is a disruption of the STATE's electronic capabilities, the MCO has the time period specified in Section 3.2.5.A. to disseminate enrollment information to its Enrollees.

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 3.4.4. 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 in this paragraph.

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 Section, the STATE shall provide the MCO with reasonable written notice of the new timelines.

Section 3.1.3. ***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. To be furnished health care services in accordance with 42 CFR 438.206 through 438.210.

H. That each Enrollee is free to exercise his or her rights and that the exercise of these rights will not adversely affect the way the Enrollee is treated.

Section 3.2. ***MCO and Enrollee Communication.***

Section 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 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, pursuant to that document. 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.

Section 3.2.2. ***Americans with Disability Act Compliance***.

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 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 711, or through the Minnesota Relay at 1-877-627-3848 (speech to speech relay service)," or similar language approved by the STATE pursuant to Section 3.2.4.B.

Section 3.2.3. ***Requirements for Written Information.***

A. ***Written Information.*** The MCO will make available written material, including Marketing, enrollment, and member handbooks. 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 1,000 persons, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered speak a non-English language in the MCO's Service Area. For purposes of this Section, "prevalent" means a non-English language spoken by a significant number or percentage of Enrollees and Potential Enrollees. 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 or 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 a language block, printed in the languages required by Minnesota Statutes, section 256B.69,

subdivision 27, that informs the Enrollee or Recipient that the document contains important information, and directs the Enrollee or Recipient to call the MCO to have the document translated. 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, section 72C.09. The results of the Flesch score must be submitted at the time all documents specified in this Section 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 ID 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, section 62D.22, subdivision 8, and applicable rules and regulations promulgated by the Minnesota 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.

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.

Section 3.2.4. ***Marketing Materials.***

A. ***Inducements to Enroll.*** The MCO, its agents and Marketing representatives, may not offer or grant any reward, favor or compensation as an inducement to a Recipient or Enrollee to enroll in the MCO. Additional health care benefits or services are not included in this restriction. The MCO shall not seek to influence a Recipient's or Enrollee's enrollment with the MCO in conjunction with the sale of any other insurance.

B. ***Prior Approval of Materials.*** The MCO shall present to the STATE for approval all Marketing Materials that the MCO, or its subcontractors, plan to undertake 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 which 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.

C. ***Marketing Restrictions.*** 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.

1.) ***Mailings to Recipients.*** The MCO may make no more than two mailings per calendar year to all Medical Assistance, GAMC, and MinnesotaCare Recipients who are Enrollees of an MCO under contract with the STATE or are eligible to become Enrollees of an MCO under contract with the STATE, and who reside in the Service Area. Any such mailing shall be at the MCO's expense, using a mailing list provided by the STATE supplied in a format as determined by the STATE. All mailings must be sent to all Recipients within a specified region (such region shall be approved by the STATE) who are in the same program who are Enrollees of an MCO or are eligible to become Enrollees of an MCO in the Service Area receiving the mailing.

2.) ***Other Publications.*** The MCO, acting indirectly through the publications and other Marketing Materials distributed by the Local Agency or the STATE, or through mass media advertising Marketing Materials (including the Internet), may inform Medical Assistance, GAMC and MinnesotaCare Recipients who reside in the Service Area of the availability of medical coverage through the MCO, the location and hours of service and other plan characteristics, subject to Section 3.2.4.B.

a) The MCO may 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, provided that all MCOs to which the Provider subscribes have an equal opportunity to be represented.

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

Section 3.2.5. ***Enrollment Materials.***

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

1.) ***Certificate of Coverage (COC).*** A Certificate of Coverage (COC) that has been prior-approved by the STATE and that will 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 how Enrollee Grievances and Appeals are resolved, including the telephone number of the department or person handling Grievances and Appeals, and information on how to access the State Fair Hearing Process.

c) For the MinnesotaCare limited benefit set, the MCO shall ensure these Enrollees have information about which services are limited to specific Providers (e.g. refractions not covered by optometrists).

d) A description of the Enrollee's rights and protections as specified in 42 CFR 438.100.

e) Cost sharing, if applicable.

f) Notification of the open access of Family Planning Services and services prescribed by Minnesota Statutes, section 62Q.14.

g) Information about providing coverage for prescriptions that are dispensed as written (DAW).

h) A statement informing Enrollees that, upon request, an Enrollee can obtain a COC in the languages specified in Minnesota Statutes, section 256B.69, subdivision 27. Upon request, the MCO shall provide the Enrollee with a COC in the specified language of preference. Until such time as the translation and printing of the COC is complete, the MCO may use a reasonable method of complying with this Section, (e.g., a photocopy of the translated model, or an oral interpreter translating requested sections). If the MCO makes changes to the translated model COC, and the MCO chooses to use a vendor other than the vendor used by the STATE, the MCO shall provide a written affirmation to the STATE verifying that the translation is correct. The STATE shall provide the MCO with an electronic and a hard copy version of each translated model COC.

i) 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.

j) a description of how Enrollees may access services to which they are entitled under Medical Assistance, such as abortion services, or mental health services described in Section 6.11.12., but that the MCO does not provide under this Contract.

k) a description of Medical Necessity for mental health services under Minnesota Statutes, section 62Q.53.

l) a description of how transportation is provided.

2.) ***Provider Directory.*** A provider directory which lists the Providers within the MCO's network, including Primary Care Providers, specialty Providers and hospitals, and also includes their names, locations, and telephone numbers. The directory shall also indicate those current contracted Providers who speak a non-English language and identify any contracted Provider that is not accepting new patients. The provider directory shall be updated annually and shall include a phone number where an Enrollee may call to verify or receive current information. The information required by this Section may also be listed on the MCO's web site.

3.) ***Membership Card.*** A membership card that conforms to the requirements in Minnesota Statutes, section 62J.60, subd. 3, and has been approved by the STATE prior to printing, which identifies the Recipient as an MCO Enrollee and contains 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.

4.) ***Access to Service.*** A description of how the Enrollee may obtain services, including: 1) hours of service; 2) appointment procedures; 3) Service Authorization requirements and procedures; 4) what constitutes Medical Emergency and Post Stabilization care; 5) the process and procedures for obtaining both Medical Emergency and Post Stabilization care, including a 24-hour telephone number for Medical Emergency Services; and 6) procedures for Urgent Care and Out of Plan care. 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.

5.) ***Toll-free Numbers.*** A toll-free telephone number that the Enrollee may call regarding MCO coverage or procedures.

6.) ***EPSDT.*** An explanation of the MCO's Early and Periodic Screening, Diagnosis and Treatment (EPSDT), known in Minnesota and hereinafter as the Child and Teen Checkups (C&TC) program for preventive care for Children.

7.) ***Grievance and Appeals.*** A description of all Grievance, Appeal and State Fair Hearing rights and procedures available to Enrollees, including the MCO's internal Grievance System procedures, the availability of an expert medical opinion from an external organization pursuant to Sections 8.2.1.B.13. and 8.7.7.A., the ability of internal 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:

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

b) The right to file Grievances and Appeals.

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

d) The availability of assistance in the filing process.

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

f) The fact that, when 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

(ii) The Enrollee may be required to pay the cost of services furnished while the Appeal is pending, if the final decision is adverse to the Enrollee.

g) Any Appeal rights under state law available to Providers to challenge the failure of the MCO to cover a service.

h) Appeal rights for denial of prescription drug coverage.

8.) 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 Care.

9.) General descriptions of the coverage for durable medical equipment, level of coverage available, criteria and procedures for any Service Authorizations, and also the address and telephone number of an 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.

10.) 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 arrangement, whether stop-loss protection is provided, and a summary of survey results.

11.) A description of the Enrollee's right to request the results of an external quality review study, pursuant to 42 CFR 438.364.

12.) 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. The MCO shall provide a link from this website to the STATE's HealthMatch system when that system is operational.

B. ***Advance Approval.*** The STATE must approve all new enrollment materials 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 30 days of receipt of these documents from the MCO.

C. ***Primary Care Network List.***

1.) ***Primary Care Network List Specifications.*** The MCO must supply all Local Agencies within its Service Area, and the STATE for MinnesotaCare, with copies of a standardized document (known as a "Primary Care Network List" or "PCNL") that provides information about the MCO's 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 be prior approved by the STATE in accordance with Section 3.2.4.B. The document must be printed on a grade of paper that is equivalent to bond paper which is not less than twenty (20) pound bond but not greater than 28 pound bond. If the PCNL has a cover, the grade of paper must be on uncoated offset paper or on glossy paper. The paper must be 8 ½" x 11" or 17" x 11", and the 17" x 11" document must fold to 8½" x 11". The document must contain the following information:

a) 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, and hospitals. 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 also be listed on the MCO's web site.

b) A toll-free MCO telephone number that the Recipient may contact regarding MCO coverage or procedures, and updated information regarding providers, languages spoken, and open and closed panels.

c) Oral interpretation is available for any language and written information will be available in prevalent non-English languages.

d) Information about how to access mental health, chemical dependency, dental, and Medical Emergency and Urgent Care services.

e) Information concerning the selection process, including a statement that the Enrollee must select an MCO in which their

Primary Care Provider or specialist participates if they wish to continue to obtain services from him or her.

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

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

h) 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.

i) 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 heath care costs. Read your contract, or 'Certificate of Coverage,' carefully to find out what is covered."

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

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

3.) When the MCO is new to a Service Area, the MCO must supply the STATE, or in certain cases, the Local Agency, with a supply of the final, printed and approved Primary Care Network List pursuant to the STATE's specifications, in quantities sufficient to meet the STATE need for a calendar quarter. If the MCO's Service Area expands for MinnesotaCare, additional Primary Care Network Lists must be supplied to the STATE sixty (60) days prior to the effective date of the expanded Service Area. The MCO must update the Primary Care Network List as necessary to maintain accuracy, particularly with regard to the list of Participating Providers, but not less than on a quarterly basis. The Primary Care

Network List and all revisions to the Primary Care Network List must be submitted to the STATE along with a cover letter detailing all changes in the Primary Care Network List. The Primary Care Network List must be approved in writing by the STATE pursuant to Section 3.2.4.B. Such approval by the STATE shall not be unreasonably withheld. The STATE shall distribute the PCNLs to the Local Agencies 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.

4.) ***Local Agency Training and Orientation.*** When the MCO or an MCO product is new to a Service Area, the MCO must provide training and orientation to the Local Agency, or the STATE for MinnesotaCare, 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, and the STATE and Local Agency for MinnesotaCare, with training and orientation materials to be used by the Local Agency or the STATE in educating new Enrollees in the Service Area about the MCO. Such materials shall be provided by the MCO to the Local Agency and the STATE twenty (20) working days in advance of the Education Begin Date. Training and orientation materials are: 1) lists of contacts and their phone numbers at the MCO; 2) complete network listings or additional provider directories, if any; and 3) organization charts.

5.) ***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.

D. ***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 network. For purposes of this Section, Health Care Professionals means professionals with whom the Recipient or Enrollee has or may have an appointment for services under this Contract.

3.) Other information, 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.

E. ***Recipient Education.***

1.) The STATE or the Local Agency will inform 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 Recipients in a particular geographic area and complete enrollment of Recipients by obtaining the signature of Recipients or their lawful representatives on the enrollment form. For Recipients 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 30 days to respond to the tribal government and no MCO materials will be distributed until there is mutual agreement on the revisions.

2.) 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.

F. The MCO, or its subcontractors, is not prohibited from providing information 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 this Contract.

Section 3.2.6. ***Significant Events.*** MCO must notify the STATE as soon as possible of significant events affecting the level of service either by the MCO or its 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 that a Material Modification is likely to occur. A Material Modification shall be reported in writing to the STATE no less than 120 days prior to the effective date or within two (2) working days of becoming aware of it, whichever occurs first. An MCO may terminate a sub-contract without 120 days notice in those situations where the termination is for cause. For the 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 who will be affected by a Material Modification. Such prior written notice shall be approved by the STATE. The notice must inform each affected Enrollee that:

a) one of the Primary Care Providers they have used in the past are no longer available and that 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 and change MCOs up to 120 days from the date of notification, unless open enrollment occurs within 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 or her Primary Care Provider and his or her physician specialists. Examples of methods of provider access include, but are not limited to: 1) Enrollee has open access to all Primary Care Providers; 2) Enrollee may self-refer to a physician specialist; 3) Enrollee must choose one Primary Care Provider; and 4) Enrollee must receive a referral to a physician specialist from his or her Primary Care Provider. For 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. ***Network Stability.*** The MCO shall provide the same network of Providers for all Enrollees covered under this Contract.

D. ***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 country-based purchasing project. The MCO shall submit any such proposed changes to the STATE at least 180 days prior to the proposed implementation date.

Section 3.2.7. ***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 contracted Provider within 15 days after the MCO's, or if applicable its subcontractor's, receipt or issuance of the contracted Provider termination notice, to an Enrollee who receives his or her Primary Care from, or was seen on a regular basis by, that contracted Provider. A sample Enrollee notice must be prior

approved by the STATE. The MCO must comply with Minnesota Statutes, section 62Q.56, and 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. MCO's remedy to the situation.

Section 3.3. ***Required MCO Participation in STATE Programs.*** The MCO must comply with Minnesota Statutes, sections 256B.0644 and 62D.04, subdivision 5.

Section 3.4. ***Termination of Enrollee Coverage.***

Section 3.4.1. ***Termination by STATE.*** An Enrollee's coverage in the MCO may be terminated by the STATE for one of the following reasons:

A. The Enrollee becomes ineligible for Medical Assistance, GAMC or MinnesotaCare.

B. 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.

C. The Enrollee changes MCOs pursuant to Minnesota Rules, Part 9500.1453 because of problems with access, service delivery, or other good cause.

D. The Enrollee changes MCOs without cause pursuant to 42 CFR 438.56(c) within 90 days following the Enrollee's initial enrollment with the MCO, but this permission does not apply to Enrollees of the MinnesotaCare Limited Benefit Set. 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.

E. The Enrollee no longer meets the eligibility criteria in Section 3.1.1.

F. This Contract expires or is terminated for any reason under the provisions of Article 5.

G. 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 60 days after a change in enrollment from an MCO that no longer participates in PMAP, PGAMC or MinnesotaCare.

H. Pursuant to Minnesota Rules, Part 9500.1453, subparts 7 or 8, the Enrollee elects to change MCOs due to substantial travel time or Local Agency error.

I. The Enrollee elects to change MCOs during the annual open enrollment period, or the Enrollee misses the opportunity to change during open enrollment due to disenrollment.

J. The Enrollee elects to change MCOs within 120 days following notice of a Material Modification of the MCO's Provider Network under Section 3.2.6.A.2.

K. A GAMC Enrollee who becomes eligible for the Medical Assistance program will be disenrolled from GAMC, and enrolled in Medical Assistance. The MCO, to the best of its ability as soon as it becomes aware, shall notify the Local Agency regarding potential changes in an Enrollee's eligibility status because of such factors as pregnancy or disability.

Section 3.4.2. ***Termination by MCO***. The MCO may not request disenrollment of an Enrollee for any reason.

Section 3.4.3. ***Notification and Termination of Coverage.*** Notification and termination of MCO coverage shall become effective at the following times:

A. When termination has been entered on the STATE MMIS on or before the Cut-Off Date, MCO coverage shall cease at midnight, Minnesota time, on the first day of the month following the month in which termination was entered on the STATE MMIS.

B. When termination has been entered on the STATE MMIS after the Cut-Off Date, MCO 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, GAMC or MinnesotaCare, or for participation in the prepaid Medical Assistance or GAMC program, and the Enrollee is receiving Inpatient Hospitalization services, excluding chemical dependency services provided in free-standing residential centers, on the effective date of ineligibility, MCO coverage shall cease at midnight, Minnesota time, on the first day following discharge from the hospital. The MCO's liability for ongoing Inpatient Hospitalization shall end when the medical director, or his or her designee, of the center or facility no longer certifies that the Enrollee is in need of continued treatment at a hospital level of care. 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, GAMC, MinnesotaCare, prepaid Medical Assistance or prepaid GAMC 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 hospital services, MCO coverage shall cease at midnight, Minnesota time, on the first day of the month following the month of discharge from the hospital. (For MCO liability for Inpatient Hospitalization, see Section 3.4.3.C.)

Section 3.4.4. ***Reinstatement***. An Enrollee whose termination from the MCO has been entered into MMIS on or before the monthly Cut-Off Date may be reinstated for the following month with no lapse in coverage if the Enrollee reestablishes his or her eligibility and such eligibility is entered into MMIS by the last business day of the month. An Enrollee whose termination from the MCO has been entered into MMIS on or before the monthly Cut-Off Date and who fails to reestablish his or her eligibility and have it entered into MMIS by the last business day of the month shall be disenrolled from the MCO for the following month unless a continuity of care issue arises and it is mutually agreed by all parties that the Enrollee will be reinstated in the MCO for that following month and subsequent months. The STATE shall pay according to Article 4 for the month of coverage in which the Enrollee was reinstated.

Section 3.4.5. ***Automatic Reenrollment.*** 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 3.4.1.

Section 3.5. ***Reporting Requirements.***

Section 3.5.1. ***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 Section 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 medical and dental diagnostic and treatment encounters, all pharmaceuticals, supplies and medical equipment dispensed to Enrollees, and all nursing facility services which the MCO provides as a Substitute Health Service. Encounter data shall include all paid lines associated with a claim, and those denied claims or lines, for which Medicare or a third party has paid in full. Third

party paid claims include immunizations which are paid for by the Minnesota Vaccines for Children Program (MNVFC).

2.) Claim-level data must be reported to the STATE using the following claim formats: 1) the X12 837 standard format for physician and professional services, inpatient and outpatient hospital services and dental services that are the responsibility of the MCO; and 2) the 5.1 NCPDP for 1.1 batch pharmacy and for physician-dispensed pharmaceuticals; and 3) may submit the 5.1 NCPDP for non-durable medical supplies which have an NDC code.

3.) All encounter claims must be submitted electronically and must comply with STATE or federal requirements, including the requirements to submit charge data and to use the standard formats and procedures, 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, as applicable, the units of service and/or procedures performed, bill type, place of service, dates of services and applicable provider numbers (See the 837 Encounter Specification Manual on the STATE's public website for encounter data requirements).

4.) 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.

5.) 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 or NPI, demographic information about the Provider that is current and complete, on a form approved by the STATE.

6.) 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. The MCO also shall cooperate with the STATE as necessary to ensure compliance.

7.) By December 31, 2007, the MCO shall submit encounter data on all personal care assistant (PCA) services using CMS 1500 and report PCAs

as treating providers. The STATE will monitor PCAs as treating providers starting in 2008.

C. The MCO shall submit encounter claims with all of the required data elements to the STATE no later than 90 days after date the MCO adjudicated the claim.

D. For all encounter claims, when the STATE returns or rejects a file of claims, the MCO shall have 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. The MCO may submit replacement claims for encounter claims previously submitted, at any time.

F. If the MCO chooses to resubmit a claim previously denied on the MCO's remittance advice, the MCO must resubmit the claim as a replacement claim or a voided claim.

G. The STATE will provide a monthly 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 the X12 835 standard transaction format. The STATE will continue to support the old format for Remittance Advice until March 31, 2007 (See the 835 Remittance Advice (RA) Manual on the STATE's public website for remittance advice requirements).

H. 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), when the Provider is part of a group practice that bills on 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 Service;

6.) Federally Qualified Health Centers;

7.) Rural Health Clinics; and

8.) Chiropractic Clinics.

No treating Provider is required for any other claim type.

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

J. ***Coding Requirements.***

1.) The MCO must use the most current version of the following coding sources, unless otherwise precluded from doing so by state or federal law:

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' Healthcare Common Procedure Coding System (HCPCS Level 2).

c) American Dental Association current dental terminology codes as specified in Minnesota Statutes, section 62Q.78.

d) National Drug Codes.

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 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)/Atypical Provider Types.*** No later than May 23, 2007, or the date of actual implementation of NPI by CMS if implementation of NPI is delayed by CMS, the MCO shall use the NPI for all Providers for whom CMS issues NPIs. For Providers of Atypical Services, the MCO shall use the provider ID issued by the STATE once NPI is implemented.

L. ***Final Encounter Data Cut-Off Dates for Risk Adjustment.*** Final Encounter Data for risk adjustment shall be submitted for Capitation Payment dates listed in the chart below:

M.

Capitation Payment Dates	Final Encounter Data	Assessment Periods

	Due Dates	
April 2007-June 2007	February 1, 2007	July 1, 2005-June 30, 2006
July 2007-September 2007	May 1, 2007	October 1, 2005-September 30, 2006
October 2007-December 2007	August 1, 2007	January 1, 2006-December 31, 2006
January 2008-March 2008	November 1, 2007	April 1, 2006-March 31, 2007

Section 3.5.2. ***Other Reporting Requirements***. The MCO must provide the STATE with the following information in a format and time frame determined by the STATE. 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. ***Birth of Child to an Enrollee.*** The MCO may report to the STATE or the Local Agency the birth of any Child to an Enrollee on a form approved by the STATE, as soon as reasonably possible after the MCO knows of the birth.

B. ***Enrollment and Marketing Materials.*** Enrollment and Marketing Materials described in this Contract.

C. ***Service Delivery Plan.*** Any substantive changes in the service delivery plan previously submitted shall be provided by the MCO to the STATE within 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.

D. ***Provider Information.*** The MCO must submit annually by April 15th of the contract year a complete list of contracted Providers, including name, specialty, and address, in a format approved by the STATE using a current version of Excel. The MCO shall also submit an update of its list of contracted Providers, in the same format, by the 15th day of August and December. (Note: this excludes pharmacies, transportation Providers, and interpreters).

E. ***Financial Statements.*** Financial statements and other information as specified by the STATE to determine the MCO's financial and risk capability.

F. ***Quality Assurance Materials.*** Information as specified in Article 7 regarding quality assurance and performance improvement.

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

H. ***Administration and Subcontracting Information.*** Information relating to MCO administration and subcontracting arrangements, as specified by the STATE and CMS.

I. ***Prenatal Risk Assessments and EPSDT/C&TC Information.*** The MCO shall report prenatal risk assessments and EPSDT/C&TC information as specified in this Contract.

J. ***Third Party Resources.*** Pursuant to Section 12.2.2., the MCO shall report to the STATE any additional third party resources in a format provided by the STATE.

K. ***Third Party Payments.*** Pursuant to Section 12.4.1., the MCO shall report all recovery/Cost Avoided amounts on the encounter claim as third party payments.

L. ***Cost Avoided and Recovered.*** Pursuant to Section 12.4.2., the MCO shall, on a quarterly basis, disclose to the STATE all Cost Avoided and recovered amounts.

M. ***Quality Assurance Workplan.*** The MCO shall submit its Quality Assurance Workplan, pursuant to Article 7.

N. ***Disclosure of Transactions***. By April 1st of each calendar year, the MCO must report to the STATE its significant business transactions, as defined in 42 CFR 417.126 that occurred in the prior calendar year. Transactions are not limited to those transactions related to serving the Medicaid enrollment.

1.) Business Transactions that must be disclosed:

a) Any sale, exchange or lease of any property between the MCO and a Party in Interest;

b) Any lending of money or other extension of credit between the MCO and a Party in Interest; and

c) Any furnishing for consideration of goods, services (including management services) or facilities between the MCO and the Party in Interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

2.) Information disclosed under paragraph 1) between the MCO and a Party in Interest shall include:

a) The name of the Party in Interest for each transaction;

b) A description of each transaction and the quantity or units involved;

c) The accrued dollar value of each transaction; and

d) Justification of the reasonableness of each transaction.

O. ***Disclosure of Ownership Information***. By April 1st of each calendar year, the MCO shall submit a copy of Form CMS-1513, if already reported to CMS, or shall report to the STATE:

1.) The name and address of each person with an ownership or controlling interest of 5% or more in the MCO or in any subcontractor in which the MCO has direct or indirect ownership of 5% or more;

2.) A statement as to whether any of the persons with ownership or controlling interest is related to any other person with ownership or controlling interest such as spouse, parent, child, or sibling; and

3.) The name of any other organization in which the person also has ownership or control interest.

P. Pursuant to the STATE's specifications found in the 2007 update to the document entitled, "FQHC/RHC Payment Data Report," the MCO shall provide to the STATE quarterly reports that identify MCO payments made to FQHCS and RHCS for all programs covered under this contract, no later than 30 days following the end of the quarter. The MCO agrees to participate with the STATE in a workgroup to develop a process for reimbursing FQHCs and RHCs.

Q. Pursuant to Minnesota Statutes, section 16A.725, the MCO shall provide to the STATE, no later than February 1st of each year, all health care service expenditures exclusive of dental, for the previous state fiscal year. The report due February 1, 2007 shall include expenditures certified by the MCO paid July 1, 2005 through June 30, 2006 combining expenditures under all Minnesota Health Care Program (MHCP) 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, GAMC 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 – including Outpatient Hospital and excluding dental expenses, Home Health, Pharmacy, and Skilled Nursing Facility).

R. Pursuant to Minnesota Statutes, section 256.969, subd. 9(f), the MCO shall submit a report to the STATE of charges and payments made under Medical Assistance, GAMC and MinnesotaCare for each claim of inpatient and outpatient hospital service. This report shall also include any other information specified by the STATE as needed by the STATE for the purpose of obtaining federal matching

funds. This report shall include all such charges, payments and other specified information for services occurring on or after July 1, 2003. This data is only to be used by the STATE for this purpose and not for any other, except with the express written consent of the MCO. This data shall be submitted by the MCO to the STATE in accordance with specifications designated by the STATE and provided to the MCO. The first report in this format shall be submitted by the MCO to the STATE within sixty (60) days after the MCO receives the report specifications from the STATE, and annually thereafter.

S. The MCO shall report to the STATE all circumcisions performed on newborns for well-established religious reasons for which the MCO provided coverage, along with data regarding the costs of the procedures. The MCO shall report on all such circumcisions performed on or after January 1, 2006 through December 31, 2006. The MCO shall provide the report to the STATE by March 31, 2007, in accordance to the specifications required by the STATE. Beginning January 1, 2007, newborn circumcision is not a covered service under this Contract.

Section 3.5.3. ***Electronic Reporting Data Capability.*** The MCO shall be capable of receiving data electronically from the STATE, which are: price files, remittance advices, enrollment data, and rates files.

Section 3.5.4. ***E-Mail Encryption.*** The MCO shall use the PGP and S/MIME standards for digital signing and encryption of e-mail communications to the STATE about Enrollees that contain Private Health Information. PGP (Pretty Good Privacy) is both an industry standard data format for encryption algorithms, and a commercial product. Free and commercial products are available which adhere to this standard. S/MIME (Security Multipurpose Internet Mail Extensions) is an industry standard data format for attaching files to e-mail. The MCO may also communicate with the STATE using MN-ITS.

Section 3.6. ***Conflicts of Interest***. Pursuant to 42 CFR 438.58, and Minnesota Statutes, section 256B.0914, the MCO shall have in effect conflict of interest rules at least as effective as those in 41 U.S.C. § 423.

Article 4. Payments to MCO.

Section 4.1. ***Payment of Capitation***. Except as noted below, on the 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 Appendices II-A, II-B, and II-C, per month, per Recipient enrolled with the MCO, as full compensation for medical goods and services provided hereunder in that month. For the Capitation Payment for those Enrollees who have been reinstated, the STATE agrees to pay the MCO on the next available warrant. This 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. 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.

Section 4.1.1. ***Capitation Payments.*** The STATE will pay to the MCO a 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 pursuant to Section 3.4. becomes effective.

Section 4.1.2. ***Newborns.*** The STATE will pay to the MCO a Capitation Payment for the birth month of an eligible newborn Enrollee if the mother was enrolled in the MCO during the month of the Child's birth and eligibility is established for the Child. Payment for succeeding months will be determined pursuant to Section 3.1.2.M.3.

Section 4.1.3. ***Pregnant Women.*** The rate paid for women in this Rate Cell category is based on an adjustment that reflects the STATE calculated MCO-specific average time period in this Rate Cell for a Pregnant Woman as compared to the expected statewide average number of months in the Rate Cell as determined by the STATE.

Section 4.1.4. ***Medical Education and Research Trust Fund Money (MERC).***

A. Appendix II-A includes for calendar year 2007:

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.

3.) A set of capitation rates with MCO specific MERC and DHU funding out of the rates.

4.) The dollar difference between 1.) and 2.), which is the amount of payment made by the STATE directly to the MERC Trust Fund on behalf of the MCO.

5.) The dollar difference between 2.) and 3.), which is the MCO's specific DHU rate.

B. The STATE shall make payments to the MERC Trust Fund on behalf of the MCO and reduce the payment to the MCO by the amount in A.4. above. The STATE shall reflect on the remittance advice the total reimbursement amount and the reduction of this total reimbursement amount due to the removal of MERC funds.

Section 4.1.5. ***PMAP/PGAMC Risk Adjusted Payments***.

A. The STATE agrees not to rebase the base rates for risk adjustment during the term of this Contract.

B. Appendix II-B includes for calendar year 2007:

1.) The MCO's risk factors for calendar year 2007 (Column 3).

New risk factors will be calculated by the STATE on a quarterly basis based on encounter data submitted by the MCO pursuant to Section 3.5.1. of this Contract. The STATE shall calculate these risk factors as follows: a) the STATE will calculate for the MCO an annual risk factor for each eligibility group by putting each Enrollee into a relative weight category as outlined in Appendix II-D, and multiplying each Enrollee's relative weight by that Enrollee's total number of Enrollee-months; and b) then, the results derived from a) for each MCO Enrollee will be summed and divided by the total number of Enrollee-months.

For the payment period January 2007 through March 2007, the MCO's specific risk factor will be based on the MCO's Enrollees' experience during the period of April 2005 through March 2006. The STATE shall base the risk factor for each subsequent quarter of payment on the MCO specific risk factor for an annual period that is advanced by one quarter of experience and used to calculate the risk adjusted payments to the MCO.

2.) The statewide capitation base rates that are used to calculate the risk adjusted payments to the MCO (Column 4).

Section 4.1.6. ***MinnesotaCare Risk Adjusted Payments***.

A. The STATE agrees not to rebase the base rates for risk adjustment during the term of this Contract.

B. Appendix II-C includes for calendar year 2007:

1.) The MCO's risk factors for the calendar year 2007 (Column 5).

New risk factors will be calculated by the STATE on a quarterly basis based on encounter data submitted by the MCO pursuant to Section 3.5.1. of this Contract. The STATE shall calculate these risk factors as follows: a) the STATE will calculate for the MCO an annual risk factor for each eligibility group by putting each Enrollee into a relative weight category as outlined in Appendix II-D, and multiplying each Enrollee's relative weight by that Enrollee's total number of Enrollee-months; and b) then, the results derived from a) for each MCO Enrollee will be summed and

divided by the total number of Enrollee-months.

For the payment period January 2007 through March 2007, the MCO's specific risk factor will be based on the MCO's Enrollees' experience during the period of April 2005 through March 2006. The STATE shall base the risk factor for each subsequent quarter of payment on the MCO's specific risk factor for an annual period that is advanced by one quarter of experience and used to calculate the risk adjusted payments to the MCO.

2.) The statewide capitation base rates (Column 6) that are used to calculate the risk adjusted payments to the MCO.

Section 4.1.7. ***Risk Adjustment Appeals.*** The MCO may appeal to the STATE the following quarter's risk factor. Any appeal of risk factors must be filed with the STATE within two weeks of notification of the new risk factors. The basis for any appeal by the MCO under this Section shall be limited to whether or not the STATE correctly calculated the MCO's risk factor based on encounter data submitted in a timely manner as required by Section 3.5.1.

A. If the MCO appeals under this Section, the STATE shall continue to pay the MCO the MCO's subsequent quarter's risk factor until the appeal is resolved. If on appeal, the STATE is found to have miscalculated the MCO's risk factor, the STATE shall adjust the MCO's subsequent rates to correct the miscalculation.

B. The MCO and the STATE shall each pay half the cost of investigating and resolving the appeal, regardless of outcome.

C. The MCO and the STATE shall work together to develop a review mechanism to ensure that this Section of the Contract is accurately implemented.

Section 4.1.8. ***PMAP/PGAMC Capitation Payment Rates***. For calendar year 2007, payments for all PMAP/PGAMC Enrollees shall be the sum of payments under A. and B. below. The MCO shall receive for each Enrollee the rate of the county of residence.

A. Monthly payments paid by the STATE to the MCO shall be paid at 50% of the rates in Appendix II-A, Column (3), plus the DHU rates in Appendix II-A, Column (5). This amount is shown in Appendix II-B, Column (2).

B. Monthly payments paid by the STATE to the MCO shall be at 50% of the statewide Base Rate in Appendix II-B, Column (4), multiplied by the MCO's risk factor for each eligibility group in Appendix II-B, Column (3). The dollar value of this add-on is shown in Appendix II-B, Column (5), and will change on a quarterly basis.

C. The sum of (A) and (B) shown in Appendix II-B, Column (6), shall be reduced by 2.5% (Medical Assistance) or 5.5% (GAMC) per Minnesota Statutes, section

256B.69, subds. 5g and 5h, with this ratable reduction. The total Capitation Payment to the MCO is identified in Appendix II-B, Column (7).

Section 4.1.9. *MinnesotaCare Payment Rates*. For calendar year 2007, payments for all MinnesotaCare Enrollees shall be the sum of payments under A. and B. below, which have an actuarial basis. The MCO shall receive for each MinnesotaCare Enrollee the rate of the county of residence.

A. Monthly payments paid by the STATE to the MCO shall be paid at 50% of the rates in Appendix II-C, Column (1) or (2). This amount is shown in Appendix II-C, Column (3) or (4).

B. Monthly payments paid by the STATE to the MCO shall be at 50% of the statewide base rate in Appendix II-C, Column (6), multiplied by the MCO's risk factor for each eligibility group in Appendix II-C, Column (5). The dollar value of this add-on is shown in Appendix II-C, Column (7) and will change on a quarterly basis.

C. The sum of (A) and (B) shall be reduced by a 1% ratable reduction per Minnesota Statutes, section 256L.12, subd. 9a. The total Capitation Payment to the MCO is identified in Appendix II-C, Column (10) or (11).

D. Monthly payments by the STATE to the MCO for Transitional MinnesotaCare Enrollees shall be 100% demographic rates, reduced by a 1% ratable reduction per Minnesota Statutes, section 256.12, subd. 9a. The total Capitation Payment to the MCO is identified in Appendix II-C column (10) or (11).

Section 4.1.10. *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., including:

A. Must be developed in accordance with generally accepted actuarial principles and practice;

B. Are appropriate for the populations to be covered, and the services to be furnished under the contract; and

C. Be certified by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

Section 4.1.11. *Assignment of Rate Cells.*

A. Assignment of Rate Cells shall be made based on information on the STATE MMIS and information provided by the MCO to the STATE.

B. The STATE will periodically review information in MMIS related to the assignment of Rate Cells to verify that appropriate rates are being paid.

Section 4.1.12. ***STATE Request for Data.*** The MCO shall comply with the STATE's request for data for rebasing risk adjustment, or for any other data required by the state for rate-setting purposes, within 30 days from the date of the request in accordance with Minnesota Rules, Part 9500.1460, subpart 16, according to the STATE's specifications.

Section 4.1.13. ***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 Sections 1816(c)(2) (42 U.S.C. § 1395(h)(c)(2)), 1842(c)(2) (42 U.S.C. § 1395u(c)(2)) and 1902(a)(37)(a) (42 U.S.C. § 1396 (a)(37)) of the Social Security Act, 42 CFR Parts 447.45 and 447.46, and Minnesota Statutes, sections 16A.124, and 62Q.75.

Section 4.1.14. ***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 or regulation, or necessary due to changes in eligibility, and benefits. Renegotiated rates will require prior CMS approval according to Section 4.3.

Section 4.1.15. ***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.

Section 4.2. ***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 Sections 4.6 and 4.7 of this Contract.

Section 4.3. ***Prior Approval of Contract***. Prior approval of the Contract by CMS is a condition for Federal Financial Participation (FFP). Payment of rates are conditional upon CMS approval and if not approved would reopen negotiations pursuant to Section 4.1.14. 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.

Section 4.4. ***Premiums and Copayments.***

Section 4.4.1. ***Premium Collection.*** The STATE shall collect any insurance premiums from Enrollees.

Section 4.4.2. ***Covered Services and Substitute Health Services.*** The MCO agrees that no copayments or deductibles shall be charged to MinnesotaCare/Medical Assistance

Enrollees for covered services or services provided as substitutes to covered services as part of the MCO's case management plan.

Section 4.4.3. ***MinnesotaCare Enrollees.*** MinnesotaCare Enrollees must make copayments for the following services:

A. ***MinnesotaCare Copays.*** These copays do not apply to pregnant women or children under age 21:

1.) Prescription drugs: $3 per prescription.

2.) Eyeglasses: $25 per pair.

3.) Inpatient Hospitalization: 10% of paid charges subject to an annual calendar year maximum of $1,000 per individual and $3,000 per family.

4.) From January 1, 2007 through June 30, 2007, Nonpregnant Adults whose income does not exceed 175% of the Federal Poverty Guidelines will have a 50% copay based on the MinnesotaCare fee schedule of the restorative dental services (not including orthodontia). Beginning July 1, 2007, this copay is no longer effective.

5.) Non-preventive visit: $3 per visit.

6.) Non-emergency visit to emergency room: $6 per visit.

B. MinnesotaCare Limited Benefit Set Copays:

1.) Prescription drugs: $3 per prescription with a maximum of $20 per month.

2.) Eyeglasses: not a covered service.

3.) Inpatient Hospitalization: 10% of paid charges subject to an annual calendar year maximum of $1,000 per individual and $3,000 per family.

4.) Restorative dental services: Not a covered service.

5.) Emergency Room: $50 per visit.

6.) Non-preventive visit with physician, physician assistant, advanced practice nurse, chiropractor, optometrist (when providing physician services), psychologist, or licensed independent clinical social worker: $5 per visit.

C. Collection and Payment of Copays.

1) The MCO may delegate to the Providers of these services the responsibility to collect the copayment. The MCO may not reduce or waive the copayment as an inducement to MinnesotaCare Enrollees to enroll or continue membership in the MCO.

2) The MCO must ensure that no Provider deny Covered Services to an Enrollee because of the Enrollee's inability to pay the copayment pursuant to 42 CFR 447.53 for Enrollees enrolled in MinnesotaCare's Basic Plus Two and Basic Plus, programs FF and JJ.

3) However, the MCO may allow its Providers to choose not to provide Covered Services to Enrollees enrolled in MinnesotaCare's Basic Plus One and the Limited Benefit Set, program BB based upon the Enrollee's history of bad debt. Upon the Enrollee's assertion that he or she is unable to pay the copayment, the MCO must ensure that its Providers: i) do not deny service to the Enrollee upon his or her first visit to the Provider; ii) give the Enrollee advance notice of the Provider's debt policy; and iii) allow the Enrollee a reasonable opportunity to make payment.

4) The MCO must also ensure that Enrollees retain the ability to seek services from other Providers.

Section 4.4.4. ***Medical Assistance and General Assistance Medical Care (GAMC) Enrollees.*** Medical Assistance and General Assistance Medical Care (GAMC) Enrollees must make copayments for the following services (A-E). The following individuals or services are exempt from these copays: 1) children under age 21; 2) pregnant women; 3) Recipients expected to reside for 30 days in an institution; 4) Recipients receiving hospice care; 5) 100 percent federally funded services provided by an Indian Health Service or 638 facility; 6) Emergency Services; 7) Family Planning; 8) services paid for by Medicare for which Medical Assistance pays the coinsurance and deductible; 9) copayments that exceed one per day per provider for non-preventive visits, eyeglasses, and non-emergency visits to a hospital-based emergency room; and 10) chemical dependency treatment services pursuant to Minnesota Statutes, section 254B.03, subd. 2:

A. ***Medical Assistance and GAMC:*** Prescription drugs ($3 per prescription for brand name drugs, $1 per prescription for generic drugs, with a maximum of $12 per month; except that no copay is required for anti-psychotic drugs).

B. ***Medical Assistance:*** Eyeglasses ($3 per pair); GAMC: ($25 per pair).

C. ***GAMC:*** 50% copay based on the Minnesota Health Care Programs fee schedule of the restorative dental services.

D. ***Medical Assistance:*** Non-preventive visits ($3 per visit, except for Physical, Occupational, or Speech Therapy, Mental Health services, and Clozaril/clozapine

blood draws).

E. ***Medical Assistance:*** Non-emergency use of the emergency room ($6 per visit); GAMC: ($25 per visit).

F. ***Collection and Payment of Copays.***

1) The MCO may delegate to the Providers of these services the responsibility to collect the copayment. The MCO may not reduce or waive the copayment as an inducement to Enrollees to enroll or continue membership in the MCO.

2) The MCO must 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 for Enrollees enrolled in the Medical Assistance program.

3) However, the MCO may allow its Providers to choose not to provide Covered Services to Enrollees enrolled in the General Assistance Medical Care program based upon an Enrollee's history of bad debt. Upon the Enrollee's assertion that he or she is unable to pay the copayment, the MCO must ensure that its Providers: i) do not deny service to the Enrollee upon his or her first visit to the Provider; ii) give the Enrollee advance notice of the Provider's debt policy; and iii) allow the Enrollee a reasonable opportunity to make payment.

4) The MCO must also ensure that Enrollees retain the ability to seek services from other Providers.

G. If the MCO places an Medical Assistance Enrollee in 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.

Section 4.5. ***Managed Care Withhold***. For Capitation Payments made for months of service on or after January 1, 2007, the STATE shall withhold 5.0 percent (5%) of the MCO's payments for PMAP, PGAMC and MinnesotaCare. 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 the contract are achieved. Withheld funds shall be returned to the MCO pursuant to Section 4.5.1.

Section 4.5.1. ***Withhold Return Scoring for Calendar Year 2007***.

A. The withheld funds will be returned to the MCO for calendar year 2007 based on the following scoring system for each of the nine performance targets listed below:

   1.) Denial, termination or reduction of services notice shall be worth a total of 20 points.

   2.) Grievance and Appeal reporting shall be worth a total of 15 points.

   3.) Claims payment timeliness shall be worth a total of 10 points.

   4.) Identifying treating Provider in encounters shall be worth a total of 20 points.

   5.) MDH QA Examination deficiencies shall be worth a total of 10 points.

   6.) Member service phone responsiveness shall be worth a total of 10 points.

   7.) Psychiatrist UR/QA advisor shall be worth a total of 5 points.

   8.) Lead Screening shall be worth 10 points.

B. The percentage of the MCO's withheld funds to be returned shall be calculated by summing all earned points, dividing the sum by 100, 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 Sections 4.5.2.A, B, C, E, F, G and H. Points assigned for the performance targets will be all or none (e.g. 20 points or 0 points), except for identifying treating Provider in encounters, where partial number of points will be assigned as specified in Section 4.5.2.D.

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.

Section 4.5.2. ***Administrative and Access/Clinical Performance Targets for PMAP, PGAMC and MinnesotaCare for Calendar Year 2007***. Pursuant to the specific terms in Section 4.5.3., 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 as outlined below:

A. Denial, Termination, or Reduction Notice Reporting.

1.) Provides the completed Denial, Termination or Reduction Notice (DTR) report as required in Section 8.2.4., and as stated below; and

2.) Has no DTR activity for a given quarter, and notifies the STATE's Ombudsman Office by e-mail or in writing by the 15th day of the month following the end of a quarter; or

3.) Correctly completes as an aggregate at least 90 percent, calculated out to two decimal places with no rounding, of the required data fields on DTRs submitted electronically in a report format designated by the STATE.

The STATE agrees to provide a report to the MCO, on a quarterly basis, of the MCO's status on completion of required data fields. The MCO shall have 60 days from receipt of the quarterly report to resubmit DTR data.

B. ***Grievance and Appeal Reporting.***

1.) 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 15th day of the month following the quarter, or

2.) Correctly completes as an aggregate at least 90 percent, calculated out to two decimal places with no rounding, of the required data fields correctly on the Grievances and Appeals submitted electronically in a report format designated by the STATE.

The STATE agrees to provide a report to the MCO, on a quarterly basis, of the MCO's status on completion of required data fields. The MCO shall have 60 days from receipt of the quarterly report to resubmit Grievance and Appeal data.

C. ***Claims Payment Timeliness.***

1.) Pays at least 90 percent of all Clean Claims within 30 days of receipt and at least 99 percent of all Clean Claims paid within 90 days of receipt in accordance with 42 CFR 447.45.

2.) Provide an annual report to the STATE, by April 15th of the following year, in a format agreed upon by the STATE and the MCO, covering claims payment timeliness for all claims paid under this contract in the previous year.

3.) For purposes of this Section, a Clean Claim is defined as a bill for services that can be processed without obtaining additional information from the provider of the service or from a third party, and has no defect or impropriety, including any lack of any required substantiating

documentation or particular circumstance or has no particular circumstances requiring special treatment that prevents timely payment from being made on the claim pursuant to the MCO's requirements for submission of a bill. Calculations shall be based on the payment of claims and percentages on a yearly aggregate, and shall not be rounded to the next point. The STATE shall be allowed access to MCO information required to audit a sample of claims from the MCO to validate the reported information.

D. ***Identifying Valid Treating Provider Encounters.***

1.) Provides valid treating provider information in the submitted encounter data for physician and mental health provider types, as required in the most recent version of the STATE document titled "Method Used to Develop Percent of Valid Treating Provider Numbers." For purposes of calculating the return of the Managed Care withhold under Section 4.5.2.D., treating providers will not include PCAs. The calculation shall be computed as whole numbers rounding to the nearest whole number (e.g. 45.6 becomes 46 and 45.5 becomes 45).

2.) For purposes of this Section, the STATE shall calculate the percentage of encounter claims lines with valid treating provider numbers divided by the total number of claims lines (HCFA-1500/CMS-1500 claim type, with provider types 10, 14, 20, 25, 41, 42, 47 or 68). Group (pay-to) provider numbers and pseudo provider numbers shall not be considered to be valid treating provider numbers. Duplicate claim lines shall be excluded from the calculation.

3.) The percentage of encounters with valid treating provider numbers will then be applied against the available points (e.g. 80% valid treating provider is equivalent to 16 of 20 points). If the percentage is 90% or greater, the MCO will receive all 20 points.

4.) 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 treating Provider percentage.

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

1.) Comply with the MDH licensing requirements and have no repeated deficiencies 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.

F. ***Member Services Phone Responsiveness.***

1.) Maintain an annual telephone abandonment rate of 10 percent or less for incoming calls to the member services department, and an average annual time spent on hold, prior to initial person-to-person contact, an average of 120 seconds or less, from 8:00 a.m. to 4:30 p.m.(Central Time), or the regular hours of operation for the MCO, if longer. This does not apply to subcontractors of the MCO.

2.) The MCO shall provide a report to the STATE, in a format agreed upon by the STATE and the MCO, on the MCO's telephone call abandonment rate and the telephone call hold time during the contract year. The report shall be submitted no later than April 15th of the following year.

G. ***Psychiatrist UR/QA Advisor.***

1.) MCO contracts with, has access to, or has on its administrative staff one or more board certified psychiatrists for consultation on quality and utilization issues regarding mental health issues. The UR/QA Advisor is responsible for oversight and evaluation of the Utilization Management (UM) and Quality Assurance (QA) as demonstrated by:

a) providing UM and QA policies and procedures for mental health services;

b) reviewing consistency the application of UM decision criteria and implementation of corrective action when needed; and

c) participating in UM and QA committee meetings.

2.) The MCO shall submit a copy of its contract(s) with the board certified psychiatrist(s) or organizational chart, the psychiatrist(s) job description and resume, and the amount of funds it paid to the psychiatrist(s) or percentage Full Time Employee for utilization review and quality assurance support during the contract year, to the STATE no later than April 15th of the following year.

H. ***Clinical Performance:*** Lead Screening. Provide an increase in the number of lead screening tests given to Children age nine (9) months through thirty (30) months in accordance with the C&TC Screening Guidelines and submitted with a CPT code of 83655. The MCO's lead screening rate must be 10% greater than the difference between the 80 percent target and the 2006 screening rate. The

calculation shall be computed as whole numbers rounding to the nearest whole number.

Section 4.5.3. ***Return of Withheld Funds for Funds withheld for Calendar Year 2007.*** The funds returned shall be calculated as follows:

A. The difference between the total CY 2007 PMAP/PGAMC/MinnesotaCare Capitation payments to the MCO as of 5/31/08 divided by 0.95 (95%) and the total CY 2006 Capitation Payments to the MCO as of 5/31/08. This amount has been reduced to reflect removal of the MERC funding and the legislated rate reductions of 2.5% for PMAP, 5.5% for PGAMC, and 1% for MinnesotaCare.

B. The percentage determined in 4.5.1.B. shall be multiplied by 4.5.3.A.

C. The amount of the unreturned withheld funds shall be limited to 20 percent of all funds withheld from the MCO.

Section 4.6. ***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.

Section 4.6.1. ***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.

A. 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.

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

C. Neither the STATE nor the MCO shall be bound by the results of the audit.

D. 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.

Section 4.6.2. ***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 this Section.

Section 4.6.3. ***Two Year Limit to Assert Claim.***

A. The STATE shall not assert any claim for or seek the payment of or make any adjustment for any alleged overpayment made by the STATE to the MCO pursuant to Section 4.1. of this Contract, 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 payment of or make any adjustment for any alleged underpayment made by the STATE to the MCO pursuant to Section 4.1. of this Contract, more than two years after the date such payment was actually received by the MCO from the STATE. The MCO must have filed a timely appeal of risk factors under Section 4.1.7. in order to assert any claims regarding risk adjusted payments.

Section 4.6.4. ***Payment Offset.*** When possible, a recovery for an overpayment or payment due because of an underpayment shall be offset against or added to future payments made according to Section 4.1. of this Contract.

Section 4.6.5. ***Notice.*** The parties shall notify each other in writing of an intent to assert a claim under this Section.

Section 4.7. ***Payment Errors 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 Section 4.1. 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.

Section 4.7.1. ***One Year Limit to Assert Claim.***

A. The STATE shall not assert any claim for or seek the payment of or make any adjustment for any alleged overpayment made by the STATE to the MCO under Section 4.1. more than one year after the date such payment was actually received by the MCO from the STATE, except for duplicate payments because of multiple identification numbers for the same Enrollee, and payments for months after the death of the Enrollee.

B. The MCO shall not assert any claim for or seek the payment 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. The MCO must have filed a timely appeal of risk factors under Section 4.1.7. in order to assert any claims regarding risk adjusted payments.

Section 4.7.2. ***Notice.*** The parties shall notify each other in writing of an intent to assert a claim under this Section.

Section 4.8. ***Premium Tax***. Pursuant to Minnesota Statutes, section 297I.15, subd. 4, the MCO shall be taxed on the premiums paid by the STATE under the Medical Assistance, GAMC and MinnesotaCare programs. 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.

Section 4.9. ***Rate Increase for Specific Mental Health Providers.*** Effective July 1, 2007, the MCO shall increase payments rates to mental health Providers pursuant to Law of Minnesota 2006, Chapter 282, Article 16, Section 10.

Article 5. Term, Termination and Partial Breach.

Section 5.1. ***Term.*** The term of this Contract shall be from January 1, 2007, and shall remain in effect through December 31, 2007, and will renew for an additional one year term, unless the MCO or the STATE provides notice of termination in accordance with Article 5 of this Contract. Except for Section 5.2.1. and for all obligations set forth in this Contract that have not been satisfactorily fulfilled, this Contract shall remain in effect until the end of the Contract term or until terminated, whichever occurs earlier. If the Contract 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 rates under this Contract in effect at the time of the renewal, minus any legislated rate reductions.

Coverage will begin at 12:00 a.m. on January 1, 2007 and end at 11:59:59 p.m. on December 31, 2007 (Central Standard Time).

Section 5.1.1. ***Renewal.*** The Commissioner of Human Services shall have the option to offer an automatic renewal of this Contract on an annual basis, upon a 120 day written notice to the MCO. The MCO has the right to decline the option to renew this Contract.

Section 5.1.2. ***Notice.*** The MCO shall provide the STATE with 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.

Section 5.1.3. ***Notice of County Based Purchasing.*** After the STATE approves any new counties for County-Based Purchasing, the STATE shall provide the MCO with no less than 180 days written notice of intent to remove any counties from the MCO's Service Area.

Section 5.2. ***Contract Termination Provisions***.

Section 5.2.1. ***Survival.*** Notwithstanding the termination of this Contract for any reason, Article 14 (Indemnification), Sections 3.5. and 9.4. (reporting and access to records), Section 4.5 (Managed Care Withhold), Sections 4.6. and 4.7. (payment error), Section 7.11. (Financial Performance Incentives) and Section 13.5. (Information Privacy and Security) shall survive the termination of this Contract.

Section 5.2.2. ***Termination Without Cause.*** This Contract may be terminated by the STATE at any time without cause, upon a 150 calendar day written notice to the MCO.

Section 5.2.3. ***Termination for Cause.***

A. ***By the MCO.*** This Contract may be terminated by the MCO, except as provided in Section 5.1.1. related to renewal of this Contract, in the event of the STATE's material breach of this Contract, upon a 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.*** The STATE may terminate this Contract for any material breach by the MCO after 150 days from the date the STATE provides the MCO notice of termination. In the event the material breach consists of fraudulent or criminal action by the MCO, termination may occur after 30 days from the date the STATE provides notice. The MCO may request, and must receive if requested, a hearing before the mediation panel described in Section 5.3.3. prior to termination.

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 that year.

Section 5.2.4. ***Contract Termination Procedures.***

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 60 calendar days in advance of the termination. Such notice must be approved by the STATE. Such notice must include a description of alternatives available for obtaining 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 notices by the parties shall be sent by U.S. Postal Service certified mail, return receipt requested. The required notice periods set forth in Article 5 of this Contract shall be calendar days measured from the date the receipt is signed.

F. Termination under Article 5 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.

Section 5.3. ***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 5.3.4. or 5.3.5., 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.

Section 5.3.1. ***Determination of Remedy.*** In determining the remedy, the STATE shall consider the following factors:

A. The number of Enrollees or Recipients, if any, affected by the breach;

B. The effect, if any, 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, if any, derived by the MCO by virtue of the breach.

Section 5.3.2. ***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 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. If the STATE determines that the MCO failed to cure the breach within the specified time period, the STATE may enforce a remedy or remedies under this Section. The remedies shall be consistent with the factors specified at Section 5.3.1. of this Contract.

Section 5.3.3. ***Mediation Panel.*** If the STATE enforces a remedy under this Section, the STATE shall provide the MCO written notice of the remedy to be imposed. The MCO may request the recommendation of a three-person mediation panel within three working days of receiving notice of a remedy from the STATE. The Commissioner of the Department of Human Services 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. 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. The mediation panel shall meet, accept both written and oral argument as requested, and make its recommendation within fifteen days of receiving the request for recommendation unless the parties mutually agree to a longer time period.

Section 5.3.4. ***Remedies for Partial Breach.***

A. Withhold capitation premiums 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 30 days after the Local Agency or the STATE receives the required Marketing and enrollment Materials.

E. 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 is not submitted pursuant to Section 3.5.1. of this Contract.

F. 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.

Section 5.3.5. ***Temporary Management***. In addition to the remedies listed in Section 5.3.4., 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 sections 1903(m) or section 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.

C. Maintain temporary management of the MCO until the STATE determines that the MCO can ensure that the sanctioned behavior will not recur.

Article 6. Benefit Design and Administration. All terms of Article 6 apply to Medical Assistance, GAMC, MinnesotaCare, MinnesotaCare Limited Benefit Set, and MinnesotaCare/MA Enrollees, unless otherwise stated.

Section 6.1. ***Medical Assistance and MinnesotaCare/Medical Assistance Covered Services.*** The MCO shall provide, or arrange to have provided to Medical Assistance and MinnesotaCare/Medical Assistance Enrollees comprehensive preventive, diagnostic, therapeutic and rehabilitative health care services as defined in Minnesota Statutes, section 256B.0625 and Minnesota Rules, Parts 9505.0170 to 9505.0475. Except for Sections 6.1.24. and 6.1.29., these services shall be provided to the extent that the above law and rules were in effect on the effective day of this Contract. Sections 6.1.24. and 6.1.29. shall be provided to the extent that the above law and rules are in effect. Pursuant to Section 6.9.1., all covered benefits, except for services mandated by state or federal law, are subject to determination by the MCO of Medical Necessity, as defined in Section 2.44. For purposes of this Section, mandated services do not include the benefits described in Minnesota Statutes, Chapters 256B, 256D, and 256L. Covered services shall include, but are not limited to, the following:

Section 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.

Section 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 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.

Section 6.1.3. ***Care Management Services.*** The MCO shall be responsible for the Care Management of all Enrollees. The MCO's Care Management system 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 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. 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.

C. A method for coordinating the medical needs of an Enrollee with his or 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 or seriously emotionally disturbed Children; 2) pre-petition screening, preadmission screening or Home and Community-Based services; 3) extended care or halfway house services covered by the Consolidated Chemical Dependency Treatment Fund; 4) Child protection; 5) court ordered treatment; 6) developmental disabilities; 7) assessment of medical barriers to employment; or 8) a STATE medical review team or social security disability determination. It may also involve working with Local Agency social service staff or county attorney staff for Enrollees who are the victims or perpetrators in criminal cases. 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 a MCO within the previous 180 days.

D. Procedures and criteria for making referrals to specialists and sub-specialists.

E. Capacity to implement, when indicated, Care Management functions such as: 1) individual needs assessment, including screening for special needs (e.g. mental health and/or chemical dependency problems, mental retardation, high risk health problems, difficulty living independently, functional problems, language or comprehension barriers); 2) individual treatment plan development; 3) establishment of treatment objectives; 4) treatment follow-up; 5) monitoring of outcomes; or 6) revision of treatment plan. The MCO shall coordinate with Local Agency human service agencies for assessment and evaluation related to judicial proceedings.

F. For MinnesotaCare Enrollees who are hospitalized, the MCO's responsibility for certifying the inpatient admission must include a Medical Necessity review of the entire confinement, not just the portion covered by the MCO.

G. Procedures for coordinating care for American Indian Enrollees.

H. Procedures for coordinating with IEP IFSP services and supports.

I. Procedures for coordinating with care coordination and services provided by children's mental health collaboratives and family services collaboratives.

Section 6.1.4. ***Chemical Dependency (CD) Treatment Services.*** CD treatment services do not include detoxification (unless it is required for medical treatment), halfway house care, extended care and transitional care. Notwithstanding Section 6.24.2., CD services shall be provided in accordance with 42 CFR 8.12, and Minnesota Rules, Parts 9530.6600 through 9530.6660, and by programs and facilities licensed under Minnesota Rules, Parts 9530.6405 through 9530.6605.

The MCO agrees to work with the STATE in discussing and preparing for the implementation of the Chemical Dependency Rule (Rule 25) changes scheduled to be effective January 1, 2008.

Section 6.1.5. ***Child and Teen Checkups.*** The MCO agrees to provide, or arrange to provide Child and Teen Checkups (C&TC) screenings to each Enrollee under age 21, as follows, and shall be subject to 42 U.S.C. § 1396d(r):

A. Pursuant to 42 CFR 441.56 and the State Medicaid Manual (SMM; CMS-Pub. 45.5) 5122-5123.2, the following C&TC components are currently required and must be performed in accordance with C&TC program standards and according to the periodicity schedule as specified in the current C&TC Chapter of the Provider Manual, which is herein incorporated by reference:

   1.) Assessment of physical growth.
   2.) Vision screening.
   3.) Hearing screening.
   4.) Health history.
   5.) Developmental and behavioral assessment.
   6.) Physical examination.
   7.) Nutritional assessment.
   8.) Immunization and review.
   9.) Laboratory tests.
   10.) Health education and anticipatory guidance.
   11.) An initial examination by a dentist is required for each Enrollee beginning at age three.

B. In order for the MCO to have an encounter considered countable as a C&TC screening, the MCO must provide all components of the C&TC program in the Enrollee's screening and must be made according to the age-related periodicity schedule.

C. The MCO must:

1.) notify Enrollees under the age of 21 of the availability of C&TC screening at least annually;

2.) provide and document all of the required screening components according to the C&TC standards and current periodicity schedule (although the MCO may offer additional preventive services beyond these minimal standards); and

3.) provide all Medically Necessary healthcare, diagnostic services, treatments and other measures, to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, which are mandatory or optional Medical Assistance-covered services under 42 U.S.C. § 1396d(a). See 42 U.S.C. § 1396d(r)(5).

D. The STATE agrees to arrange for C&TC training and consultation, in cooperation with the MCO, on the screening components, screening standards, age-related periodicity schedule, reporting requirements, and other C&TC provider-related matters.

E. The STATE agrees to work with the MCO on policy issues and process improvements regarding C&TC during the Contract year. The MCO agrees to work with the STATE towards WebCATCH implementation.

F. The MCO must report to the STATE on a monthly basis, well-child visit data identified by codes specified by the STATE in a document entitled, "MCO Monthly CATCH 3 Data Submission," and submitted electronically in the ASCII file format as required by the STATE. The report for each month must be according to the most current specifications which have been provided by the STATE and is due to the STATE between the 1st and 10th day after the last day of the month. The MCO must report the data of all health services provided to Enrollees under age 21 pursuant to Section 3.5.1. The MCO shall submit this data to the STATE no later than one month after the date the MCO adjudicated the claim. For all well-child visit data submitted, when the STATE rejects the file, the MCO shall have 15 days from the date of return to resubmit an accurate file.

Section 6.1.6. ***Chiropractic Services.***

Section 6.1.7. ***Clinic Services.***

Section 6.1.8. ***Dental Services***. Dental services includes dentures. Replacement of dental prosthesis may be limited to one replacement every three years unless the MCO gives Service Authorization to a replacement within the three-year period. Coverage of orthodontics is limited to disfigurement of the face and/or impaired biting function.

The MCO shall cooperate with the STATE in its implementation of the Oral Health Pilot Project.

Section 6.1.9. ***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, and the Family Planning Services prescribed by Minnesota Statutes, section 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, section 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 (i.e., 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; and

   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.) non-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 Notices about claims sent to the Enrollee, including the Explanation of Benefit and/or Explanation of Medical Benefit Notices.

Section 6.1.10. ***Home Care Services.***

A. Home Care Services include:

1.) Skilled Nursing visits provided by a certified Home Health Agency, up to the service limit described in Minnesota Statutes, section 256B.0651, subdivision 6(a).

2.) Home Health Aide services provided by a certified Home Health Agency, up to the service limit described in Minnesota Statutes, section 256B.0651, subdivision 6(a).

3.) Personal Care Assistant (PCA) Services, up to the service limits established in Minnesota Statutes, section 256B.0655, including but not limited to subdivisions 2, 6 (flexible use of hours), and 7 (fiscal intermediary and PCA choice option). The MCO must ensure that PCA Providers keep specific documentation on file for each Enrollee, including but not limited to a physician statement of need, service plan, and a care plan. The MCO shall also ensure PCA services are provided in accordance with Minnesota Statutes, section 256B.0655 including but not limited to, the limitations and Service Authorization for the option for flexible use of PCA hours and as described in the Disability Services Program Manual (DSPM) at www.dhs.state.mn.us/dspm.

4.) Qualified Professional supervision of PCA Services as defined in Minnesota Statutes, section 256B.0625, subdivision 19c, up to the service limits specified in Minnesota Rules, Part 9505.0335, subp. 4.

5.) Private Duty Nursing Services, up to the limits established in Minnesota Statutes, section 256B.0654, subdivision 2. The MCO shall also use the criteria established in Minnesota Statutes, section 256B.0654, subdivision 4 to determine whether or not to grant a hardship waiver for these services to an Enrollee's parent, spouse or legal guardian.

6.) Therapy Services, including physical therapy, occupational therapy, speech therapy and respiratory therapy, up to the limits established in Minnesota Statutes, section 256B.0653 and Minnesota Rules, Part 9505.0390.

7.) Medical Equipment and Supplies, pursuant to Section 6.1.16.

B. For Enrollees who are ventilator-dependent, the limits described in 1 through 6 above do not apply; the limits for these Enrollees are as described in Minnesota Statutes, section 256B.0651, subdivision 6(b).

C. If the MCO Service Authorizes Home Care Services, it shall comply with Section 6.23. of this Contract.

Section 6.1.11. ***Hospice Services.*** 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 from a Medicare certified hospice agency.

Section 6.1.12. ***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.

Section 6.1.13. ***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 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. The MCO is not required to provide an interpreter for activities of daily living, but is responsible to provide an interpreter for medical services, including those provided in institutional facilities under this Contract.

Section 6.1.14. ***Laboratory, Diagnostic and Radiological Services.***

Section 6.1.15. ***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 urgent care 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 6.24.1. 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 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, and that the determination of the treating Provider is binding on the MCO for coverage and payment purposes.

Section 6.1.16. ***Medical Supplies and Equipment.*** Replacement of lost, stolen or irreparably damaged hearing aids for an Enrollee who is 21 years of age or older may be limited to two replacements in a five-year period.

Section 6.1.17. ***Medical Transportation Services.*** Also see Section 6.6. for Common Carrier Transportation Services. Medical transportation services includes:

A. Ambulance services required for Medical Emergency care;

B. Special transportation services for a person who is physically or mentally incapable of transport by taxicab or bus (which are not covered for MinnesotaCare Enrollees).

Section 6.1.18. ***Mental Health Services.*** 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, section 62Q.53 or described in Section 2.47.

A. ***General Mental Health Services.*** 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. The MCO must ensure that the following services are available to its Enrollees:

1.) Diagnostic assessment, psychological testing, and explanation of findings to establish or rule out the appropriate mental illness (MI) diagnosis and develop the individual treatment plan. A psychiatric assessment must include the direct assessment of the Enrollee.

2.) Crisis assessment and intervention provided in an emergency room or urgent care setting (phone and walk-in).

3.) Day treatment and partial hospitalization.

4.) Individual, family, and group therapy and multiple family group psychotherapy, including counseling related to adjustment to physical disabilities or chronic illness.

5.) Inpatient and outpatient treatment.

6.) Assessment of Enrollees whose health care seeking behavior and/or mental functioning suggests underlying mental health problems.

7.) Neuropsychological assessment.

8.) Neuropsychological rehabilitation and/or cognitive remediation training for Enrollees with a diagnosed neurological disorder who can benefit from cognitive rehabilitation services.

9.) Medication management.

10.)Travel time for mental health Providers as specified in Minnesota Statutes, section 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.

11.) 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.

12.)Upon federal approval, consultation provided by a psychiatrist via telephone, e-mail, facsimile, or other means of communication, to Primary Care Providers, including pediatricians. 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 consent.

13.) Enrollees receiving the benefit set described in Section 6.1 of this Contract are entitled to receive mental health targeted case management (MH-TCM) services through Local Agencies or their contracted vendors. With the exception of crisis stabilization services provided by an Intensive Residential Treatment facility, nonresidential crisis response services are covered under this contract, pursuant to Minnesota Statutes, section 256B.0624. Beginning July 1, 2007, Adult Rehabilitative Mental Health Services (ARMHS) are covered under this Contract, as authorized by Minnesota Statutes, section 256B.0623.

B. ***Additional Children's Mental Health Services***. All Mental Health professional services for children must be delivered in a manner so as to establish or sustain the Enrollee at a level of mental health functioning appropriate to the Enrollee's developmental level.

1.) Subacute psychiatric care for children under age 21.

2.) Children's Therapeutic Services and Supports.

3.) Children's Mental Health Crisis Response Services.

4.) Treatment Foster Care services, in accordance with Minnesota Statutes, sections 245.4885, subdivisions 1, 1a, and 2; 256B.0625, subd. 47; and 256B.0946 are effective upon federal approval. The MCO shall be paid for these services pursuant to Section 7.10.4. The MCO shall ensure that Treatment Foster Care service providers:

   a) Determine an Enrollee's eligibility to receive treatment foster care services based upon a diagnostic assessment, an evaluation of the level of care needed, and development of an individual treatment plan.

   b) Are eligible providers as determined by Minnesota Statutes, section 256B.0946, subd. 3 and meet the responsibilities outlined in subd. 4.

   c) Have written policies and procedures for Treatment Foster Care services that ensure:

      i) mental health services meet the standards established in the Comprehensive Children's Mental Health Act, Minnesota Statutes, sections 245.487 to 245.4887;

      ii) case management service component meet the standards in Minnesota Rules, Parts 9520.0900 to 9520.0926, and Part 9505.0322, excluding subparts 6 and 10;

      iii) Psychotherapy, crisis assistance when authorized in law, and skills training components must meet the standards for Children's Therapeutic Services and Supports in Minnesota Statutes, section 256B.0943; and

      iv) family psychoeducation services are provided under supervision of a mental health professional.

   d) Authorize services in compliance with Minnesota Statutes, section 256B.0625, subd. 25.

e) Exclude as not eligible components of treatment foster care services, the services listed in Minnesota Statutes, section 256B.0946, subd. 6.

5.) The MCO agrees to work with the STATE in implementing Assertive Community Treatment for Transition Youth.

C. ***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, sections 62Q.535, subdivisions 1 and 2; 253B.045, subdivision 6; and 260C.201, subdivision 1, which are otherwise covered under this Contract. The services must have been ordered by a court of competent jurisdiction and based upon a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist. The MCO shall assume financial liability for the behavioral evaluation which includes diagnosis and an individual treatment plan, if the evaluation has been performed by one of the Participating Providers in its network.

2.) The court-ordered mental health services shall not be subject to a separate Medical Necessity determination by the MCO as provided for in Section 6.9.1. of this Contract. However, the MCO may make a motion for modification of the court-ordered plan of care, including a request for a new behavioral care evaluation, according to the rules of procedure for modification of the court's order.

3.) The MCO must provide a 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.

Section 6.1.19. ***Obstetrics and Gynecological Services.*** Such services include nurse-midwife services and prenatal care services as described below.

A. ***Nurse-Midwife.*** Nurse-Midwife services are certified nurse-midwife services, pursuant to Section 1905(a)(17) of the Social Security Act, Minnesota Rules, Part 9505.0320.

B. ***Prenatal Care Services.*** The MCO must ensure that its Providers perform the following tasks:

1.) All pregnant Enrollees must be screened during their initial prenatal care office visit using a standardized prenatal assessment, or its equivalent,

which must be maintained in the Enrollee's medical record. The purpose of the screening is to determine the Enrollee's risk of poor pregnancy outcome as well as to establish an appropriate treatment plan, including enhanced health services if the Enrollee is an at-risk Pregnant Woman as defined in Minnesota Rules, Part 9505.0353. A referral to the Women, Infants, Children Supplemental Food and Nutrition Program (WIC) must be made when WIC assessment standards are met.

2.) Those women who are identified as at-risk must be offered enhanced perinatal services. Enhanced perinatal services include: at-risk antepartum management, care coordination, prenatal health education, prenatal nutrition education, and a postpartum home visit.

Section 6.1.20. ***Outpatient Hospital Services.*** Outpatient hospital services includes emergency care.

Section 6.1.21. ***Personal Care Assistant (PCA) Services*** as specified in Section 6.1.10.A.3.

Section 6.1.22. ***Physician Services***, including Telemedicine Consultations. Coverage of Telemedicine Consultations is limited to three Telemedicine Consultations per Enrollee per week.

Section 6.1.23. ***Podiatric Services.***

Section 6.1.24. ***Prescription Drugs and Over-the-Counter Drugs.*** Covered prescription and over-the-counter drugs that are: 1) prescribed by a Provider who is licensed to prescribe drugs within the scope of his or her profession; 2) dispensed by a Provider who is licensed to dispense drugs within the scope of his or her profession; and 3) 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. Pursuant to Minnesota Statutes, section 256B.0625, subd. 13(c), the MCO may allow pharmacists to prescribe over-the-counter drugs. For Dual Eligibles, the MCO may cover drugs from the drug classes listed in 42 U.S.C. § 1396r-8(d)(2), except that drugs listed in 42 U.S.C. § 1396r-8(d)(2)(E), shall not be covered.

A. 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.

B. Upon request of the STATE, the MCO shall submit a copy of the MCO's drug formulary, in order for the STATE to comply with the monitoring requirements

under the CMS Waiver Number 11-W-OO039/5 (i.e. Minnesota's PMAP+/§1115 Waiver). The MCO may fulfill this requirement by making the drug formulary available on the MCO's website and providing the link to the STATE.

C. The STATE shall notify the MCO of any inadequacies in the MCO's formulary and the MCO shall submit a corrective action plan. For the purposes of this Section, inadequacies means that the MCO's formulary does not contain a therapeutic equivalent for a class of drugs.

D. 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.

E. 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, section 62Q.527. 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.

F. Subject to conditions specified in Minnesota Statutes, section 62Q.527, 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.

G. Pursuant to Minnesota Statutes, section 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.

H. ***Medication Therapy Management (MTM) Care Services.*** Pursuant to Minnesota Statute, section 256B.0625, subd. 13h, and the Medication Therapy Management Services listed on the STATE's MHCP Enrolled Providers website (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_055325), MTM services are covered, except for Enrollees receiving drugs covered by Medicare Part D, for whom MTM services are covered by Medicare.

Section 6.1.25. ***Prosthetic and Orthotic Devices.*** Prosthetic and orthotic devices include related medical supplies.

Section 6.1.26. ***Public Health Services.*** Public health clinic services and public health nursing clinic services as they are described in Chapter 8 of the Provider Manual. Also see Section 9.3.9.

Section 6.1.27. ***Reconstructive Surgery***, as described in Minnesota Statutes, section 62A.25, subdivision 2, and the Women's Health and Cancer Rights Act of 1998 (WHCRA).

Section 6.1.28. ***Rehabilitative and Therapeutic Services***. Rehabilitative and therapeutic services (related to evaluation and treatment) include:

A. physical therapy (including specialized maintenance therapy, pursuant to Minnesota Rules, Section 9505.0390);

B. speech therapy (including specialized maintenance therapy, pursuant to Minnesota Rules, Section 9505.0390);

C. occupational therapy (including specialized maintenance therapy, pursuant to Minnesota Rules, Section 9505.0390);

D. audiology; and

E. respiratory therapy.

Section 6.1.29. ***Transplants.*** Covered transplants: 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).

Section 6.1.30. ***Tuberculosis-Related Services.*** Tuberculosis related services include Case Management and direct observation of the intake of drugs prescribed to treat tuberculosis. The MCO shall make reasonable efforts to contract with and use the Local Agency's public health nursing as the Provider for direct observation of the intake of drugs prescribed to treat tuberculosis, except for persons who are Institutionalized. The MCO shall communicate to medical care Providers that tuberculosis patients should be referred to the Local Agency's public health agency for direct observed therapy.

Section 6.1.31. ***Vaccines and Immunizations.*** Covered vaccines and immunizations include, but are not limited to, recommendations by the Minnesota Department of Health and HPV immunizations for females ages 9 to 26.

Section 6.1.32. ***Vision Care Services.*** Vision care 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.

Section 6.2. ***GAMC Covered Services.*** The MCO shall provide, or arrange to have provided, to Enrollees comprehensive preventive, diagnostic, therapeutic and rehabilitative health care services as defined in Minnesota Statutes, section 256D.03. Except for Sections 6.2.16.C. and 6.2.17., these services shall be provided to the extent that this law was in effect on the effective day of this Contract. Sections 6.2.16.C. and 6.2.17. shall be provided to the extent that the above law and rules are in effect. Pursuant to Section 6.9.1., all covered benefits, except for services mandated by state or federal law, are subject to determination by the MCO of Medical Necessity, as defined in Section 2.47. For purposes of this Section, mandated services do not include the benefits described in Minnesota Statutes, Chapters 256B, 256D, and 256L. Covered services shall include, but are not limited to, the following:

Section 6.2.1. ***Advanced Practice Nurses*** , as specified in Section 6.1.1.

Section 6.2.2. ***Cancer Clinical Trials***, as specified in Section 6.1.2.

Section 6.2.3. ***Care Management***, as specified in Section 6.1.3.

Section 6.2.4. ***Chemical Dependency Treatment Services***, as specified in Section 6.1.4.

Section 6.2.5. ***Chiropractic Services***.

Section 6.2.6. ***Dental Services***, as specified in Section 6.1.8.

Section 6.2.7. ***Family Planning Services***, as specified in Section 6.1.9.

Section 6.2.8. ***Hearing Aids, Prosthetic and Orthotic Devices***. Replacement of lost, stolen or irreparably damaged hearing aids for an Enrollee who is 21 years of age or older may be limited to two replacements in a five-year period.

Section 6.2.9. ***Inpatient and Outpatient 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.

Section 6.2.10. ***Interpreter Services***, as specified in Section 6.1.13.

Section 6.2.11. ***Laboratory, Diagnostic and Radiological Services***.

Section 6.2.12. ***Medical Emergency, Post-Stabilization Care and Urgent Care Services***, as specified in Section 6.1.15.

Section 6.2.13. ***Medical Supplies and Equipment***, including those necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar levels.

Section 6.2.14. ***Medical Transportation Services***, as specified in Section 6.1.17., except that 6.1.17.B. is covered only for Enrollees who reside in an Institution for Mental Disease (IMD).

Section 6.2.15. ***Mental Health Services***, as specified in Section 6.1.18, except for ARMHS and nonresidential crisis services, which are not covered.

Section 6.2.16. ***Physician, Clinic and Community Health Clinic Services***, including:

A. Telemedicine Consultations. Coverage of Telemedicine Consultations is limited to three Telemedicine Consultations per Enrollee per week.

B. Ob-Gyn services as described in Section 6.1.19.

C. Transplant Services as described in Section 6.1.29.

D. Vaccines and Immunizations as described in Section 6.1.31.

Section 6.2.17. ***Prescription Drugs and Over-the-Counter Drugs.*** Covered prescription and over-the-counter drugs that are: 1) prescribed by a Provider licensed in Minnesota to prescribe drugs within the scope of his or her profession; 2) dispensed by a Provider who is licensed in Minnesota to dispense drugs within the scope of his or her profession; and 3) contained in the Medical Assistance Drug Formulary or are the therapeutic equivalent of Medical Assistance formulary drugs, except those drugs covered under the Medicare Prescription Drug Program under Medicare Part D for Medicare eligible Enrollees. Pursuant to Minnesota Statutes, section 256B.0625, subd. 13(c), the MCO may allow pharmacists to prescribe over-the-counter drugs.

A. 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.

B. Upon request of the STATE, the MCO shall submit a copy of the MCO's drug formulary, in order for the STATE to comply with the monitoring requirements under the CMS Waiver Number 11-W-OO039/5 (i.e. Minnesota's PMAP+/Section 1115 Waiver). The MCO may fulfill this requirement by making the drug formulary available on the MCO's website and providing the link to the STATE.

C. The STATE shall notify the MCO of any inadequacies in its formulary and the MCO shall submit a corrective action plan. For the purposes of this Section, inadequacies mean that the MCO's formulary does not contain a therapeutic equivalent for a class of drugs.

D. In addition, the MCO shall notify the STATE of any changes in its drug formulary within 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.

E. 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, section 62Q.527. 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.

F. Subject to conditions specified in Minnesota Statutes, section 62Q.527, 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.

G. Pursuant to Minnesota Statutes, section 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 patient.

H. **Medication Therapy Management (MTM) Care Services.** Pursuant to Minnesota Statute, section 256B.0625, subd. 13h, and the Medication Therapy Management Services listed on the STATE's MHCP Enrolled Providers website (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_055325), MTM services are covered, except for Enrollees receiving drugs covered by Medicare Part D, for whom MTM services are covered by Medicare.

Section 6.2.18. ***Public Health Nursing Clinic Services.*** Services of a certified public health nurse or a registered nurse practicing in a Public Health Nursing Clinic as they are described in Chapter 8 of the Provider Manual.

Section 6.2.19. ***Reconstructive Surgery***, as described in Minnesota Statutes, section 62A.25, subdivision 2, and the Women's Health and Cancer Rights Act of 1998 (WHCRA).

Section 6.2.20. ***Rehabilitative Services*** as described in Section 6.1.28. that are provided by a Medicare-certified agency.

Section 6.2.21. ***Vision Care Services***, as specified in Section 6.1.32.

Section 6.3. ***MinnesotaCare Covered Services***.

Section 6.3.1. ***MinnesotaCare/Medical Assistance Enrollees***. The MCO shall provide, or arrange to have provided to MinnesotaCare/Medical Assistance Enrollees comprehensive preventive, diagnostic, therapeutic and rehabilitative health care services as defined in Minnesota Statutes, section 256B.0625 and Minnesota Rules, Parts 9505.0170 through 9505.0475. Except for Sections 6.1.24. and 6.1.29., these services shall be provided to the extent that the above law and rules were in effect on the effective day of this Contract. Sections 6.1.24. and 6.1.29. shall be provided to the extent that the above law and rules are in effect. Pursuant to Section 6.9.1., all covered benefits, except for services mandated by state or federal law, are subject to determination by the MCO of Medical Necessity, as defined in Section 2.45. For purposes of this Section, mandated

services do not include the benefits described in Minnesota Statutes, Chapters 256B, 256D, and 256L.

Section 6.3.2. ***MinnesotaCare Enrollees.*** The MCO shall provide, or arrange to have provided, to MinnesotaCare Enrollees the same services described in Section 6.1. above with the following modifications. Co-pays apply to some covered services as specified in Section 4.4.3.

A. Inpatient Hospital Service billings covered up to a $10,000 per calendar year benefit limit.

    1.) Parents (including Legal Guardians) whose income is less than or equal to 175% of Federal Poverty Guidelines (FPG), shall not be subject to a limit on Inpatient Hospital services.

    2.) For Enrollees who change MCOs during the calendar year, charges submitted toward the $10,000 Inpatient limit and out of pocket expenses incurred toward the Inpatient limit, that were submitted or incurred prior to the change in MCOs, are disregarded.

B. Dental services covered for preventive and restorative services only, based on the designation of categories of preventive and restorative dental services as determined by the STATE.

C. Non-Pregnant Adults (including Legal Guardians) whose income is less than or equal to 175% of FPG shall receive restorative dental benefits (not including orthodontia).

D. Outpatient mental health services covered are limited to:

    1.) diagnostic assessments;
    2.) psychological testing;
    3.) explanation of findings;
    4.) medication management by a physician;
    5.) day treatment;
    6.) partial hospitalization;
    7.) mental health telemedicine;
    8.) psychiatric consultations; and
    9.) individual, family, and group psychotherapy.

    ARMHS and nonresidential crisis services are not covered.

E. Home Care Services are covered, with the exception of private duty nursing and personal care assistant services.

F. Non-emergency medical transportation is not covered.

Section 6.3.3. ***MinnesotaCare Limited Benefit Set Enrollees.*** The MCO shall provide, or arrange to have provided, to MinnesotaCare Limited Benefit Set Enrollees the services, as described in Minnesota Statutes, sections 256B.0625 and 256L.035 and Minnesota Rules, Parts 9505.0170 to 9505.0475, subject to the limits indicated below. Co-pays apply to some covered services as specified in Section 4.4.3.

A. Inpatient Hospital Service payments covered up to a $10,000 per calendar year benefit limit, based on paid charges, including physician services provided during an inpatient stay, and including chemical dependency assessments necessary to determine the level of care. Physician service charges during a covered inpatient stay are covered but do not accrue towards the $10,000 benefit limit. For Enrollees who change MCOs during the calendar year, charges paid toward the $10,000 inpatient limit and out of pocket expenses incurred toward the inpatient limit, that were submitted or incurred prior to the change in MCOs, are disregarded.

B. The following services are covered:

1.) Chiropractic Services.

2.) Physician Services provided by Physicians, Physician Assistants and Advanced Practice Nurses. Physician services also include services provided by an Optometrist that are related to treatment of accident, injury, infection, or foreign body in the eye, pursuant to the STATE's list of MLB Optometrist Procedure Codes.

3.) Mental health services provided by psychologists and licensed independent clinical social workers within the scope of their practice.

4.) Laboratory, Diagnostic and Radiologic Services.

5.) Outpatient Hospital Services and Ambulatory Surgical Center Services, including chemical dependency assessments necessary to determine the level of care.

6.) Prescription Drugs and Over-the-Counter Drugs.

7.) Diabetic supplies and diabetic equipment.

Additionally, the MCO shall provide interpreter services as an access benefit.

Section 6.4. ***Substitute Health Services Permitted***. To the extent consistent with Minnesota Statutes, Chapter 256B and sections 256L.03, et seq., and 256D.03, subdivision 4, the MCO shall have the right, in its discretion, to pay for or provide Substitute Health Services if such

services are, in the judgment of the MCO, medically appropriate and cost-effective. This Section does not apply to Section 6.3.3. Substitute Health Services submitted as encounter data will be considered in calculations of MCO costs pursuant to Section 4.6.

Section 6.5. ***Additional Services Permitted.*** The MCO may provide or arrange to have provided services in addition to the services described in Article 6, Sections 6.1., 6.2., and 6.3., as permitted through waivers granted by the U.S. Department of Health and Human Services-Centers for Medicare and Medicaid Services under Title XI, Section 1115 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. This Section does not apply to Section 6.3.3.

Section 6.6. ***Common Carrier Transportation Services.***

Section 6.6.1. ***General.*** In addition to the medical transportation services described in Section 6.1.17., and except for the services described in Section 6.6.2., the MCO shall provide Common Carrier Transportation to its Medical Assistance and GAMC Enrollees for the purpose of obtaining covered health care services. The STATE will provide Common Carrier Transportation services to MinnesotaCare/Medical Assistance Enrollees. County-Based MCOs shall not be responsible for providing common carrier transportation.

Section 6.6.2. ***Common Carrier Transportation That is Not the Responsibility of the MCO.*** The Local Agency shall remain responsible for reimbursing the Enrollee or the Enrollee's driver for mileage 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 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 or more from the Enrollee's home, unless the MCO approves the travel because the non-emergency service required is not available within thirty (30) miles from the Enrollee's residence. Providing non-emergency transportation to medical services located outside of Minnesota that have been approved by the MCO is the responsibility of the STATE's contracted transportation coordinator within the Metro Area and remains the responsibility of the Local Agency outside of the Metro Area.

Section 6.6.3. ***Common Carrier Transportation.*** The STATE shall reimburse the MCO on a capitation basis for transporting an Enrollee to or from the site of a non-emergency service covered under this Contract, pursuant to Minnesota Statutes, section 256B.691.

Section 6.7. ***Deficiencies.***

Section 6.7.1. ***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. or to enforce remedies pursuant to Sections 5.3.4. and 5.3.5.

Section 6.7.2. ***Failure to Provide Services.*** The MCO shall be subject to one of the remedies listed in Section 5.3.4. and 5.3.5. 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, if the failure has adversely affected or has a substantial likelihood of adversely affecting the Enrollee.

Section 6.8. ***Vaccines for Children.*** The MCO agrees to participate in the Vaccines for Children (VFC) immunization program, pursuant to 42 U.S.C. § 1396s and Minnesota Statutes, section 256B.0625, subd. 39. The MCO will also collaborate as reasonably requested with public health agencies to ensure childhood immunizations to all enrolled families with Children, pursuant to Minnesota Statutes, section 256L.12, subd. 10.

Section 6.9. ***Limitations on MCO Services***.

Section 6.9.1. ***Medical Necessity***. Unless otherwise provided in this Contract, or otherwise mandated by state or federal law, 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.

Section 6.9.2. ***Coverage Limited to Program Coverage***. Except as otherwise provided under this Contract, all healthcare services prescribed or recommended by a participating physician, dentist, care manager, or other practitioner, or approved by the MCO are limited to services that are covered under Medical Assistance, GAMC, or MinnesotaCare.

Section 6.10. ***Special Education Services.*** The MCO may not deny the provision of or payment for Medically Necessary medical services for which the MCO is otherwise responsible under this Contract, solely because, pursuant to Section 6.11.10., those services are or could be included in a Child's individualized education plan, or an infant's or toddler's individualized family service plan, adopted pursuant to parts B and C of the Individuals with Disabilities Education Act, Public Law No. 105-17 (June 4, 1997), amending 20 U.S.C. § 1400 et seq. (1996).

Section 6.11. ***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.

Section 6.11.1. ***Abortion Services.***

Section 6.11.2. ***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.

Section 6.11.3. ***Circumcision for Newborns.*** Newborn circumcision is not covered under this contract.

Section 6.11.4. ***Experimental or Investigative Services.***

Section 6.11.5. ***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.

Section 6.11.6. ***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) unless the services are approved by the MCO or unless the services are court-ordered pursuant to Minnesota Statutes, sections 62Q.535; 253B.045, subdivision 6; or 260C.201, subdivision 1.

Section 6.11.7. ***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.

Section 6.11.8. ***Sex Reassignment Surgery.*** Sex reassignment surgery is not covered.

Section 6.11.9. ***IEP and IFSP Services***. Medically Necessary Medical Assistance services that would otherwise be covered by this Contract, identified in an Enrollee's Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) and provided by school districts are not covered.

Section 6.11.10. ***Incidental Services.*** Incidental services are not covered, including but not limited to: 1) rental of television or telephone; 2) barber and beauty services; and 3) guest services that are not Medically Necessary.

Section 6.11.11. ***Certain Mental Health Services.*** Mental health case management services for persons with serious and persistent mental illness, according to Minnesota Rules, Parts 9520.0900 through 9520.0926, and mental health case management for Children with severe emotional disturbances according to Minnesota Rules, Part 9505.0322, are not covered. Adult Rehabilitative Mental Health Services (ARMHS) are not covered under this Contract from January 1, 2007 through June 30, 2007. Assertive Community Treatment (ACT), Intensive Residential Treatment (IRT), and residential crisis response services are not covered under this Contract but are available through Local Agencies or their contracted vendor.

Section 6.11.12. ***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.

Section 6.11.13. ***Children's Residential Mental Health Treatment Facility Services (Rule 5).*** Enrollees needing children's residential mental health treatment facility services may obtain them from the Local Agency. The MCO shall be responsible for other medical costs while the Child resides in the children's residential mental health treatment facility and remains in managed care.

Section 6.11.14. ***Waivered Services.*** Waivered services provided under home-based and community-based waivers authorized under 42 U.S.C. § 1396 are not covered.

Section 6.11.15. ***Drugs covered under the Medicare Prescription Drug Program*** are not covered for Medicare-eligible Enrollees.

Section 6.11.16. ***Nursing Facility Services.*** Nursing facility services are not covered under this contract, unless provided as a Substitute Health Service under Section 6.4 of this Contract.

Section 6.11.17. ***Other.*** All other exclusions set forth in Minnesota Statutes, section 256B.0625, Minnesota Statutes, section 256B.69, Minnesota Rules, Part 9505.0170 to 9505.0475, and Minnesota Rules, Part 9500.1450 to 9500.1464 are not covered.

Section 6.12. ***Enrollee Liability.*** The MCO agrees and will ensure that its subcontractors agree that, except for Sections 4.4.3. and 4.4.4., the Enrollee shall not be billed or be held 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. The MCO shall further ensure that an Enrollee will be protected against liability for payment when:

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; and

D. A non-Participating Provider attempts to balance-bill the Enrollee.

Section 6.12.1. If the MCO or its subcontractors violate 42 U.S.C. §1320a-7b(d)(1), the MCO and its subcontractors may be subject to the criminal penalties stated therein.

Section 6.12.2. The MCO shall not make payment to an Enrollee in reimbursement for a service provided under this Contract. (See 42 CFR 447.25).

Section 6.13. ***Designated Source of Primary Care***. The MCO shall have written procedures that ensure that 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.

Section 6.14. ***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.

Section 6.15. ***Access Standards.*** The MCO shall provide care to Enrollees through the use of an adequate number of hospitals, service locations, service sites, and professional, allied and paramedical personnel for the provision of all Covered Services, pursuant to the following standards:

Section 6.15.1. ***Primary Care.***

A. Distance/Time: No more than 30 miles or 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.

D. Appointment Times: Not to exceed 45 days from the date of an Enrollee's request for routine and preventive care and 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.

Section 6.15.2. ***Specialty Care.***

A. Transport Time: Not to exceed 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.

Section 6.15.3. ***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.

Section 6.15.4. ***Hospitals.*** Transport time: Note to exceed 30 minutes, or the STATE's Generally Accepted Community Standards.

Section 6.15.5. ***Dental, Optometry, Lab, and X-Ray Services.***

A. Transport Time: Not to exceed 60 minutes, or the STATE's Generally Accepted Community Standards.

B. Appointment/Waiting Time: Not to exceed 60 days for regular appointments and 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.

Section 6.15.6. ***Pharmacy Services.*** Travel Time: Not to exceed 60 minutes, or the STATE's Generally Accepted Community Standards.

Section 6.15.7. ***Other Services.*** All other services not specified in this Section shall meet the STATE's Generally Accepted Community Standards or other applicable standards.

Section 6.16. ***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 24-hour, seven-day-per-week basis. The MCO must provide a 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.

Section 6.17. ***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.

Section 6.17.1. ***Seriously and Persistently Mentally Ill (SPMI):*** ongoing medications review and monitoring, day treatment, and other alternatives to conventional therapy, and coordination with the Enrollee's case management service provider to assure appropriate utilization of all needed psycho social services.

Section 6.17.2. ***Elderly, Physically Handicapped and Chronically Ill:*** in-home services, neurological assessments.

Section 6.17.3. ***Abused Children and Adults, Abusive Individuals:*** comprehensive assessment and diagnostic services and specialized treatment techniques for victims and perpetrators of maltreatment (physical, sexual, emotional).

Section 6.17.4. ***Enrollees with Language Barriers:*** interpreter services, bilingual staff, culturally appropriate assessment and treatment. When an individual is enrolled in PMAP, the enrollment form will indicate whether the Enrollee needs the services of an interpreter and what language she or he speaks. Upon receipt of enrollment information indicating interpreter services are needed, the MCO shall contact the Medical Assistance, GAMC or MinnesotaCare/Medical Assistance 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 6.1.13.

Section 6.17.5. ***Cultural and Racial Minorities:*** culturally appropriate services rendered by Providers with special expertise in the delivery of health care services to the various cultural and racial minority groups.

Section 6.17.6. ***Dual MI/Developmentally Disabled (DD) or MI/CD Clients:*** comprehensive assessment, diagnostic and treatment services provided by staff who are trained to work with clients with multiple disabilities and complex needs.

Section 6.17.7. ***Lesbians, Gay Men, Bisexual and Transgender Persons:*** sensitivity to critical social and family issues unique to lesbians, gay men, bisexual and transgender persons.

Section 6.17.8. ***Hearing Impaired:*** access to TDD and hearing impaired interpreter services.

Section 6.17.9. ***Enrollees in Need of Gender Specific Mental Health and/or Chemical Dependency Treatment:*** The MCO must provide its Enrollees with an opportunity to receive mental health and/or chemical dependency services from the same sex therapist and the option of participating in an all male/all female group therapy program.

Section 6.17.10. ***Children and Adolescents, Including Severely and Emotionally Disturbed (SED) Children and Children Involved in the Child Protection System:*** services specific to the needs of these groups, including day treatment, home-based mental health services, and Inpatient services. The services which the MCO delivers must be: 1) provided in the least restrictive setting; 2) individualized to meet the specific needs of each Child; and 3) designed to provide early identification and treatment of mental illness. The MCO must coordinate services with the Child's Local Agency case management service provider(s), children’s mental health collaborative service coordination and family services collaborative service coordination, and must arrange for participation in the Child’s wraparound services planning, upon request.

Section 6.17.11. ***Developmentally Disabled (DD):*** Specialized mental health and rehabilitative services and other appropriate services covered by Medical Assistance services 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.

Section 6.17.12. ***Membership Materials for Enrollees with Disabilities:*** 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 711, or through the Minnesota Relay Service at 1-877-627-3848 (speech to speech relay service)," or similar language approved by the STATE pursuant to Section 3.2.4.B.

Section 6.17.13. ***American Indians:*** Culturally appropriate services rendered by Providers with special expertise in the delivery of health care services to the various tribes.

Section 6.18. ***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.

Section 6.19. ***Primary Care Provider.*** The MCO will reasonably provide each Enrollee with a choice of a Primary Care Provider who will coordinate the Enrollee's care.

Section 6.20. ***Geographic Accessibility of Providers.*** In accordance with Minnesota Statutes, section 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.

Section 6.21. ***Direct Access to Obstetricians and Gynecologists.*** Pursuant to Minnesota Statutes, section 62Q.52, the MCO shall provide Enrollees direct access without a referral or Service Authorization to the following obstetric and gynecologic services: 1) annual preventive health examinations and any subsequent obstetric or gynecologic visits determined to be Medically Necessary by the examining obstetrician or gynecologist; 2) maternity care; and 3) evaluation and necessary treatment for acute gynecologic conditions or emergencies. Direct access shall apply to obstetric and gynecologic Providers within the Enrollee's network or care system, including any Providers with whom the MCO has established referral patterns.

Section 6.22. ***Services Received at Indian Health Service and Tribal Providers.*** American Indian Medical Assistance/GAMC and MinnesotaCare Recipients, living on or off a

reservation, will have direct out-of-network access to Indian Health Service (IHS) facilities and facilities operated by a tribe or tribal organization under funding authorized by 25 U.S.C. §§ 450f to 450n, or title III of the Indian Self-Determination Act, Public Law Number 93-638 (Section 638 Facilities or Providers), for services that would otherwise be covered under Minnesota Statutes, section 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.

Section 6.22.1. ***Referrals from IHS and 638 Providers***. When a physician in a facility described in Section 6.22 refers an American Indian PMAP/PGAMC or MinnesotaCare 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. The Participating Provider to whom the IHS or 638 physician refers the Enrollee may determine that services are not Medically Necessary or not covered.

Section 6.22.2. ***Payment for IHS and Tribal Services***. The STATE shall pay facilities described in Section 6.22. directly on a fee-for-service basis for services provided to American Indian PMAP/PGAMC and MinnesotaCare 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 Recipient, and the diagnosis code.

Section 6.22.3. 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.

Section 6.23. ***Service Authorization and Utilization Review.***

Section 6.23.1. ***General Exemption.*** 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 9505.0501 through 9505.0540, except for the following services:

A. Elective outpatient high-technology imaging (positive emission tomography (PET) scans, magnetic resonance imaging (MRI), computed tomography (CT), and nuclear cardiology;

B. Spinal fusion, unless in an emergency situation related to trauma;

C. Bariatric surgery;

D. Cesarean section or insertion of tympanostomy tubes except in an emergency situation;

E. Hysterectomy; and

F. Orthodontia.

In accordance with Laws of Minnesota 2005, First Special Session, Chapter 4, Article 8, Section 82, the MCO may exempt the services listed in A-F from Service Authorization if the MCO uses evidence-based practices for each of the services listed. The MCO must make its best efforts to ensure that services are not being reimbursed unless the Provider has used evidence-based practice in determining Medical Necessity for any of these services or the MCO has authorized the services. The MCO shall keep documentation on file as to the use of Service Authorization or evidence-based practices for each of these services.

Section 6.23.2. ***Medical Necessity Standard.*** The MCO may Service Authorize services, except for Medical Emergency Services and services as described in Section 6.24. Service Authorization shall be based on Medical Necessity, pursuant to Section 2.47., and, in the case of mental health services, shall also be based on Minnesota Statutes, section 62Q.53.

Section 6.23.3. ***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 as specified in Minnesota Statutes, sections 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 Sections 8.2.1 and 8.2.2.

Section 6.23.4. ***Denials Based Solely on Lack of Service Authorization***. Pursuant to Minnesota Statutes, section 62D.12, subdivision 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.

Section 6.24. ***Out of Network and Transition Services.***

Section 6.24.1. ***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.

D. The Enrollee is Out of Service Area 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 6.24.3.

E. The Enrollee moves Out of Service Area 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, at no less than the Medical Assistance or GAMC fee-for-service rate, 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. 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 services needed to respond to a Medical Emergency.

F. Pregnancy-related services the Enrollee receives in connection with an abortion, including, but not limited to, transportation and interpreter services.

Section 6.24.2. ***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 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, for Medical Assistance, GAMC, or MinnesotaCare/Medical Assistance Enrollees, orthodontia care 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 an MCO Provider, if such a transfer would not create undue hardship on the Enrollee, and is clinically appropriate.

C. ***At Risk Pregnancy.*** When the Recipient enrolls in the MCO while in her third trimester of pregnancy, and her non-participating physician has reported her pregnancy as at-risk on the STATE prenatal risk assessment form, the MCO must authorize the care by non-Participating Providers for services related to prenatal care and delivery, including Inpatient Hospital costs for the mother and Child. The MCO need not authorize payment for services by a non-Participating Provider if the non-Participating Provider does not accept from the MCO the Medical Assistance rate that would be paid if the Enrollee was not enrolled in the MCO. As a condition of payment, the MCO must require the non-Participating Provider to agree in writing to refrain from billing the Recipient for any portion of the cost of the authorized service. The MCO may not offer a non-Participating Provider less than the comparable Medical Assistance fee-for-service payment. The MCO is not responsible for additional out-of-plan care for the mother and Child after discharge from the hospital.

D. ***CD Services.*** Services that have been authorized by the Consolidated Chemical Dependency Treatment Fund (CCDTF) prior to the Recipient's enrollment in PMAP will continue to be reimbursed by the CCDTF through the duration of the period authorized. After the authorization period expires, the MCO will be responsible for providing all Medically Necessary services. For Enrollees who are in an Inpatient Hospital or a Chemical Dependency Residential Treatment Facility (Rule 31 facility) (i.e. extended care, halfway house or free-standing residential CD treatment facility) at the time of enrollment in the MCO, the effective date of the enrollment will be delayed until the month following the Enrollee's discharge from the CD facility.

E. ***Mental Health Services.*** At the time of initial enrollment in PMAP, the MCO shall consider the individual Enrollee's prior use of mental health services and to develop a transitional plan to assist the Enrollee in changing mental health Providers, should this be necessary, and to develop a plan to assure the need for continuity of care for any individual or family who is receiving ongoing mental health services. The MCO shall also develop a transitional plan for Children who have previously been excluded from PMAP because they have been involved in the Child protection system, placed in foster care, diagnosed as severely and

emotionally disturbed, or placed in a juvenile corrections facility. While excluded from PMAP, a treatment regimen may be initiated for those Children who are assessed as having behavioral or other mental health problems. However, because the duration of the exclusion from PMAP will vary from one Child to the next, some of these Children may be enrolled in the MCO before their treatment program is completed. As part of this transition plan, the MCO should have a process to assure proper communication and coordination between the Local Agency social services agency and the MCO regarding the specific needs of each Child.

F. ***Enrollee Change of Major Program.*** The Enrollee was enrolled with the MCO in the same county, but under a different major program covered under another STATE MCO contract; the MCO products do not have the same Participating Providers; and 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 or her right to choose to remain with their original Participating Providers. See Section 3.2.6.C. for MCO products covered under this contract.

G. ***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 90 days, whichever occurs first, for all those Enrollees who have identified themselves to the MCO or have been identified to the MCO by an appropriate representative as requiring such continuation.

Section 6.24.3. *Reimbursement Rate.* 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 Section 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, GAMC or MinnesotaCare fee-for-service rate or its equivalent, unless another rate is required by law.

Section 6.25. *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 service and covering the cost of the service required by the physician's or dentist's order.

Section 6.26. *Timeframe to Evaluate Requests for Services.*

Section 6.26.1. *General Request for Services.* The MCO must evaluate all requests for services, either by Participating Providers or Enrollees within 10 business days of receipt

of the request for services, pursuant to Section 8.2.2.C. 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.

Section 6.26.2. ***Request for Urgent Services.*** If the need for services is Urgent or required to prevent 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. In no circumstance shall the review exceed 72 hours.

Section 6.26.3. ***Request for Mental Health and/or Chemical Dependency Services.*** The MCO must provide Mental Health and/or Chemical Dependency services in a timely manner. Enrollees requiring chemical dependency or mental health crisis intervention services should be seen immediately. Other Enrollees in need of mental health and chemical dependency services should have an appropriate assessment performed within two weeks.

Section 6.27. ***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 linguistical competence includes Providers who serve Enrollees that are deaf and use sign language or an alternative mode of communication.

Section 6.27.1. 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.

Section 6.27.2. 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.

Section 6.28. ***Public Health Goals***. The MCO shall engage in the following public health activities, toward the achievement of public health goals.

A. ***For the Metro Area.*** These goals were mutually developed by a "PMAP Public Health Goals" ad hoc work group, composed of members of the Metropolitan Local Public Health Association and the Minnesota Council of Health Plans. The goal statements for immunizations and tobacco use prevention were derived from local, state, and federal population health improvement goals:

1.) ***Response to Violence.*** By undertaking the following activities, the MCO will continue to work towards the goal of 100% of participating medical clinics that include assessments for family violence in their protocols, along with client care plans that connect clients to community resources:

   a) To the extent possible, the STATE will share data from the standardized prenatal risk assessment tool with the MCO and the Local Public Health Agencies, for the purposes of jointly analyzing the data to determine the exposure of Pregnant Women to violence, and to identify the best use of the data to improve services and outcomes.

   b) The MCO and Counties will work together to develop collaborative responses to families exposed to violence.

2.) ***Immunizations.*** By undertaking the following activities, the MCO will continue to work toward the goal that 90% of all infants should receive age-appropriate immunizations by age 24 months:

   a) The MCO will work with the Minnesota Department of Health, the Minnesota Department of Human Services, and local public health agencies to develop and implement a funding plan for ongoing operation of the metropolitan immunization registry.

   b) The MCO will work with the Minnesota Department of Health, the Minnesota Department of Human Services and local public health agencies to share information about underserved sub-groups of the PMAP populations and strategies and best practices to improve immunization outcomes.

3.) ***Tobacco Use Prevention and Control.*** By undertaking the following activities The MCO will work to reduce tobacco use among select population groups:

   a) The MCO will work with local public health agencies on the implementation and evaluation of community based tobacco use prevention programs funded through the tobacco prevention endowments.

   b) The MCO will collaborate with the Center for Population Health tobacco subcommittee to disseminate AHRQ smoking cessation guidelines or other approved guidelines to their provider networks.

   c) To the extent possible, the STATE will share data from the Minnesota Pregnancy Assessment Forms with the MCO and Counties, for the purposes of jointly analyzing the data to assess

the exposure of Pregnant Women to cigarette smoke, and to identify the best use of the data to improve services and outcomes.

B. ***For the counties of Aitkin, Itasca, Koochiching, Carlton, Cook, Lake, and St. Louis:***

1.) ***Immunizations***. By undertaking the following activity, the MCO will continue to work toward the goal that 90% of all infants should receive age-appropriate immunizations by age 24 months:

a) The MCO will work with the Minnesota Department of Health, the Minnesota Department of Human Services, local public health agencies and other stakeholders to support the development of the northeastern Minnesota immunization registry through participation in the Community Health Information Collaborative (CHIC) immunization registry task force.

C. ***For other counties in the Non-Metro Area:*** The MCO agrees to meet with the Local Agency to develop and discuss mutual objectives related to public health priorities.

Article 7. Quality Assessment and Performance Improvement.

Section 7.1. ***Quality Assessment and Performance Improvement Program.*** The MCO shall provide for a quality assessment and performance improvement program consistent with federal requirements under Title XIX of the Social Security Act, 42 CFR Part 438, 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 guidelines for accreditation, as specified in this Contract.

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.

Section 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.

Section 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.

Section 7.1.3. ***Utilization Management***. The MCO shall adopt a utilization management structure consistent with state regulations and current NCQA "Standards for Accreditation of Managed Care Organizations." Pursuant to 42 CFR 438.240(b)(3) this structure must include an effective mechanism and written description to detect both under- and overutilization 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 overutilization. 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 overutilization.

   3.) Conduct qualitative analysis to determine the cause and effect of 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 overutilization and measure the effectiveness of its interventions.

Section 7.1.4. ***Special Health Care Needs***. The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs. If the MCO has in place an alternative mechanism(s), or is proposing a new mechanism(s) that meets or exceeds the requirements of Section 7.1.4.A, the MCO may submit a written description to the STATE for approval. If the MCO's

mechanism(s) have been approved by the STATE and there has been a material change, the MCO must submit a revised description to the STATE for approval.

A. ***Mechanism to Identify Persons with Special Health Care Needs.*** The MCO must identify Enrollees that may need additional services through method(s) approved by the STATE.

1.) The MCO must analyze claim data for diagnoses and utilization (both under and over) patterns to identify Enrollees that may have special health care needs. At a minimum the MCO must quarterly analyze claim data to identify Enrollees 18 years and older for the following:

a) Prevention Quality Indicators as described in the "Guide to Prevention Quality Indicators: Hospital Admission for Ambulatory Care Sensitive Conditions" by AHRQ for bacterial pneumonia, dehydration, urinary tract infection, adult asthma, congestive heart failure, hypertension and chronic pulmonary disease.

b) Hospital emergency department utilization as determined by the MCO.

c) Inpatient utilization stays for the MCO's identified key Minnesota Health Care Program diagnoses or diagnoses clusters.

d) Hospital readmission for the same or similar diagnoses as defined by the MCO within a timeframe specified by the MCO.

e) Individual Enrollee claims totaling more than $100,000.00 per year.

f) Home Care Services as identified and defined by the MCO.

2.) In addition to claims data, the MCO may use other methods, such as: a) health risk assessment surveys; b) performance measures; c) medical record reviews; d) Enrollees receiving PCA services; e) requests for Service Authorizations; and/or f) other methods developed by the MCO or its contracted Providers.

B. ***Assessment of Enrollees Identified.*** The MCO must implement mechanisms to assess Enrollees identified and monitor the treatment plan set forth by the MCO's treatment team, as applicable. The assessment must utilize appropriate Health Care Professionals to identify any ongoing special conditions of the Enrollee that require a course of treatment or regular care monitoring.

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.

D. ***Annual Reporting to the STATE.*** The MCO shall incorporate into, or include as an addendum to, the MCO's Annual Quality Assessment and Performance Improvement Program Evaluation (as required in Contract Section 7.1.8) a Special Health Care Needs summary describing efforts to identify Enrollees that may need additional services and the following items:

1.) The number of Adults identified in Section 7.1.4.A.(1) with special health care needs.

2.) Annual number of assessments completed by the MCO or referrals for assessments completed.

3.) If the MCO adds the information in this Section as an addendum, the addendum must include an evaluation of items 7.1.4.D, parts 1 and 2.

Section 7.1.5. ***Practice Guidelines***. The MCO shall adopt preventive and chronic disease practice guidelines appropriate for Children, adolescents, prenatal care, young adults, and adult populations. The MCO must adopt, disseminate and apply practice guidelines consistent with the QCare Preventive Care Standards on Child and Adolescents immunization, well-child visits, Chlamydia screening, breast and cervical cancer screening.

A. ***Adoption of practice guidelines***. The MCO shall: 1) adopt guidelines 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) adopt in consultation with contracting Health Care Professionals; and 4) review and update them 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 priority to audit, using an appropriate data source. The MCO shall incorporate into, or include as an

addendum to, the MCO's Annual Quality Assessment and Performance Improvement Program Evaluation (as required in Contract Section 7.1.8) a written summary that shall include:

1.) How the MCO implemented Section 7.1.5., A through C;

2.) All adopted guidelines, source of guidelines, date the guideline was reviewed and/or revised;

3.) Results of the audit; and

4.) Improvement strategies and/or necessary corrective action that will be undertaken.

5.) If the MCO adds the information in this Section as an addendum, the addendum must include an evaluation of items 7.1.5.D, parts 1 through 4.

Section 7.1.6. ***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 for Accreditation of Managed Care Organizations." For organizational Providers, including 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. Other waivered and Personal Care Provider Organizations enrolled with the STATE or contracted with counties are exempt from this requirement.

A. ***Selection and Retention of Providers.*** The MCO must implement written policies and procedures for the selection and retention of Providers.

B. ***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.

C. ***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.

D. ***Sanction Inquiry.*** The MCO shall inquire of a provider prior to entering into or renewing an agreement whether the Provider: 1) has 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 of Minnesota; or 2) is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines interpreting such order, or who is

an affiliate of such a Provider. The MCO shall not knowingly contract with such a Provider.

E. ***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, section 72A.20, subdivision 33 and as required under 42 CFR 417.479.

F. ***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.

G. ***Affiliated Provider Access Standards.*** The MCO shall require all affiliated Providers to meet the access standards required by Section 6.15. of this Contract, 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.

Section 7.1.7. ***Annual Quality Assurance Work Plan***. On or before May 1st of each 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. If the MCO chooses to substantively amend, modify or update its work plan at anytime during the year, it shall provide the STATE with material amendments, modifications or updates in a timely manner.

Section 7.1.8. ***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, and current NCQA "Standards for Accreditation of Managed Care Organizations." This evaluation must review the impact and effectiveness of the MCO's quality assessment and performance improvement program including performance on standardized measures and MCO's performance improvement projects. The MCO must submit the written evaluation to the STATE by May 1st of each year.

Section 7.2. ***Performance Improvement Projects (PIP)***. The MCO must conduct performance improvement projects 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. Projects must comply with 42 CFR 438.240(b)(1) and (d) and CMS protocol: Conducting Performance Improvement Projects. The MCO is encouraged to participate in PIP collaborative initiatives that coordinate performance improvement project topics.

Section 7.2.1. ***New Performance Improvement Project Proposal.*** On September 1st of each year, the MCO must submit to the STATE for review and approval, a written description of the performance improvement project MCO proposes to conduct beginning the first quarter of the next calendar year. The project proposal 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 performance improvement project proposal must include steps one through seven of the CMS protocol.

Section 7.2.2. ***Performance Improvement Project Interim Progress Assessment.*** By December 1st of each calendar 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 measure(s), the MCO shall submit changes to the STATE for approval.

C. Upon the request of the STATE, the MCO shall make available to the STATE, or the STATE's designated review agency, a copy of the reports.

Section 7.2.3. ***Final Performance Improvement Project Report.*** The MCO must submit to the STATE for review and approval, upon completion of each Performance Improvement Project, a final written report by September 1st. The report must include any changes to protocol steps one through ten as appropriate. Each completed project must have a separate report.

Section 7.2.4. ***Performance Improvement Project Lifecycle.*** 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). An alternative methodology to demonstrate significant (real) improvement that is sustained over time may be submitted by the MCO to the STATE for approval. Implementation of the project must begin within the first quarter of the year following project approval.

Section 7.2.5. ***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.

Section 7.2.6. ***Performance Improvement Project Categories.*** The MCO shall select a new Performance Improvement Project based on one or more of the four QCare Standards: Diabetes Care, Cardiac Care, Prevention or Hospital Care/Safety.

Section 7.3. ***Disease Management Program***. The MCO shall make available a Disease Management Program for its Enrollees with diabetes, asthma and heart disease.

Section 7.3.1. The MCO's Disease Management Program shall be consistent with current NCQA "Standards for Accreditation of Managed Care Organizations" -- QI Standard Disease Management.

Section 7.3.2. If the MCO is able to demonstrate that a Disease Management Program: 1) is not effective based upon Provider satisfaction, and 2) is unable to achieve meaningful outcomes; or 3) will have a negative financial return on investment, the MCO may request that the STATE waive this requirement for the remainder of the contract term.

Section 7.4. ***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.

Section 7.4.1. ***Enrollee Disenrollment Survey.*** 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.

Section 7.5. ***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.

Section 7.5.1. ***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 information collected by the EQRO, if the following 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;

D. All Medicare or accrediting reports, findings and results, related to services provided under this Contract, are provided to the STATE.

Section 7.5.2. ***EQR Nonduplication Workgroup.*** The STATE agrees to work with the MCO in a workgroup to specifically identify which information collected by Medicare or a private accreditation review organization will meet the terms of the Contract and BBA requirements.

Section 7.5.3. ***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.

Section 7.5.4. ***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 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.

Section 7.5.5. ***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 the EQRO in the Annual Technical Report for obligations under this Contract.

Section 7.6. ***Delegation of Quality Improvement Program Activities***. The MCO shall meet the requirements for delegation as specified in Section 9.3.7. of this contract for any delegated activities related to quality improvement.

Section 7.7. ***Documentation of Care Management***. The MCO shall maintain documentation sufficient to support its Care Management responsibilities set forth in Section 6.1.3. Upon the reasonable request of the STATE, the MCO shall make available to the STATE, or the STATE's designated review agency, access to a sample of Enrollee Care Management plans.

Section 7.8. ***Inspection***. The MCO shall provide that the STATE, CMS or their agents may evaluate through inspection or other means, the quality, appropriateness, and timeliness of services or administrative procedures performed under this Contract.

Section 7.9. ***Committee Participation***. The MCO shall appoint a representative to participate in the STATE's quality improvement committee(s) to provide input on quality management and improvement issues, external quality review studies, disenrollment surveys, and consumer satisfaction surveys.

Section 7.10. ***Financial Performance Incentives*.** All incentives outlined in this Section 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. The total of all payments paid to the MCO under this contract shall not exceed 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.

Section 7.10.1. ***Well-Child Primary Care Accessibility Incentive.***

A. The MCO may be eligible for a financial performance incentive payment based on the MCO's well-child and lead screening services as reported in encounter data pursuant to Section 3.5.1. The payment will depend on the MCO's access rate to well-child services among unduplicated Medical Assistance, MinnesotaCare and MinnesotaCare/Medical Assistance Enrollees age 0 through age 20 under this Contract. For purposes of this Section, "recipient" means an Enrollee who received any well-child service from the MCO during the Contract year for Section 7.10.1. B.1. and 7.10.1.B.3., or 180 days following enrollment for Section 7.10.1.B.2.; any "well-child service" means services which are billed using the codes determined to be well-child visits, provided by the STATE; well-child services "access rate", means the number of unduplicated Medical Assistance, MinnesotaCare and MinnesotaCare/MA recipients per 1000 Enrollee months who received a well-child service during the Contract year for Sections 7.10.1.B.1. and 7.10.1.B.3., or during the 180 days following enrollment for Section 7.10.1.B.2.

B. The MCO's incentive payment, if any, shall depend upon the increase in the access rate achieved by the MCO in the Contract year. Well-child and Lead Screening services described in Section 7.10.1.B.1. and 7.10.1.B.3. will be based on encounter data received by the STATE from the MCO pursuant to Section 3.5.1., no later than May 31, 2008 for well-child services with dates of service in 2007. The STATE shall pay the MCO the incentive payment, if any, on the next available warrant 60 days after the finalization of the encounter data submission.

1.) Well-Child Visits.

a) If the MCO has an access rate for the Contract year equal to, or below its 2006 access rate, the MCO shall not receive an incentive payment for that respective year.

b) If the MCO exceeds the 2006 well-child access rate for the Contract year, the MCO incentive payment will equal: the number of recipients per 1000 Enrollee months in calendar year 2007, minus the number of recipients per 1000 Enrollee months in calendar year 2006, multiplied by the number of Enrollee months in 2007, divided by 1000, multiplied by $90.00.

c) Access rate calculations shall be computed as whole recipient numbers per 1000 Enrollee months, with rounding to the nearest whole number (e.g. 45.6 becomes 46 and 45.5 becomes 45).

2.) Children Newly Enrolled in Managed Care.

a) The MCO shall receive an incentive payment if the well-child visits access rate increases, as defined in 7.10.1.A., within 180 days of enrollment to newly enrolled children age one through age 20, with age determined as of the last day of the Contract year.

b) Children are considered newly enrolled if they have not been in managed care in the previous calendar year and in the current calendar year, before enrolling with the first MCO under contract with the STATE. Newly enrolled children shall be identified by the STATE. The STATE shall supply the MCO with a list of identified children newly enrolled in managed care on a monthly basis, which shall include the name, address, county, phone number and language of the Enrollee, to the extent they are available to the STATE.

c) The STATE shall pay an incentive payment of $30.00 for each unduplicated newly enrolled child who during the Contract year receives a well-child visit within 180 days of enrollment as defined in Section 7.10.1.B.2.d.

d) The incentive amount for children newly enrolled in managed care, if any, will equal the percentage of children during 2007 with a well-child visit within 180 days of enrollment, minus calendar year 2006 percentage of well-child visits within 180 days of enrollment, times the 2007 number of Enrollees, times $30.00.

e) Incentive payments for well-child services for children newly enrolled in managed care will be based on encounter data submitted by the MCO pursuant to Section 3.5.1., and received by the STATE no later than October 31, 2008 for calendar year 2007 well-child services with dates of service beginning January 1, 2007 through 180 days following December 2007 enrollment.

f) Incentive payment calculations for children newly enrolled in managed care shall be computed as whole numbers, with rounding to the nearest whole number (e.g. 45.6 becomes 46 and 45.5 becomes 45).

g) The STATE shall pay the MCO the incentive payment, if any, on the next available warrant 60 days after the finalization of the encounter data submission.

3.) Lead Screening.

a) The MCO may receive an incentive payment if it provides a lead screening blood2 test to children age nine (9) months through age thirty (30) months for the contract year. A lead screening blood test is defined by the STATE as a blood test submitted with a CPT code of 83655.

b) The MCO may receive $50.00 for each lead screening blood test performed, up to two lead screening blood tests per unduplicated Child, in accordance with C&TC Screening Guidelines.

c) The amount of the incentive payment, if any, will be equal to; the number of Enrollees for calendar year 2007 multiplied by the 2006 lead screening rate, subtracted from the number of tests provided during calendar year 2007 times $50.00 per test.

d) The lead screening incentive shall be computed from encounter data submitted by the MCO pursuant to Section 3.5.1. and received by the STATE no later than May 31, 2008, for lead screening blood tests with dates of services in 2007.

e) The lead screening incentive calculations shall be computed as whole numbers with rounding to the nearest whole number (e.g. 45.6 becomes 46 and 45.5 becomes 45).

f) The STATE shall pay the MCO the incentive payment, if any, on the next available warrant 60 days after the finalization of the encounter data submission.

C. Description of how the above incentives are calculated by the STATE are available on the DHS MHCP Enrolled Providers website at: http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs_id_038536.hcsp.

Section 7.10.2. ***Critical Access Dental Incentive Payment.***

A. The MCO shall participate in a dental access initiative whereby the MCO agrees to incent designated dentists to provide increased dental services for Medical Assistance and MinnesotaCare Enrollees in accordance with the following:

1. ***Designation of Critical Access Dental Providers*** - Prior to the beginning of the calendar year, the STATE provided to the MCO a list of dental Providers eligible for the critical access dental designation. The STATE identified in the list those Providers it proposed to designate for the critical access dental payments. The MCO reviewed the list and provided information to the STATE on the Providers the MCO recommended for critical access dental designation. The STATE determined the final list of critical access dental designations and provided the list to the MCO.

2. ***Quarterly Reporting of MCO's 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 the MCO paid to the specific designated critical access dental provider in a format specified by the STATE. Payments made under the major programs Non-citizen Medical Assistance (NM) and General Assistance Medical Care (GM) shall be excluded from the report. For each Provider listed, the MCO shall report payments for the major programs Medical Assistance and MinnesotaCare separately. For the Medical Assistance program, the report should include only those payments made for services provided during the period October 1, 2006 through June 30, 2007. In the event that the Legislature extends authorization for critical access dental payments under the Medical Assistance program after June 30, 2007, the MCO shall report payments for services provided within the period specified by the Legislature. For the MinnesotaCare program, the report should include only those payments made for services provided on or after January 1, 2007. The report must be certified in accordance with Section 9.16.

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 covered services, this amount will be calculated using a 38% increase over the payment amount the designated Provider would otherwise have been paid.

c. For MinnesotaCare covered services, this amount will be calculated using a 50% increase over the payment amount the designated Provider would otherwise have been paid.

d. The STATE will issue a gross payment adjustment to the MCO which 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 report.

4. *Designation of Critical Access Dental Providers* - The STATE shall provide to the MCO a list of dental Providers eligible for the critical access dental designation no later than October 10th of each calendar year. The list will also identify those Providers the STATE proposes to designate for the critical access dental payments. The MCO shall review the list and provide to the STATE information on those Providers the MCO recommends for critical access dental designation, no later than 10 business days from the date of receipt of the list. The STATE will determine the final list of critical access dental designations and provide that list to the MCO no later than October 31st of each calendar year.

Section 7.10.3. ***Quality Improvement Effort for Coronary Artery Disease, Heart Failure and/or Stroke Incentive.*** To assist smaller hospitals in Minnesota in training, adopting and monitoring clinician practice patterns for recognized best practices for cardiac care, the STATE shall reimburse the MCO for the cost of initial implementation of the Get With The Guidelines Program (American Health Association) modules in Minnesota hospitals with 99 beds or less. In 2007, the STATE will reimburse for each module implemented in up to 50 hospitals. The three modules are: Heart Failure, Coronary Artery Disease, and Stroke. The Stroke version also has an advanced version for $2750 that will meet the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) certification requirements.

The STATE will reimburse the MCO up to $2890/hospital for the three basic modules, or up to $5640/hospital for implementing the two basic modules for Heart Failure and Coronary Artery Disease and the advanced Stroke module. The reimbursement is contingent on a collaborative process between the American Heart Association and MCO to identify hospitals that have not otherwise received reimbursement from other sources.

Section 7.10.4. ***Treatment Foster Care Services Incentive.*** The STATE shall pay the MCO $125 per person per day for Treatment Foster Care Services provided pursuant to Section 6.1.18.B. The MCO and the STATE agree to work towards the most efficient mechanism for payment of these services, if possible, using encounter data to identify such services provided, and if not, through a report furnished by the MCO on a periodic

basis. The MCO agrees to work with the STATE to encourage and develop a provider network that meet the standards specified in law.

Section 7.10.5. ***QCare Preventive Care Incentives.*** The MCO may be eligible for a financial performance incentive payment based on the MCO's preventive care services as reported in the encounter data pursuant to Section 3.5.1, or currently available to the STATE, no later than May 31, 2008, for services with dates of service in 2007. The incentive payment, if any, shall depend upon the increase in unduplicated preventive care services provided to Medical Assistance, MinnesotaCare and MinnesotaCare/Medical Assistance Enrollees in the Contract year. The STATE shall pay the MCO the incentive payment, if any, on the next available warrant sixty (60) days after the finalization of the encounter data submission.

If any of the Contract year preventive care incentive rates are equal to or below its 2006 rate, the MCO shall not receive an incentive payment for that measure for that respective year. The rates shall be calculated as a whole number per 1000 Enrollee months, with rounding to the nearest whole number (e.g. 45.6 becomes 46 and 45.5. becomes 45).

A. ***Chlamydia Screening of Women 16 through 25.*** The rate of women, age 16 through 25 years of age, who were identified as sexually active, and had at least one test for Chlamydia during the Contract year. If the MCO exceeds the 2006 Chlamydia screening rate for the Contract year the MCO incentive payment will equal: the number of eligible women per 1000 Enrollee months in calendar year 2007, minus the number of eligible women per 1000 Enrollee months in calendar year 2006, multiplied by the number of Enrollee months in 2007, divided by 1000, multiplied by $50.00.

B. ***Child Immunizations.*** The rate of children, age 2 years, who received all vaccinations (4 DtaP/DT; 3 IPV; 1 MMR; 3 HiB; 3 HepB and 1 VSZ) by their second birthday. If the MCO exceeds the 2006 Child Immunizations rate for the Contract year the MCO incentive payment will equal: the number of eligible children per 1000 Enrollee months in calendar year 2007, minus the number of eligible children per 1000 Enrollee months in calendar year 2006, multiplied by the number of Enrollee months in 2007, divided by 1000, multiplied by $50.00.

C. ***Breast Cancer Screening.*** The rate of women, age 40 through 69 years, who had a mammogram during the Contract year or prior measurement year. If the MCO exceeds the 2006 Breast Cancer screening rate for the Contract year, the MCO incentive payment will equal: the number of eligible women per 1000 Enrollee months in calendar year 2007, minus the number of eligible women per 1000 Enrollee months in calendar year 2006, multiplied by the number of Enrollee months in 2007, divided by 1000, multiplied by $50.00.

D. ***Cervical Cancer Screening.*** The rate of women, age 21 through 64 years, who had one or more Pap tests during the Contract year or two years prior to the measurement year. If the MCO exceeds the 2006 Cervical Cancer screening rate for the Contract year, the MCO incentive payment will equal: the number of eligible women per 1000 Enrollee months in calendar year 2007, minus the number of eligible women per 1000 Enrollee months in calendar year 2006, multiplied by the number of Enrollee months in 2007, divided by 1000, multiplied by $50.00.

Section 7.10.6. ***Developmental and Mental Health Screening Incentives.*** The MCO may be eligible for a financial performance incentive payment based on the MCO's development and mental health screening services as reported in the encounter data pursuant to Section 3.5.1, no later than May 31, 2008, for services with dates of service in 2007. The incentive payment, if any, shall depend upon the increase in unduplicated development and mental health screening services provided to Medical Assistance, MinnesotaCare and MinnesotaCare/Medical Assistance Enrollees in the Contract year. The STATE shall pay the MCO the incentive payment, if any, on the next available warrant 60 days after the finalization of the encounter data submission.

A. ***Child Developmental Screening.*** The rate of children age 0 through 6 years of age, who received a standardized developmental screening during the Contract year and billed using CPT code 96110. If the Contract year development screening incentive rate, is equal to or below its 2006 rate, the MCO shall not receive an incentive payment for that respective year. If the rate is greater then the 2006 rate, the amount of the incentive payment, if any, will be equal to: the number of Enrollees for calendar year 2007 multiplied by the 2006 development screening rate, subtracted from the number of development screenings provided during calendar year 2007 times $25.00 per screening. The rates shall be calculated as a whole number per 1000 Enrollee months, with rounding to the nearest whole number.

B. ***Child Mental Health Screening.*** The incentive payment will equal the number of Enrollees age 0 through 20 year of age in calendar year 2007, who received a standardized mental health screening and billed using CPT code 96110 with a UC modifier, multiplied by $25.00.

Section 7.11.7. ***Pay for Performance.*** The MCO shall cooperate with the STATE to pay Providers who have met the STATE's requirements under its Pay for Performance initiative.

Section 7.12. ***Community Measurement Project Development.*** The STATE will work with MDH and the marketplace of purchasers and Providers on the development and application of the Community Measurement Project.

Article 8. The Grievance System: DTRs, Grievances, Appeals, and State Fair Hearings.

Section 8.1. ***General Requirements.***

Section 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.

Section 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.

Section 8.1.3. ***Legal Requirements***. The Grievance System must meet requirements of Minnesota Statutes, sections, 62D.11, 62M.06, 62Q.68 through 62Q.73, and 256.045, Subd. 3a; and 42 CFR 438, Subpart F.

Section 8.1.4. ***STATE Approval Required.*** The MCO's Grievance System is subject to approval of the State.

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 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 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 under this Contract.

Section 8.1.5. ***Response to Investigation.*** Pursuant to Minnesota Statutes, section 256B.69, Subdivision 3a, the MCO must respond directly to county advocates, established under Minnesota Statutes, section 256B.69, Subdivision 21, and the STATE ombudsman, established under Minnesota Statutes, section 256B.69, Subdivision 20, regarding service delivery.

Section 8.2. ***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.

Section 8.2.1. ***General Requirements***.

A. ***Written Notice.*** The DTR must be a written Notice, which meets the language requirements of 42 CFR 438.10(c). It must also meet the following requirements:

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.B.

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.) The MCO must send the DTR form 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 form that will be used by subcontractor and a sample written explanation of the MCO and State Grievance System. STATE approval will only be granted for major MCO subcontractors, as determined by the STATE, who provide a single type of health service.

B. ***Content of DTR.*** The DTR must include:

1.) A clear detailed description in plain language of the reason for the denial, termination, or reduction (DTR); and of the Enrollee's rights;

2.) The Action that the MCO has taken or intends to take;

3.) The type of service or claim that is being denied, terminated, or reduced;

4.) The reasons for the Action;

5.) The specific federal or state regulations or MCO policies that support or require the Action, whichever applies;

6.) The date the DTR was issued;

7.) The effective date of the Action if it results in a reduction or termination of on-going or previously authorized services;

8.) The Enrollee's right (or Provider on behalf of Enrollee with the Enrollee's written consent) to file an Appeal with the MCO;

9.) The Enrollee's right to file a request for a State Fair Hearing without first exhausting MCO's Grievance or Appeal procedures, or up to 30 days after the MCO's final determination of the Grievance or Appeal;

10.) The process the Enrollee must follow in order to exercise these rights;

11.) The circumstances under which expedited resolution is available and how to request it for an Appeal or State Fair Hearing;

12.) The Enrollee's right to continuation of benefits, how to request that benefits be continued, and under what circumstances the Enrollee may have to pay for these services if the Enrollee files an Appeal at the MCO or requests a State Fair Hearing;

13.) The Notice of Member Rights;

14.) The requirements and timelines for filing an MCO Appeal pursuant to 42 CFR 438.402;

15.) 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;

16.) A language block in the languages specified by Minnesota Statutes, section 256B.69, subd. 27, in a format determined by the STATE; and

17.) A phone number at the MCO where Enrollees may call to obtain information about the DTR, including how to receive a translation of the notice into Spanish, Hmong, Laotian, Russian, Somali, Vietnamese, or Cambodian.

C. ***Notice to Provider.*** The MCO must notify the Provider of the Action, but this 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 8.4.1 of the Contract, 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.

Section 8.2.2. ***Timing of the DTR Notice***.

A. ***Previously Authorized Services.*** For previously authorized services, the MCO must mail the Notice to the Enrollee at least ten (10) days before the date of the proposed Action in accordance with 42 CFR 438.404(c)(1).

1.) The ongoing medical service must have been ordered by a Participating or treating physician, osteopath, dentist, mental health professional, or chiropractor.

2.) The service must be eligible for payment according to Minnesota Statutes, section 256B.0625 and Minnesota Rules, Part 9505.0170 to 9505.0475.

3.) All procedural requirements must have been met.

4.) Advance notice and continuation of benefits are not required if the provider who orders the service is not an MCO Participating Provider or authorized non-Participating Provider.

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, notice must be provided as expeditiously as the Enrollee's health condition requires, not to exceed ten (10) business days following receipt of the request for the service, with a possible extension, pursuant to Section 8.2.2.D.

D. ***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. The MCO must issue a determination no later than the date the extension expires. The STATE may review the MCO's justification upon request.

E. ***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

F. ***Expedited Authorizations.*** For expedited Service Authorizations, as expeditiously as the Enrollee's health condition requires, but within 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.

Section 8.2.3. ***Continuation of Benefits Pending Decision.*** If an Enrollee files an Appeal with the MCO before the date of the Action proposed on a DTR, the MCO in accordance with 42 CFR 438.420(b) may not reduce or terminate the service until 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.

Section 8.2.4. ***Reporting Procedures.*** The MCO must submit to the STATE a quarterly DTR compilation report, which 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. The report is due quarterly, on or before the 15th day of the month following the end of the quarter, for all DTRs issued in the previous quarter. The STATE must approve a sample quarterly DTR compilation report prior to submittal of the actual compilation report.

Section 8.3. ***MCO Internal Grievance Process Requirements***:

Section 8.3.1. ***Filing Requirements***. The Enrollee, or the Provider acting on behalf of the Enrollee with the Enrollee's written consent, may file a Grievance within 90 days of a matter involving an Enrollee's dissatisfaction with the health care received. A Grievance may be filed orally or in writing. The Enrollee may also request a State Fair Hearing.

Section 8.3.2. ***Timeframe for Resolution of Grievances***.

A. Oral Grievances must be resolved within 10 days of receipt.

B. Written Grievances must be resolved within 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.

Section 8.3.3. ***Timeframe for Extension of Resolution of Grievances***. The MCO may extend the timeframe by an additional fourteen (14) days for resolution of the Grievance 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 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 upon request.

Section 8.3.4. ***Handling of Grievances***.

A. The MCO must mail a written acknowledgment to the Enrollee within 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 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 action 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.

Section 8.4. ***MCO Internal Appeals Process Requirements***.

Section 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 90 days of the DTR Notice of Action or for any other Action taken by the MCO as it is defined in 42 CFR 438.400(b), except that 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, section 62M.06. An Appeal may be filed orally or in writing. If the Appeal is filed orally the MCO must offer to assist the Enrollee, or Provider filing on behalf of the Enrollee, in completing a written Appeal. The Enrollee may also request a State Fair Hearing.

Section 8.4.2. ***Timeframe for Resolution of Standard Appeals***. The MCO must resolve each Appeal as expeditiously as Enrollee's health requires, and no later than 30 days, including resolution of those oral Appeals that were not reduced to writing by the Enrollee, or the Provider acting on behalf of the Enrollee.

Section 8.4.3. ***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 no later than 72 hours after receipt of the Appeal. The MCO shall make reasonable efforts to provide an oral notice prior to sending the written notice of resolution.

B. The MCO must not take punitive action against a Provider who requests an expedited resolution or supports an Enrollee's Appeal.

C. 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 24 hours and follow up with a written notice within two days.

Section 8.4.4. ***Timeframe for Extension of Resolution of Appeals***. An extension of the timeframes of resolution of Appeals of fourteen (14) days is available for standard 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 upon request.

Section 8.4.5. ***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 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 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 or one that involves clinical issues, 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, section 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 Appeals, the MCO must inform the Enrollee of limited time available for this to happen.

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.

Section 8.4.6. ***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.

Section 8.4.7. ***Notice of Resolution of Appeal.*** The written notice of resolution of Appeal must include: 1) the results of the resolution process and date it was completed; 2) the Enrollee's right to request a State Fair Hearing and how to do so; 3) the Enrollee's right to receive benefits during the State Fair Hearing process; 4) the fact that the MCO may hold the Enrollee liable for the cost of benefits provided if the MCO's decision is upheld; and 5) the STATE's Notice of Rights.

Section 8.4.8. ***Reversed Appeal Resolutions.*** If a decision by an MCO is reversed by the State Fair Hearing process, the MCO:

A. Must comply with the hearing 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 State Fair Hearing.

Section 8.4.9. ***Upheld Appeal Resolutions.*** The MCO may bill the Enrollee if the MCO's denial is upheld and the Enrollee already received the service.

Section 8.4.10. This section does not prohibit an MCO from offering additional levels of internal resolution mechanisms so long as the minimum requirements set forth herein are complied with.

Section 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 and Appeals.

Section 8.6. ***Reporting of Grievances and Appeals to the STATE***.

Section 8.6.1. ***Quarterly Electronic Report of Written Grievances and Oral and Written Appeals***. The MCO shall send a quarterly electronic report of all written Grievances and all oral and written Appeals in a format determined by the STATE and per STATE specifications. The report is due on or before the 15th day of the month following the end of the quarter, for all written Grievances and all oral and written Appeals resolved in the previous quarter. If the 15th day of the month falls on a weekend or holiday, the report is due to the STATE on the following business day.

Section 8.6.2. ***Quarterly Summary Report of Oral Grievances***. This report is pursuant to specifications mutually determined by the STATE and MCOs. The report is due on or before the 15th day of the month following the end of the quarter, for all oral Grievances resolved in the previous quarter. If the 15th day of the month falls on a weekend or holiday, the report is due to the STATE on the following business day. The report may be submitted on disk or e-mail attachment.

Section 8.7. ***State Fair Hearings.***

Section 8.7.1. ***Matters Heard by State Fair Hearing Referee***. Pursuant to Minnesota Statutes, section 256.045, the State Fair Hearing Referees may review any Action or Grievance.

Section 8.7.2. ***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 30 days of receipt of the Notice of Action, decision, or final disposition and within 90 days, if there is good cause for the delay pursuant to Minnesota Statutes, section 256.045.

B. The STATE must take final administrative action on any request for a State Fair Hearing within 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 a 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 an Appeal of the same issue filed at the MCO, date the Appeal was filed, and 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: whether an Appeal was filed with an MCO, the date the Appeal was filed, the resolution of the Appeal, and 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.

Section 8.7.3. ***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.

Section 8.7.4. ***Expedited Hearing Decisions.***

A. The STATE must take final action within 3 working days of receipt of the file from the MCO 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 no later than one working day.

Section 8.7.5. ***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 pursuant to Minnesota Statutes, section 256.045, subdivision 3a, before the date of the proposed Action in either the MCO's Notice or Grievance 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. In the case of a reduction or termination of ongoing services, services must be continued under Section 8.2.3. pending outcome of all Grievance and 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 8.2.1.B. shall include this right.

Section 8.7.6. ***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 from the Enrollee the cost of medical services furnished solely by reason of Section 8.7.5. of this Contract.

Section 8.7.7. ***Representation 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 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.

Section 8.7.8. ***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, section 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, section 62Q.73, subd. 6(a).

Section 8.7.9. ***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.

Section 8.8. ***Sanctions for Enrollee Misconduct***. The MCO may place an Enrollee in the Restricted Recipient Program for the conduct described in Minnesota Rules, Part 9505.2165. The MCO may place restrictions on the use of medical services for such an Enrollee or impose any of the sanctions in Minnesota Rules, Part 9505.2210.

Section 8.8.1. ***Notice to Enrollees.*** The MCO must notify Enrollees in writing of placement in the Restricted Recipient Program. The notice must be sent 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 for placement;

C. The right to dispute the MCO's factual allegations; and

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.

Section 8.8.2. ***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 30 days of the date of notice, placement will occur and the designated providers will be assigned.

Section 8.8.3. ***Reporting of Restrictions.***

A. Until the MCO is entering 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 (5) 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 (5) working days of the Enrollee's placement in the Restricted Recipient Program.

Section 8.8.4. ***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.

Section 8.9. ***Second Opinions.***

Section 8.9.1. The MCO shall provide for a second medical opinion within the MCO, at the Enrollee's request and shall comply with any order of the STATE pursuant to Minnesota Statutes, section 256B.69, subdivision 11, and Minnesota Rules, Part 9500.1462.

Section 8.9.2. The MCO shall provide for a second medical opinion for mental health conditions pursuant to Minnesota Statutes, section 62D.103.

Section 8.9.3. The MCO shall provide for a second opinion for chemical dependency services as provided for in Minnesota Statutes, section 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.

Article 9. Required Provisions.

Section 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, sections 62J.695 through 62J.76 (Patient Protection Act), Minnesota Statutes, section 62Q.47 (mental health parity), Minnesota Statutes, section 62Q.53 (mental health Medical Necessity), Minnesota Statutes, sections 62Q.56 and 62Q.58 (Continuity of Care and Care Coordination) and Minnesota Statutes, section 62Q.19 (essential community providers).

Section 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 and 5.2.4. In the event any certificate is canceled, revoked, suspended or expires during the term of this Contract, the MCO agrees to so inform the STATE immediately.

Section 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 (HMOs) or community integrated service networks (CISNs), including: A) Minnesota Statutes, section 62A.0411 (48-hour hospital stay for maternity patients); B) Minnesota Statutes, sections 62J.695 through 62J.76 (Patient Protection Act); and C) Minnesota Statutes, sections 62D.03, subdivision 4(a)-(d), (h)-(i), (k), (m)-(n), (p), (r)-(s) & (u), 62D.041, subdivision 3 & 9, 62D,06-.08, 62D.11, 62D.123, 62M..04-.12, 62N.28, 62N.29, 62N.31 & 72A.201, 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).

Section 9.2. ***MCO Solvency Standards***. 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 are significant changes 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.

Section 9.2.1. 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.

Section 9.3. ***Subcontractors.***

Section 9.3.1. All subcontracts must be in writing. All subcontracts are subject to STATE and CMS review and approval, upon request by the STATE and/or CMS.

Section 9.3.2. The MCO shall submit to the STATE, in a format provided by the STATE, a file of all the Providers who do not already have a STATE provider number or NPI, pursuant to Section 3.5.1.B.5.

Section 9.3.3. The MCO must submit, upon STATE request, proof of subcontractor status prior to submission of Primary Care Network List.

Section 9.3.4. The MCO shall require that all subcontractors shall provide CMS, the Comptroller General, or their 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.

Section 9.3.5. All subcontracts shall comply with 42 CFR 434.6.

Section 9.3.6. Notwithstanding Section 9.3.1., 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.

Section 9.3.7. ***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 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 onsite.

Section 9.3.8. ***FQHCs and RHCs Contracting Requirements.*** If the MCO negotiates a provider agreement or subcontract with a federally qualified health center (FQHC) as defined in Section 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, for services under this Contract, 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 offer to contract with any FQHC or RHC in the MCO's Service Area. The MCO is not required to pay any settle-up payments in addition to the negotiated payment rate.

Section 9.3.9. ***Nonprofit Community Health Clinic, Community Mental Health Centers, and Community Health Services Agencies Subcontracting 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 services agencies (community health boards) as defined in Minnesota Statutes, section 256B.0625, subdivision 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, section 256B.69, subdivision 22. The MCO may reasonably require a nonprofit community health clinic, community mental health center, or Community Health Services 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 shall provide the MCO with a list of all nonprofit community health clinics, community mental health centers, and community health services agencies within the MCO's Service Area.

Section 9.3.10. ***Essential Community Providers.*** The MCO shall offer to contract with any designated essential community provider, as described in a listing provided by the STATE, located within its Service Area, pursuant to Minnesota Statutes, section 62Q.19.

Section 9.3.11. ***Children's Mental Health Collaborative.*** The MCO must subcontract with a children's mental health collaborative organized under Minnesota Statutes, sections 245.491 through 245.495, that: 1) has an integrated services system approved by the Children's Cabinet; 2) has entered into an agreement with the STATE to provide Medical Assistance, GAMC or MinnesotaCare services; 3) is capable of providing inpatient and outpatient mental health services in return for an actuarial based capitated

payment from the MCO to be determined by the STATE; and 4) requests to become a subcontractor. The MCO must provide Enrollees that meet the membership requirements of the collaborative the choice to receive mental health services through either the collaborative or the MCO. The MCO must work cooperatively with a collaborative to assure the integration of physical and mental health services to Enrollees of the collaborative. The collaborative must be willing to hold the MCO harmless from all liability of any kind associated with the collaborative's performance. The MCO may reasonably require in its contract with a collaborative the same or similar contract terms that the MCO requires of its other subcontractors. See Minnesota Statutes, section 245.494, subdivision 3.

Section 9.3.12. ***Enrollees Held Harmless.***

A. Except for copays pursuant to Sections 4.4.3. and 4.4.4., 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: 1) notify Enrollees in writing of Enrollee liability for non-covered services; and, 2) 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 Area or Out of Plan, the MCO shall pay the Out of 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).

Section 9.3.13. The MCO shall not have a person described in Section 7.1.6.D. as a director, officer, partner, or person with beneficial ownership of more than 5 percent (5%) of the MCO's equity, nor have an employment, consulting, or other agreement with a person in Section 7.1.6.D. for the provision of items and services that are significant and material to the MCO's obligation under this Contract.

Section 9.3.14. The MCO shall not have any agents, management staff, or persons with ownership or control interests who have been convicted of criminal offenses related to their involvement in Medicaid.

Section 9.3.15. The MCO shall not employ or contract with, directly or indirectly, entities or individuals excluded from participation in Medicaid under Sections 1128 or

1128A of the Social Security Act for the provision of health care, utilization review, medical social work, or administrative services.

Section 9.3.16. The MCO shall not enter into any subcontract that is prohibited, in whole or in part, under Section 4707(a) of the Balanced Budget Act of 1997 or under Minnesota Statutes, section 62J.71.

Section 9.3.17. 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 2.47., and in subcontracts for the delivery of mental health services that the subcontractor additionally follow the Medical Necessity definition found in Minnesota Statutes, section 62Q.53. Subcontracts shall include the definition found in Section 2.47., and the definition found in Minnesota Statutes, section 62Q.53, where applicable.

Section 9.3.18. The MCO agrees to pay health care Providers on a timely basis consistent with the claims payment procedure described in Section 1902 (a)(37)(a) of the Social Security Act (42 U.S.C. § 1396a(a)(37)) and 42 CFR Parts 447.45 and 447.46. Additionally, the MCO shall allow 12 months from the newborn's date of birth for any Provider to bill for services provided during the period of retroactive enrollment of a newborn.

Section 9.3.19. ***Medical Error Reporting.*** The MCO, in all future or renewing provider contracts, shall encourage its Participating Hospital Providers to report through Leapfrog, a national patient safety initiative, and 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.

Section 9.3.20. ***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.

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.

Section 9.4. ***Maintenance, Inspection and Retention of Records.***

Section 9.4.1. The MCO shall provide that the STATE and CMS or their agents may evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under this Contract.

Section 9.4.2. 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.

Section 9.4.3. The MCO must provide that the STATE and CMS may evaluate, through inspection or other means, the enrollment and disenrollment records of the MCO, when there is reasonable evidence of need for such inspection.

Section 9.4.4. 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.

Section 9.4.5. 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 period 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 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(s) retention may be extended to ten 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.

Section 9.4.6. 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.

Section 9.4.7. ***Record Retention by the 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.

Section 9.5. ***Settlement Upon Termination.*** Upon termination of the Contract, or at such time as individual Recipients terminate enrollment 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.

Section 9.6. ***Trade Secret Information.*** The STATE agrees to protect from dissemination information submitted by the MCO to the STATE which the MCO can justify as trade secret information, pursuant to Minnesota Statutes, section 13.37, subdivision 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, section 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.

Section 9.7. ***Date of Issue of Enrollee Materials***. 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 3.2.5. The MCO must notify the STATE and provide a brief explanation in writing within two working days if the MCO cannot comply with the time frame specified in Section 3.2.5.

Section 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.

Section 9.8.1. ***Notice***. The STATE will give the MCO not less than 45 days notice, including the time-sensitive nature of the data, and data specifications for the required data.

Section 9.8.2. ***Data Specification Issues***. The MCO must notify the STATE within one week of any issues concerning the data specifications.

Section 9.8.3. ***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.

Section 9.8.4. ***Requirements***. The MCO must submit accurate and complete data within the time periods that meet the data specifications.

Section 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.

Section 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.

Section 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.

Section 9.12. *Workers' Compensation.* In accordance with the provisions of Minnesota Statutes, section 176.182, the MCO shall provide acceptable evidence of compliance with the workers' compensation insurance coverage requirement of Minnesota Statutes, section 176.181, subdivision 2.

Section 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, section 363A.36. County administered MCOs are exempt from this statute.

Section 9.14. *Voter Registration.* The MCO certifies that it will comply with Minnesota Statutes, section 201.162.

Section 9.15. *Fraud and Abuse Requirements.*

Section 9.15.1. *Integrity Program.*

A. 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.

B. The MCO shall document all activities and corrective actions taken under its integrity program.

C. 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 year of the Contract, 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.1. through 11, and must specifically describe the activities it has undertaken to safeguard against Fraud and Abuse by PCA Providers, as required by Section 9.15.4.B.

E. 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.

Section 9.15.2. ***Fraud and Abuse by MCO and/or 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 Minnesota Medicaid Fraud Control Unit (MFCU) any suspected Fraud and/or Abuse by providers within 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.

Section 9.15.3. ***Fraud and Abuse by Recipients***. The MCO shall report to the STATE any suspected Fraud and/or patterns of Abuse by Recipients.

Section 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, pursuant to Minnesota Statutes, section 256B.04, subd. 5, and to ensure that PCA Providers have a background study completed, Minnesota Statutes, section 245C.13.

B. The MCO shall likewise safeguard against unnecessary or inappropriate use of PCA services, excess payments, and ensure that PCA providers have a background study completed. The MCO may work with the STATE to utilize the STATE's system for these purposes.

Section 9.16. ***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.

Section 9.16.1. 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, the date it was submitted, and certifies all data submitted, unless otherwise specified in the Contract. The following data must be certified:

A. Encounter data;

B. Data associated with the reporting requirements of the managed care withhold;

C. IHS and Tribal Services claims data submitted by the MCO to settle previous contracts;

D. Data submissions as requested by the STATE for the development of rates;

E. Health care expenditures;

F. Quarterly dental payment report for Critical Access Dental Designated Providers as specified in Section 7.10.2.;

G. GAMC inpatient and outpatient hospital data;

H. Any other data or document determined by the STATE to be necessary to comply with 42 CFR 438.604; and

I. Data regarding circumcisions performed on newborns for well-established religious practices on or after January 1, 2006 through December 31, 2006.

Section 9.16.2. The MCO shall also 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 or costs related to providing those services, such as the MCO's administrative costs. If the MCO does not in its statutory filing distinguish these costs from the cost of services provided as alternative or additional services, the MCO must then certify what percentage of the expenses stated in its financial filing are for State Plan services. The MCO must provide this certification no later than May 1st of the Contract year.

Section 9.16.3. 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 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 9.16.1.

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. Prohibition Against Discrimination. In the performance of obligations under this Contract, the MCO agrees to comply with provisions of: 1) the Constitutions of the United States and the State of Minnesota; 2) Title VI of the Civil Rights Act of 1964 and pertinent regulations at 45 CFR 80; 3) Executive Order 11246 (30 FR 12319), Equal Employment Opportunity, dated September 24, 1965; 4) Section 504 of the Rehabilitation Act of 1973 and pertinent regulations at 45 CFR 84; 5) Age Discrimination Act of 1975 and pertinent regulations at 45 CFR 91; 6) Minnesota Statutes, section 363A.36; 7) Title IX of the Education Amendments of 1972; 8) the Americans with Disabilities Act; and 9) 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.

Article 12. Third Party Liability and Coordination of Benefits.

Section 12.1. ***Agent of the STATE.*** Pursuant to 42 CFR 433, Subpart D, and Minnesota Statutes, sections 256B.042, subdivision 2, 256B.056, subdivision 6, 256L.03, subdivision 6, 256D.03, subdivision 8, 256.015, subdivision 1, and 256B.37, subdivision 1, the STATE hereby authorizes the MCO as its agent to obtain third party reimbursement by any lawful means including asserting subrogation interest, filing liens, asserting independent claims, and to coordinate benefits, for MCO Enrollees.

Section 12.2. ***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.

Section 12.2.1. The STATE shall include information about known third party resources on the electronic enrollment data given to the MCO twice a month under Section 3.1.2.N.

Section 12.2.2. 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 business days of verification of such information. The MCO shall report any known change to health insurance information in the same manner.

Section 12.2.3. The MCO's efforts to determine liability and use Cost Avoidance Procedures or Post Payment Recovery Processes shall not require that the plan spend more on an individual claim basis than could be recovered through those efforts.

Section 12.2.4. The MCO is entitled to retain any amounts recovered through its efforts, provided that:

A. 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;

B. STATE fee-for-service and reinsurance benefits have not duplicated this recovery; and

C. Such recovery is not prohibited by federal or state law.

Section 12.2.5. The MCO may require its capitated Providers to return any third party payments to the MCO.

Section 12.2.6. If the MCO is unsuccessful in its efforts to obtain necessary cooperation from an Enrollee to identify potential third-party resources after 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.

Section 12.3. ***Coordination of Benefits.***

Section 12.3.1. ***Coordination of Benefits.*** For Enrollees who have private health care coverage, the MCO must coordinate benefits in accordance with Minnesota Rules, Part 9505.0070 and Minnesota Statutes, section 62A.046. Coordination of benefits includes paying any applicable copayments or deductibles on behalf of an Enrollee, except for copays pursuant to Sections 4.4.3. and 4.4.4 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.

Section 12.3.2. ***Cost Avoidance.***

A. ***General.*** Except as described in paragraph B, 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 copays, coinsurance and deductibles to a Non-Participating Provider. If the MCO refers an Enrollee to a third-party insurer for a service which the MCO covers, and the third-party insurer requires payment in advance of all copayments, coinsurance and deductibles, the MCO shall make such payments in advance or at the time such payments are required.

B. For prenatal care services, preventive pediatric services and services provided to a dependent covered by health insurance pursuant to a court order, the MCO must ensure that services are provided without regard to insurance payment issues. The MCO must provide the service first and then coordinate payment with the potentially liable third party.

Section 12.3.3. ***Post Payment Recoveries.*** 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 coverages include, but are not limited to: Medicare, Uninsured/Underinsured motorist insurance, First and third party liability insurance, awards as a result of a tort action, Workers' Compensation, Medical payments insurance for accidents (otherwise known as "med pay" provisions or benefits of policy), and Indemnity/accident insurance. The MCO shall develop procedures to identify trauma diagnoses and investigate potential liability. The MCO shall not pursue reimbursement under estate recovery or Medical Support recovery provisions (recovery of medical expenses paid for an Enrollee out of an Enrollee's estate or from an absent Parent).

Section 12.4. ***Reporting of Recoveries.***

Section 12.4.1. The MCO shall report on the encounter claim all third party liability payments (including Medicare reimbursement) as required in Section 3.5.1.

Section 12.4.2. The MCO shall, on a quarterly basis, disclose to the STATE all cost avoided and recovered amounts made from private insurance carriers, Medicare, 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.

Section 12.5. ***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.

Section 12.6. ***Determination of Compliance.*** The STATE may determine whether the MCO is in compliance with the requirements in this Article by inspecting source documents for:

Section 12.6.1. Appropriateness of recovery attempt.

Section 12.6.2. Timeliness of billing.

Section 12.6.3. Accounting for third party payments.

Section 12.6.4. Settlement of claims.

Section 12.6.5. Other monitoring deemed necessary by the STATE.

Article 13. Governing Law, Jurisdiction, and Venue, and Compliance with State and Federal Laws.

Section 13.1. ***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.

Section 13.2. ***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, including but not limited to: Minnesota Statutes, section 256B.69 et seq.; Minnesota Rules, Parts 9500.1450 to 9500.1464; Minnesota Statutes, section 256D.03; Minnesota Statutes, section 256L.01 et. seq.; Minnesota Rules, Parts 9506.0010 to 9506.0400; 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; Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans With Disabilities Act. If any terms of this Agreement are determined to be inconsistent with rule or law, the applicable rule or law provision shall govern.

Section 13.2.1. Any revisions to applicable provisions of federal or state law and implementing regulations, and policy issuances and instructions, except where otherwise excluded in this Contract, apply as of their effective date.

Section 13.2.2. 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).

Section 13.2.3. 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.

Section 13.2.4. The MCO shall comply with Executive Order 11246, "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.

Section 13.2.5. 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.

Section 13.2.6. 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.

Section 13.2.7. 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.

Section 13.2.8. 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.

Section 13.3. ***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, section 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 3.5.1.B. The MCO shall be in compliance with these requirements consistent with the applicable effective dates contained in state or federal law.

Section 13.4. ***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. PHI is considered "private data on individuals" (as defined in Minnesota Statutes, section 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).

Both the STATE and the MCO are "Covered Entities" 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.

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.

Unless otherwise provided for in this Contract, capitalized terms in this Section have the same meaning as set forth in the Privacy Regulation.

Section 13.5. ***Information Privacy and Security.***

Section 13.5.1. ***Information Covered by this Provision.*** In carrying out its duties, MCO will be handling "protected health information" and other private information, collectively referred to as "protected information," concerning individual STATE clients. "Protected information," for purposes of this agreement, includes any or all of the following:

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

B. Medical records (as governed by the Minnesota Health Records Act [Minnesota Statutes, section 144.335]);

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

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

E. 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.

Section 13.5.2. ***Duties Relating to Protection of Information***.

A. ***Duty to ensure proper handling of information.*** MCO shall be responsible for ensuring proper handling and safeguarding by its employees, subcontractors, and authorized agents of protected information collected, created, used, maintained, or disclosed on behalf of STATE. This responsibility includes ensuring that employees and agents comply with and are properly trained regarding, as applicable, the laws listed in Section 13.5.1.

B. ***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 Minnesota Statutes, section 13.05 subd. 3.

C. ***Part of Welfare System.*** MCO will be considered part of the "welfare system," as defined in Minnesota Statutes, section 13.46, subd. 1, and agrees to be bound by applicable state and federal laws governing the security and privacy of information.

D. ***Additional Privacy and Security Safeguards.*** MCO shall comply with the requirements set forth below regarding "Use of Information."

Section 13.5.3. ***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 employees, 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 any privacy or security incident of which it becomes aware. For purposes of this agreement, "*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. "*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 it has been breached. The MCO shall comply with any

corrective actions required by the STATE as a result of the privacy 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. disclosing the breach to any Enrollee whose protected information was, or is reasonably believed to have been, accessed;

d. providing updates to the STATE regarding any confirmed or suspected incidents, or lack thereof, involving misuse of the unauthorized data.

4.) 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.

5.) 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 in violation of this Agreement.

6.) Make available PHI in accordance with 45 CFR §164.524 and Minnesota Statutes, section 13.04, subdivision 3, within ten days of the date of the request, excluding Saturdays, Sundays and legal holidays, of receipt of written request by the STATE.

7.) Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526 within 15 days of receipt of written request by the STATE.

8.) Make its internal practices, books, records, policies, procedures, and documentation relating to the use, disclosure, and/or security of PHI available to the other Party 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.

9.) Comply with any and all other applicable provisions of the HIPAA Privacy Rule and Security Standards, including future amendments thereto.

10.) 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.

11.) Either: 1) 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 15 days of receipt of written request by the STATE; or 2) upon the STATE's request, respond directly to the individual requesting an accounting of disclosures from the MCO.

B. 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.

Section 13.5.4. ***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 MCO for purposes associated with this Agreement. MCO will retain no copies of such protected information, provided that such return or destruction is not feasible, 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.

Section 13.5.5. ***Sanctions.*** In addition to acknowledging and accepting the terms set forth in Section 9.10 of 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.

Section 13.5.6. ***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 Protected Health Information.

Section 13.5.7. ***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.

Section 13.5.8. ***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 employees except as provided in Minnesota Statutes Chapter 13 and in Section 1106 of the Social Security Act and implementing regulations.

Section 13.5.9. ***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. 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 Contract. The MCO must get prior approval from the STATE for disclosures of such data on the PMAP, PGAMC, and MinnesotaCare populations.

Section 13.5.10. ***Data Sharing with Local Agency Welfare and Public Health Offices.*** The STATE authorizes the MCO to enter into data sharing agreements with Local Agency welfare and public health offices for the purpose of administering the C&TC program and county outreach for C&TC. The STATE shall provide, upon request, a model data sharing agreement and technical assistance with establishing the agreement.

Section 13.5.11. ***Authorized Representatives.*** 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).

Section 13.6. ***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. Indemnification. 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 13.5.1. 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:

Section 15.1. 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.

Section 15.2. 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 or 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.

Section 15.3. The undersigned will require that the language of this certification be included in the award documents for all subawards 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 Amendments (C.L.I.A.) requirements in 42 CFR Part 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. For purposes of this Section, the term "advance directives" has the meaning given in 42 CFR 489.100. Pursuant to 42 U.S.C. § 1396a(a)(57) and (58) and 42 CFR 489.100-104, the MCO agrees:

Section 17.1. To provide all Enrollees at the time of enrollment a written description of applicable State law on advance directives and the following:

Section 17.1.1. 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.

Section 17.1.2. Written policies of the MCO respecting the implementation of the right;

Section 17.1.3. Updated or revised changes in State law as soon as possible, but no later than 90 days after the effective date of the change; and

Section 17.1.4. Information that complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency (i.e. Minnesota Department of Health), pursuant to 42 CFR 422.128, as required in 42 CFR 438.6(i).

Section 17.2. To require MCO's providers to ensure that it has been documented in the Enrollee's medical records whether or not an individual has executed an advance directive.

Section 17.3. To not condition treatment or otherwise discriminate on the basis of whether an Enrollee has executed an advance directive.

Section 17.4. 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, Section 38.

Section 17.5. To provide, individually or with others, education for MCO staff, Providers and the community on advance directives.

Article 18. Americans with Disabilities Act Compliance. In fulfilling the duties and responsibilities of this Contract, the MCO shall comply with P.L. 101-336, Americans with Disabilities Act of 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.

Article 19. Disclosure.

Section 19.1. ***Disclosure Requirements.*** The MCO must consent to any financial, character, and other inquiries by the STATE. The MCO shall disclose the following information upon request by the STATE, or as indicated in the following Sections:

Section 19.1.1. The MCO shall notify the STATE in a timely manner of changes to the MCO's Government Programs staff and management.

Section 19.1.2. 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.

Section 19.1.3. The MCO's full legal or corporate name and any trade names, aliases, and/or business names currently used.

Section 19.1.4. 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.

Section 19.1.5. 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.

Section 19.1.6. 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 and a description of the nature and extent of control.

Section 19.1.7. Any agreements or understandings that the MCO has entered into regarding ownership or operation of the MCO.

Section 19.2. ***Disclosure of Management/Fiscal Agents.*** The MCO must disclose the following, if applicable:

Section 19.2.1. A description of the terms and conditions of any contract or agreement between the MCO and the management or fiscal agent.

Section 19.2.2. All corporations, partnerships or other entities providing management of fiscal agent services.

Section 19.2.3. 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.

Section 19.2.4. 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 past five years. 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.

Section 19.2.5. 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.

Section 19.3. ***Disclosure of, Compliance With, and Reporting of Physician Incentive Plans***. The MCO may operate a Physician Incentive Plan (PIP), as defined in 42 CFR 417.479(c), only if the requirements of 42 CFR 417.479 are met.

Section 19.3.1. ***Disclosure to the STATE***. The MCO must report to the STATE in writing no later than March 31st of each year that the MCO is in compliance with the PIP requirements as set forth in 42 CFR 417.479. The MCO shall maintain in its files the following information in sufficient detail to enable the STATE or CMS to determine the MCO's compliance with 42 CFR 417.479 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 PIPs 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, the STATE shall annually conduct the survey of Enrollees who have disenrolled, and make available the survey results to the MCO.

Section 19.3.2. ***Disclosure to Enrollees***. The MCO must provide the following information in accordance with 42 CFR 417.479(h)(3) to any Enrollee or Potential Enrollee upon request:

A. Whether the MCO or its subcontractors use a PIP 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 20. Federal Audit Requirements and Debarment Information.

Section 20.1. MCO will certify that it will comply with the Single Audit Act, OMB Circular A-133, as applicable. The MCO shall obtain a financial and compliance audit made in accordance with the Single Audit Act, A-133, as applicable. Failure to comply with these requirements could result in forfeiture of federal funds.

Section 20.2. ***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, Minnesota Statutes, section 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:

Section 20.2.1. 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

Section 20.2.2. Have not within a three-year period preceding this Contract: 1) 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; 2) violated any federal or state antitrust statutes; or 3) committed embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property; and

Section 20.2.3. Are not presently indicted or otherwise criminally or civilly charged by a governmental entity for: 1) commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (federal, state or local) transaction; 2) violating any federal or state antitrust statutes; or 3) committing embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property; and

Section 20.2.4. 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; and

Section 20.2.5. Shall immediately give written notice to the STATE should MCO come under investigation for allegations of fraud or a criminal offense in connection with: 1) obtaining, attempting to obtain, or performing a public (federal, state or local government) transaction; 2) violating any federal or state antitrust statutes; or 3) committing embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property.

Article 21. Modifications. Any material alteration, modification or variation in the terms of this Contract shall be reduced to writing as an amendment hereto and signed by the parties.

Article 22. 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 items referred to in this Contract are incorporated or attached and deemed to be part of the Contract. Any amendments to this Contract shall be in writing, signed by all parties, and attached hereto.

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

By: _______________________________

Title: ______________________________

Date: ______________________________

_____________________________(MCO)
(Two corporate officers must execute)

By: _______________________________

Title: ______________________________

Date: ______________________________

and

By: _______________________________

Title: _____________________________

Date: _____________________________

Appendices

Appendix I - MCO Service Areas

PMAP and PGAMC Counties:

MinnesotaCare Counties:

Appendix II - Rates