2014 MSHO/MSC+ Contract

HEALTHPARTNERS

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

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

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

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

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 USC § 1396 et seq., 42 CFR, Parts 434 and 438, Minnesota Statutes, § 256B.69 and § 256B.692, and may request waivers for the Medical Assistance program pursuant to § 1115 of the Social Security Act, 42 USC § 1315 et seq., and pursuant to § 1915 of the Social Security Act for Home and Community-based waiver services; and,

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

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

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

WHEREAS, the STATE and CMS have signed a Memorandum of Understanding, attached as Appendix VII, that creates a federal-state partnership to align administrative functions for improvements in Medicare-Medicaid beneficiary experience and

Through this Renewal Contract, **60841**, the STATE and the MCO have agreed to renew the 2012 Contract, number 49512 for the next Contract Year, January 1, 2014 through December 31, 2014;

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

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

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

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

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

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

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

2.2 Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Enrollee practices that result in unnecessary cost to the Medicaid program. Abuse shall also include substantial failure to provide Medically Necessary items and services that are required to be provided to an Enrollee under this Contract if the failure has adversely affected or has a substantial likelihood of adversely affecting the health of the Enrollee.

2.3 Action means 1) the denial or limited authorization of a requested service, including the type or level of service; 2) the reduction, suspension, or termination of a previously authorized service; 3) the denial, in whole or in part of payment for a service; 4) the failure to provide services in a timely manner; 5) the failure of the MCO to act within the timeframes defined in Article 8; or, 6) for a resident of a Rural Area with only one MCO, the denial of an Enrollee's request to exercise his or her right to obtain services outside the network.

2.4 Acupuncture Services means acupuncture practice, as defined in Minnesota Statutes, § 147B.01, subd. 3.

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

2.6 Adult Guardianship means:

(A) Private Guardian refers to a person or party who has been appointed and ordered by the court to execute the powers, authority, duties and responsibilities involved in the protective arrangement of a guardianship, whereby the agent manages the personal life

affairs, as needed, for a ward, who has been deemed or determined to be an incapacitated person by the court in accordance with Minnesota Statutes, §§ 524.5-101 through 524.5 502.

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

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

2.8 Adverse Action means suspension, termination, denial, limitation or restriction of a provider, individual, or entity to apply or to participate with the MCO for any of the reasons listed in Minnesota Statutes § 256B.064 or for any reason for which the provider, individual, or entity could be excluded from participation in Medicare under Sections 1128, 1128A, or 1866(b)(2) of the Social Security Act. This includes, but is not limited to, suspension actions, settlement agreements and situations where an individual or entity voluntarily withdraws from the program to avoid a formal sanction. Adverse action does not include network business decisions such as when a provider applies but there are already enough of the provider type in the network.

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

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

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

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

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

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

2.15 Benefit Period (Medicare) means, under Medicare, the period of consecutive days that begins with the first day on which an Enrollee is furnished Inpatient Hospitalization or extended care services by the MCO, and ends at the close of a period of sixty (60) consecutive days during

which the Enrollee was neither an inpatient in a hospital nor met the criteria for payment for a Skilled Nursing Facility.

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

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

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

2.19 Care Management for All Enrollees means the overall method of providing ongoing health care in which the MCO manages the provision of primary health care services with additional appropriate services provided to an Enrollee. See section 6.1.6.

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

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

2.22 Case Management for MSC+ Enrollees means the assignment of an individual who assesses the need for and coordinates Medicaid health and long-term care services for an MSC+ Enrollee receiving Elderly Waiver Services among different health and social service professionals and across settings of care. This individual, if assigned to the MSC+ Enrollee, must be a social worker, public health nurse, registered nurse, physician assistant, nurse practitioner, or physician.

2.23 Clean Claim means, pursuant to 42 CFR § § 447.45 and 447.46, and Minnesota Statutes, § 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.

2.24 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) the results of which will be reported upon completion of the trial regardless of their positive or negative nature.

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

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

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

2.28 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, § 145.891 through 145.897.

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

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

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

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

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

2.34 Coordination of Benefits has the meaning described in Minnesota Statutes, §62A.046, subd. 6, except that MCOs must coordinate benefits, and must coordinate pursuant to Minnesota Rules Parts §4685.0905, et seq.

2.35 Cost Avoidance Procedure means the techniques described in Minnesota Rules, Part 9506.0080, subp. 4 to ensure benefit coordination and by which the MCO ensures that a Provider obtains payment from the identified Third Party Liability resources before billing the MCO, except that these techniques apply to all MHCP.

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

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

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

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

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

2.41 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.

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

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

2.44 Elderly. See Aged.

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

2.46 Emergency Care. See Medical Emergency at section 2.84.

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

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

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

2.50 Essential Community Supports (ECS) means a state-funded service to provide Home and Community Based services to eligible individuals, pursuant to Minnesota Statutes, § 256B.0922. ECS are paid by the STATE under FFS.

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

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

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

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

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

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

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

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

2.59 Home and Community Based Services (HCBS) means services provided under a federal waiver under § 1915(c) of the Social Security Act, 42 USC § 1396n, and pursuant to Minnesota Statutes, § 256B.092 subd. 4, and § 256B.0915. These services are for Enrollees who meet specific eligibility criteria including being at risk of institutional care if not for the provision of HCBS services. The services are intended to prevent or delay Nursing Facility placements. See also Elderly Waiver Services as listed in section 6.1.13.

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

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

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

(C) Private duty nursing as listed in Minnesota Statutes, § 256B.0625 subd. 7.

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

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

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

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

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

2.63 Improper Payment means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory,

contractual, administrative, or other legally applicable requirements. This includes, but is not limited to: 1) any payment for an ineligible Recipient; 2) any duplicate payment; 3) any payment for services not received; 4) any payment incorrectly denied; and 5) any payment that does not account for credits or applicable discounts.

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

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

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

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

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

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

2.70 Institutionalized means Recipients who are coded as being in an Institutionalized living arrangement in MMIS at the time of enrollment. For changes in MSHO Rate Cell Categories after initial enrollment, Institutionalized Recipients are those MSHO Enrollees who have been Institutionalized for thirty (30) consecutive days. For MSC+ Enrollees, Institutionalized means a category of Enrollees used as a factor to determine the Rate Cell of an Enrollee who resides in a Nursing Facility or intermediate care facility for persons with developmental disability (ICF/DD).

2.71 Integrated Care System Partnership (ICSP) means relationships between MCOs and providers including long term care providers, and/or Care Systems, which are designed to coordinate and/or integrate Medicare and Medicaid primary, acute, long term care, and/or mental health services in order to assist Enrollees to remain in their homes or choice of community settings, and to improve health outcomes in all settings, under contracting arrangements that

include gain and/or risk sharing, performance-based payments, or other payment reforms tied to financial performance and STATE-approved quality metrics.

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

2.73 Level of Care Criteria means classifications and questions developed by the Minnesota Departments of Health and Human Services used to determine whether an Enrollee's assessed needs meet the institutional level of care criteria established by the Department of Human Services for purposes of medical assistance payment for Nursing Facility services, and service eligibility determination and payment for home and community-based alternatives to institutional care.

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

2.75 Long Term Care Consultation (LTCC) means the assessment of Enrollees, pursuant to Minnesota Statutes, § 256B.0911, for the purpose of preventing or delaying Nursing Facility placements to offer cost-effective alternatives appropriate for the Enrollee's needs, and to assure appropriate admissions to a Nursing Facility.

2.76 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 through 104; or 2) any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: a) makes the services it provides to its Medicaid Enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid Recipients within the area served by the entity; and b) meets the solvency standards of 42 CFR § 438.116.

2.77 Managing Employee means an individual, (including a general manager, business manager, administrator, or director), who exercises operational or managerial control over the entity or part thereof, or who directly or indirectly conducts the day-to-day operation of the entity or part thereof as defined in 42 CFR § 1001.1001(a)(ii)(A)(6).

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

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

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

2.80 Material Modification of Provider Network means 1) a change that would result in an Enrollee having only three remaining choices of a Primary Care Provider within thirty (30) miles or thirty (30) minutes; or 2) a change that results in the discontinuation of a Primary Care Provider who is responsible for Primary Care for one third (1/3) or more of the Enrollees in the applicable area (the same area from which the affected Enrollee chose their Primary Care Provider or sole source Provider, prior to the Material Modification); 3) a change that involves a termination of a sole source Provider where the termination is for cause. Such changes include both Medicare and Medicaid Providers, and pharmacy benefit managers as applicable, or 4) loss of the contractual agreement with a major subcontractor providing a network of providers, including but not limited to the MCO's dental or behavioral health network, pharmacy benefit manager, care systems and care coordination entities. For purposes of this section, termination of a Provider for cause does not include the inability to reach agreement on contract terms.

2.81 MDH means the Minnesota Department of Health.

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

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

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

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

2.86 Medically Necessary or Medical Necessity means, with the exception of Elderly Waiver services, pursuant to Minnesota Rules, Part 9505.0175, subpart 25, a health service that is: 1) consistent with the Enrollee's diagnosis or condition; 2) recognized as the prevailing standard or current practice by the Provider's peer group; and 3) rendered:

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

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

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

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

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

(F) As a preventive health service defined under Minnesota Rules, Part 9505.0355.

2.87 Medicare means the federal insurance program for aged and disabled people as defined under 42 USC § 1395 et. seq.

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

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

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

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

2.92 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.

2.93 Memorandum of Understanding (MOU) means the agreement between the STATE and CMS formalizing a demonstration for integration of Medicare and Medicaid for dually-eligible Enrollees.

2.94 Mental Health Professional means a person providing clinical services in the treatment of mental illness who meets the qualifications required in Minnesota Statutes, § 245.462, subd.

18(1) through (6), for adults; and Minnesota Statutes § 245.4871, subd. 27(1) through (6), for children.

2.95 Mental Illness means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that 1) is detailed in a diagnostic codes list published by the Commissioner on the DHS website and 2) seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation as defined under Minnesota Statutes, § 245.462 subd. 20.

2.96 Metro Area means the following seven Minnesota counties: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington. Non-metro Area means all other counties.

2.97 MHCP means Minnesota Health Care Programs.

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

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

2.100 MMIS means the Medicaid Management Information System.

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

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

2.102 Money Follows the Person Rebalancing Demonstration means the CMS grant that supports the STATE's efforts to transition Medicaid recipients from institutions to the community, pursuant to Minnesota Statutes, 256B.04, subd. 20. The program name in Minnesota for this demonstration is Moving Home Minnesota.

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

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

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

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

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

2.108 Nursing Home Certifiable (NHC) means a designation indicating that an Enrollee is in need of Nursing Facility level of care as defined by the Level of Care Criteria. NHC status must be determined through face-to-face assessment using the STATE Long Term Care Consultation (LTCC) tool and Level of Care Criteria according to procedures in section 6.1.22.

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

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

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

2.112 Payment Appendix or Appendices means pages attached to this Contract containing the capitation rates to be paid by the STATE to the MCO.

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

2.114 Person with an Ownership or Control Interest means a person or corporation that: 1) has an ownership interest, directly or indirectly, totaling five percent (5%) or more in the MCO or a disclosing entity; 2) has a combination of direct and indirect ownership interest equal to five percent (5%) or more in the MCO or the disclosing entity; 3) owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by the MCO or the disclosing entity, if that interest equals at least five percent (5%) of the value of the property or assets of the MCO or the disclosing entity; or 4) is an officer or director of the MCO or the

disclosing entity (if it is organized as a corporation) or is a partner in the MCO or the disclosing entity (if it is organized as a partnership).

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

2.116 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 § 438.700(b)(6) and 422.208(a).

2.117 Post Payment Recovery means seeking reimbursement from third parties whenever claims have been paid, for which there is Third Party Liability. This is also referred to as the "pay and chase" method.

2.118 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 (1) hour; or 5) the MCO and treating Provider are unable to reach agreement regarding the Enrollee's care.

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

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

2.121 Prescription Monitoring Program (PMP) means the electronic reporting system maintained and operated by the Minnesota Pharmacy Board for reporting all controlled substances dispensed within Minnesota.

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

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

2.124 Priority Services means:

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

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

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

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

(E) A process for expedited appeals for the services described in paragraphs (A) through (C); and

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

2.125 Privacy Incident means violation of the Minnesota Government Data Practices Act (MGDPA) and/or the HIPAA Privacy Rule (45 CFR Part 164, subpart E) and the laws listed in section 2.126 including, but not limited to, improper and/or unauthorized use or disclosure of Protected Information, and incidents in which the confidentiality of the information maintained by the parties has been breached.

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

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

(B) Health records (as governed by the Minnesota Health Records Act (Minnesota Statutes, § § 144.291 through 144.298);

(C) Chemical health records (as governed by 42 USC § 290dd-2 and 42 CFR § 2.1. through 2.67);

(D) Protected health information ("PHI") (as defined in and governed by the Health Insurance Portability Accountability Act ("HIPAA"), 45 CFR § 160.103);

(E) Federal tax information ("FTI") (as protected by 26 USC 6103); and

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

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

2.128 Provider Manual means the current Internet online version of the official STATE publication, entitled "*Minnesota Health Care Programs Provider Manual*."

2.129 Qualified Professional (QP) means a qualified professional for supervision of personal care assistance services as defined in Minnesota Statutes, § 256B.0625, subd. 19c.

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

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

2.132 Renewal Contract means an automatically renewing Contract under the terms of section 5.1.1 below

2.133 Restricted Recipient Program (RRP) means a program pursuant to Minnesota Rules, part 9505.2200, for Recipients and Enrollees who have failed to comply with the requirements of the program. Placement in the RRP does not apply to services in long term care facilities and/or covered by Medicare. Placement in the RRP means:

> (A) Requiring that for a period of twenty-four (24) or thirty-six (36) months of eligibility the Enrollee must obtain health services from a designated Primary Care Provider located in the Enrollee's local trade area, a hospital used by the primary care provider, a pharmacy, or any other designated Provider, including a MHCP enrolled Personal Care Provider Agency (PCPA) or Medicare certified Provider;
>
> (B) Prohibiting the Enrollee or Recipient from using the personal care assistance choice, flexible use option, or consumer directed community services for a period of twenty-four (24) or thirty-six (36) months of eligibility.

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

2.135 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. Security incident shall not include pings and other broadcast attacks on MCO's or its subcontractors' firewall, port scans, unsuccessful log-on attempts, denials of service, and any combination of the above; so long as such incidents do not result in unauthorized access, use or disclosure of the STATE's information.

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

2.137 Service Area means the counties of Minnesota in which the MCO agrees to offer coverage under this Contract. See Appendix I- MCO Service Areas.

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

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

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

2.141 Special Needs Basic Care (SNBC) means the Minnesota prepaid managed care program, pursuant to Minnesota Statutes, § 256B.69, subd. 28, that provides Medicaid services and/or integrated Medicare and Medicaid services to Medicaid eligible people with disabilities who are ages eighteen (18) through sixty-four (64).

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

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

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

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

2.146 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 what the MCO reimbursement for the Covered Service would have been, had the Covered Service been provided; and 2) that the health status of and quality of life for the Enrollee is expected to be the same or better using the Substitute Health Service as it would be using the Covered Service.

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

2.148 Third Party Liability has the same meaning as Third-party payer in Minnesota Rules, Part 9505.0015, subp. 46, and in the Medicare program.

2.149 Tribal Community Member means individuals identified as enrolled members of the tribe and any other individuals identified by the tribe as a member of the tribal community. This definition is referenced in the Tribal Assessments and Service Plans sections 6.1.13(E) below and 6.1.17(F).

2.150 Unique Minnesota Provider Identifier (UMPI) means the unique identifier assigned by the STATE for certain atypical Providers not eligible for an NPI.

2.151 Universal Pharmacy Policy Workgroup means a group composed of pharmacy policy experts from the MCOs and the STATE that will develop a Universal Pharmacy Policy for high risk and controlled substance medications. Members of the Universal Pharmacy Policy Workgroup must be pharmacists or physicians licensed by the State of Minnesota or individuals with significant pharmacy policy expertise. The workgroup meets twice monthly and is chaired by STATE staff.

2.152 Universal Pharmacy Policy means the minimum requirements for universal pharmacy policy as defined by the Universal Pharmacy Policy workgroup, including but not limited to high risk and controlled substance medications prescribed to Enrollees and FFS Recipients subject to the Universal Pharmacy Policy as defined by the Universal Pharmacy Workgroup. The Universal Pharmacy Policy includes but is not limited to:

(A) Minimum requirements for a uniform formulary and/or preferred drug list for opiates, stimulants, and other drugs as identified by the Universal Pharmacy Workgroup.

(B) Minimum requirements for approval of the non-formulary or non-preferred medications.

(C) Maximum daily morphine equivalent dose limits for opiate analgesics. Standardized criteria for doses exceeding the limits.

(D) Maximum daily doses for medication assisted treatment for addiction, including daily dose limits for Suboxone and methadone.

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

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

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

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

3.1 Eligibility and Enrollment.

3.1.1 Eligibility

(A) Service Area. Only those eligible persons who are enrolled in Medical Assistance residing within the counties of the State of Minnesota identified in Appendix I (Service Area) 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/Presumptive Eligibility Determinations. Eligibility/presumptive eligibility for Medical Assistance will be determined by the Local Agency, and any other entity designated by the STATE to make eligibility/presumptive eligibility determinations. Eligibility for Medicare will be determined by CMS. All persons who receive Medical Assistance and reside in the Service Area will participate in MSC+, except for residents described in the Enrollment Exclusions section (D) below. Persons eligible for MSC+ may voluntarily enroll in MSHO, subject to the limitations contained in this Contract.

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

(1) Both MSC+ and MSHO:

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

(b) Residents of State institutions, unless the MCO approves placement. For purposes of this Contract, approval by the MCO would include a placement that is court-ordered within the terms described in section 6.1.26(E).

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

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

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

relationship is likely to result in the patient becoming noncompliant with medication or other health services.

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

(g) Non-citizen Recipients who receive emergency medical assistance under Minnesota Statutes, §256B.06, subd.4.

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

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

(j) Persons participating in the Navigator Pilot in Minnesota Statutes, § 254B.13, or the Continuum of Care Pilot Minnesota Statutes, § 254B.14.

(2) The following exclusions apply to MSHO only:

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

(b) Individuals with a diagnosis of End Stage Renal Disease (ESRD) prior to enrollment in the MCO. See also 3.1.1(G)(1)(b) below.

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

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

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

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

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

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

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

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

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

(G) Additional Eligibility Parameters for MSHO.

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

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

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

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

3.1.2 Enrollment.

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

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

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

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

(E) 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.

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

(G) Period of Enrollment.

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

(2) For MSHO, each Enrollee may choose to disenroll at the end of any month consistent with paragraph (I) below. The MCO agrees to retain Medicare eligible Enrollees for up to three months after losing their Medicaid eligibility in the MCO, including Enrollees who no longer meet the requirements for managed care enrollment as part of the MCO's Medicare Special Needs Plan enrollment.

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

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

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

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

(L) Choice of Health Care Professional. The MCO must allow an Enrollee to choose his or her Health Care Professional to the extent possible and appropriate. "To the extent possible and appropriate" includes limiting the selection of a Primary Care Provider to participants in the MCO's network, unless the Primary Care Provider was already at capacity, and other instances discussed in the "Provisions of the Proposed Rule and Analysis of and Response to Public Comments" to 42 CFR § 438.6(m), Volume 67, Number 115, column 3 of page 41,006 and column 1 of page 41,007 of the Federal Register, June 14, 2002.

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

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

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

3.1.3 Enrollment Responsibilities Specific to MSHO and MSC+.

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

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

3.1.4 STATE and CMS MSHO Enrollment; Integrated Enrollment Procedures; Enrollment TPA Services.

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

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

(2) MCO agrees to use the real-time data exchange and enrollment processes further described in sections 3.1.2 (Enrollment), 3.3 (Capability to Receive Enrollment Data Electronically), 3.5 (LTCC Screening Document Entry.), and the timeframes in 3.6.6.

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

(C) Integrated enrollments for both Medicare and Medicaid will be conducted by a joint process between the MCO and the STATE. The MCO or the STATE will perform each duty according to the terms and conditions of a separate integrated enrollment Third Party Administrator (TPA) contract, or if the MCO chooses not to enter into a TPA contract with the STATE, by following the integrated enrollment processes posted on the DHS managed care website.

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

(E) If a TPA contract does not exist between the MCO and the STATE, the STATE may propose to contract with the MCO for processes performed by the STATE that are required to maintain integrated enrollment, and may charge for these processes, as an alternative to the TPA contract in section 3.1.4(D). If the STATE determines such a contract is necessary, the STATE will provide one hundred and fifty (150) days' notice to the MCO.

3.1.5 Effective Date of Coverage.

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

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

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

(B) Inpatient Hospitalization and Enrollment:

(1) MSHO Enrollees receiving Inpatient Hospitalization will be enrolled in accordance with section 3.1.5(A)(1) above. All charges related to Inpatient Hospitalization for any MSHO Enrollee who is receiving Inpatient Hospitalization services on the effective date of coverage will not be the responsibility of the MCO.

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

(3) MCO coverage under MSC+ for Medical Assistance Recipients who disenroll from MSHO and are required to remain enrolled in MSC+ but who are hospitalized on the first effective date of re-enrollment in MSC+ shall commence according to 3.1.5(B)(2) above.

(C) CD Services and Enrollment.

(1) For MSHO Enrollees receiving hospital based CD services paid on a *per diem* basis, or who are in a Residential Treatment Facility at the time the Recipient is scheduled to be enrolled in the MCO, enrollment will not be delayed. The MCO will be financially responsible for hospital based CD services unless these services are covered by Medicare.

(2) For MSC+ Recipients who are receiving hospital-based CD services paid on a *per diem* basis, at the time the Recipient is scheduled to be enrolled in the MCO, enrollment will not be delayed. The MCO will be financially responsible for *per diem* hospital based CD services.

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

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

(E) Enrollee Eligibility Review Dates. In accordance with Minnesota Statutes, § 256.962, subd.8, the STATE will provide a report of eligibility review dates for enrollees enrolled in the MCO.

3.2 Termination of Enrollee Coverage; Change of MCOs.

3.2.1 Disenrollment from MSHO But Not From MSC+. The Enrollee may disenroll from the MCO's MSHO product at the end of any thirty (30) day period of consecutive enrollment. Disenrollment will be effective according to the termination of coverage schedules outlined in section 3.2.5. Additional conditions for disenrollment from MSHO include:

(A) If the Enrollee disenrolls from the MCO's MSHO product, the Enrollee shall remain enrolled in the MCO's MSC+ product, subject to the MCO's participation requirement in section 9.1.1, unless the Enrollee requests the STATE to return them to the MSC+ product in which they were enrolled immediately prior to enrollment in MSHO.

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

(C) An Enrollee who disenrolls from the MCO's MSHO product and remains enrolled in the MCO's MSC+ product shall be enrolled in the MCO's MSC+ product for a

period of twelve (12) months, subject to the exceptions in sections 3.1.2(G) and 3.2.3 (as applicable), and 5.1.2 of this Contract.

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

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

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

(A) Required termination includes:

(1) The Enrollee becomes ineligible for Medical Assistance;

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

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

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

(5) The Enrollee moves out of the MCO's Service Area and the MMIS county of residence is updated per eligibility policy;

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

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

(8) For MSC+, pursuant to Minnesota Rules, Part 9500.1453, subpart 5, the Enrollee elects to change MCOs once during the first year of initial enrollment in the MCO or

during the first sixty (60) days after a change in enrollment from an MCO that is no longer participating;

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

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

(11) The Enrollee elects to change MCOs within one hundred twenty (120) days following notice of a Material Modification of the MCO's Provider network under section 3.6.14(A);

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

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

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

3.2.4 Termination by MCO. For MSHO and MSC+ the MCO may not request disenrollment of an Enrollee for any reason except as described in section 3.2.3(B).

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

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

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

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

(D) When termination takes place for any reason other than those set forth in this section, including the termination or expiration of this Contract, while the Enrollee is receiving Inpatient Hospitalization services, MCO coverage shall cease at midnight, Minnesota time, on the first day of the month following discharge from the hospital.

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

3.2.7 Re-enrollment.

(A) An MSHO or MSC+ Enrollee who is identified within ninety (90) days of losing Medical Assistance eligibility for not more than three months, or for any break of time within a three month period and establishes continuous Medical Assistance eligibility with no break in eligibility may be re-enrolled for the month following disenrollment and subsequent months in the same MCO without completing a new enrollment form. Upon re-enrollment, the STATE may update the Enrollee's Rate Cell Category using information from the MCO, Care System, or MMIS/MAXIS. The status of the one hundred and eighty (180) day SNF/NF benefit at disenrollment will resume upon re-enrollment. The STATE shall pay the Medical Assistance portion of the Capitation Payment for the month of coverage in which the Enrollee was reinstated.

(B) For MSC+, if an Enrollee is disenrolled for any reason and subsequently becomes eligible to enroll, the STATE shall reenroll the Enrollee in the same MCO, unless the Enrollee requests a change in MCOs in accordance with section 3.2.1

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

3.3 Capability to Receive Enrollment Data Electronically.

(A) 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 fifteen (15) days to disseminate enrollment information to its Enrollees, pursuant to section 3.6.6 of this Contract.

(B) 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. 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.

(C) 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.

3.4 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 contracted Providers consider the Enrollee's right to the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.6 Potential Enrollee and Enrollee Communication.

3.6.1 Communications Compliance with Title VI of the Civil Rights Act. Title VI of the Civil Rights Act of 1964, 42 USC 2000d et. seq. and 45 CFR Part 80 provide that no person shall be subjected to discrimination on the basis of race, color or national origin under any program or activity that receives Federal financial assistance and that in order to avoid discrimination against persons with limited English proficiency (LEP) and for LEP persons to have meaningful access to programs and services, the MCO must take adequate steps to ensure that such persons receive the language assistance necessary, free of charge. The MCO shall comply with the recommendations of the revised Policy Guidelines published on August 4, 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 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.

3.6.2 Communications Compliance with the Americans with Disabilities Act. (Americans with Disabilities Act of 1990, 42 USC, § 1210, et seq.; hereafter "ADA").

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

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

(C) All written materials, including all membership materials, must be updated with the following statement: "This information is available in other forms to people with disabilities by calling 000-000-0000 (voice), or 1-800-000-0000 (toll free), or 000-000-0000 (TDD), or 7-1-1, or through the Minnesota Relay direct access numbers at 1-800-

627-3529 (TTY, voice, ASCII, hearing carry over), or 1-877-627-3848 (speech-to-speech)," or similar language approved by the STATE pursuant to section 3.6.

3.6.3 Requirements for Potential Enrollee or Enrollee Communication.

(A) Written Information.

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

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

(B) Language Block. All material sent by the MCO to Potential Enrollees or Enrollees, that targets Potential Enrollee or Enrollees under this Contract, shall include the STATE's language block. The MCO may request a waiver from this requirement for materials that are not large enough to incorporate the language block, for example postcards.

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

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

(E) American Indians. All Potential Enrollee or Enrollee 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 Indian Health Care Providers, including Elderly Waiver services managed by a tribe where available.

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

3.6.4 Marketing and Marketing Materials.

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

(B) 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 Potential Enrollee 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 Potential Enrollee or Enrollee's enrollment with the MCO in conjunction with the sale of any other insurance.

(C) Development of Materials for MSHO. The MCO will participate in the collaborative MSHO Plan Member Materials Workgroup (as named in the MOU) for development of integrated model materials for MSHO. The STATE will submit the model integrated materials to CMS for review and approval prior to use by the MCO.

(D) Prior Approval of Materials.

(1) For both MSHO and MSC+. The MCO shall present to the STATE for approval, in a final format, all Marketing materials for MSHO or MSC+ that the MCO or its subcontractors plan to use during the contract period prior to the MCO's use of such Marketing Materials.

(a) Approval by the STATE shall not be unreasonably withheld or delayed.

(b) When the MCO submits the material for review, the MCO shall include information on the purpose, the intended audience and the timeline for use of the material being reviewed.

(c) If the Marketing Materials target American Indian Recipients, the STATE shall consult with tribal governments within a reasonable period of time before approval.

(d) Internet web sites that merely link to the DHS web site for information do not need prior approval.

(2) CMS and STATE Review Process for MSHO. All client education and Marketing Materials for MSHO, including, but not limited to Marketing scripts for

such activities as presentations or radio advertisements, posters, brochures, Internet web sites, any materials which contain statements regarding the benefit package, and Provider network-related materials, must be prior approved by the STATE and CMS. The MCO must submit all materials including Medicare and Part D materials. The STATE and CMS shall review all Medicare related materials. The STATE shall review Medicaid only materials. Upon receiving STATE approval of MSHO material, the MCO is responsible for submitting material subject to CMS review directly to CMS for review. If CMS requires changes to the STATE approved material, the MCO shall submit a copy of the final document to the STATE. The MOU allows for CMS to explore the feasibility of changing the review process by establishing a concurrent joint CMS and STATE approval process. The STATE will work with the MSHO Member Materials Workgroup to implement any changes that are made to the review process.

(3) STATE Review Process for MSC+. The MCO shall present to the STATE for approval, in a final format, all Marketing Materials for MSC+ that the MCO, or its subcontractors, plan to use during the contract period, including but not limited to posters, brochures, Internet web sites, any materials which contain statements regarding the benefit package, and Provider network-related materials, prior to the MCO's use of such Marketing Materials. The STATE will review Medicaid materials.

(E) Marketing Standards and Restrictions.

(1) Direct Marketing for MSHO. The MCO may do direct Marketing of its MSHO product to MSHO-eligible individuals and current MCO Enrollees who will become eligible for Medicare within the next six (6) months. Direct Marketing includes, but is not limited to, telephone contacts, mailings, face-to-face Marketing, promotions and individual and group meetings. If the MCO directly markets to MSHO-eligible individuals within a given Service Area, it must market to both Institutional and community MSHO-eligible individuals. All Marketing activities and materials for MSHO must be Prior Approved in writing by the STATE and CMS before use or implementation as stated in section 3.6.4(D).

(a) The MCO's marketing notices must not contain false or materially misleading information.

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

(2) Direct Marketing for MSC+. Direct Marketing for MSC+ is not allowed, except for mailing and publications set forth in section 3.6.4(G). Except through mailings and publications, 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. Mailings shall not contain false or 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.

(F) MSHO Marketing Consistent with CMS Requirements: The MCO, its agents and Marketing representatives, shall not:

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

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

(3) Engage in any discriminatory activities.

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

(5) Make any written or oral assertions or statements that a Recipient or Enrollee must enroll in the MCO in order to obtain or maintain Medical Assistance and covered Medicare benefits, or that the MCO is endorsed by CMS, Medicare, the STATE, or federal government. The MCO may explain that it is approved for participation in Medicare.

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

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

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

STATE may seek remedies including, but not limited to, the remedies specified in section 5.6 of this Contract.

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

(H) Other Publications. The MCO, acting indirectly through the publications and other material distributed by the Local Agency or the STATE, or through mass media advertising (including the internet), may inform Recipients who reside in the Service Area of this Contract of the availability of medical coverage through the MCO, the location and hours of service and other plan characteristics, subject to section 3.6.5.

(1) 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 contracted with the Provider have an equal opportunity to be represented.

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

(3) All posters, brochures and Provider network-related materials must be prior approved by the STATE and/or CMS as required in accordance with section 3.6.5(A).

3.6.5 Enrollment Materials.

(A) Prior Approval Required. The MCO must submit its enrollment materials in a final format before approval from the STATE can be given. Approvals by the STATE for these materials shall not be unreasonably withheld.

(1) For MSHO Materials. The MCO agrees that the integrated Medicare, Medicare Part D and Medicaid Evidence of Coverage (EOC) sent to each MCO Enrollee and all Marketing Materials, plans, procedures, mailings, enrollment forms and their revisions that are designed for Recipients shall be used only after receiving approval in accordance with section 3.6.4(D). The MCO must revise its EOC 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 Evidence of Coverage must be approved in writing by the STATE and CMS in accordance with section 3.6.4(D), and issued to Enrollees prior to implementation of the change.

(2) For MSC+ Materials. The STATE must approve all enrollment materials including the Evidence of Coverage (EOC) sent to Enrollees prior to their use. The MCO must revise its Evidence 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 EOC must be approved in writing by the STATE in accordance with section 3.6.4(D) and must be issued to Enrollees prior to implementation of the change. The STATE agrees to inform the MCO of its approval or denial of MSC+ documents within thirty (30) days of receipt of these documents from the MCO.

3.6.6 Enrollment Information to be Presented. The MCO shall present to all new Enrollees the following information within fifteen (15) calendar days of availability of readable enrollment data from the STATE. If an Enrollee becomes ineligible and is disenrolled from the MCO, but eligibility is reestablished within the following three months and the Enrollee's eligibility is reestablished in the same program and he/she is re-enrolled in the same MCO, the MCO will not be required to send a new member packet, including the EOC and a provider directory, but must send the Enrollee another MCO member identification card.

(A) An Evidence of Coverage (EOC) that has been prior approved by the STATE, and for MSHO, by CMS.

(1) For MSHO, the MCO will cooperate with the MSHO Plan Member Materials Workgroup to adjust the CMS Medicare model EOC to incorporate STATE requirements. The MCO will use the model developed by the MSHO Plan Member Materials Workgroup to develop its own EOC, which is then submitted to the STATE and includes information as below in section 3.6.6(A)(3)(a) through (s).

(2) For MSC+, the STATE will provide annually to the MCO a model EOC or EOC Addendum as the base document. Prior to distribution to the MCO, the model EOC or EOC Addendum will be prior approved by MDH to ensure that MDH's requirements are included. The MCO will not have to subsequently submit the EOC or EOC Addendum to MDH after receiving approval from the STATE. After the MCO has incorporated its specific information, the completed EOC or EOC Addendum will be submitted to the STATE for prior approval.

(3) For both MSHO and MSC+ the EOC or EOC Addendum must include the following, and must be distributed annually to MSC+ Enrollees no later than January 31 or for MSHO, as required by CMS:

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

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

(c) Cost sharing, if applicable;

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

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

(f) A statement informing Enrollees that the MCO shall provide language assistance to Enrollees that ensures meaningful access to its programs and services;

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

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

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

(j) A description of how transportation is provided;

(k) A description of how the Enrollee may obtain services, including 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 twenty-four (24) hour telephone number for Medical Emergency Services; 6) procedures for Urgent Care, and Out of Plan care; and 7) how Enrollees may access Home and Community-Based Services. The MCO must indicate that Service Authorization is not required for Medical Emergencies and that the Enrollee has a right to use any hospital or other setting for Emergency Care. If the MCO does not allow direct access to specialty care, the MCO must inform Enrollees the circumstances under which a referral may be made to such Providers;

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

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

i) For State Fair Hearing: 1) the right to a hearing; 2) the method for obtaining a hearing; and 3) the rules that govern representation at the hearing.

ii) The right to file Grievances and Appeals.

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

iv) The availability of assistance in the filing process.

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

(n) An explanation that, when an Appeal or State Fair Hearing is requested by the Enrollee,

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

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

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

(p) 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;

(q) General descriptions of the coverage for durable medical equipment, including additional equipment and home modifications available to eligible MSHO and MSC+ members through home and community based services, level of coverage available, and criteria and procedures for any Service Authorizations, and also the address and telephone number of 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;

(r) A description of the Enrollee's right to request information about Physician Incentive Plans from the MCO, including whether the MCO uses a Physician Incentive Plan that affects the use of referral services, the type of incentive arrangements, whether stop-loss protection is provided, and a summary of survey results; and

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

(B) A Pharmacy Directory. For MSHO, this directory must be an integrated Medicare and Medicaid pharmacy directory.

(C) Provider Directory.

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

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

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

(4) The Provider directory document may be posted on the MCO's web site. The document must meet all of the *Provider Directory Guidelines* and may not differ from the State-approved paper copy. Enrollees may choose to access this document electronically instead of receiving a paper copy pursuant to section 3.6.9 below.

(5) The MCO must provide a list of EW service Providers who are available to eligible Enrollees based on the Enrollee's place of residence. If the MCO uses an open network of all MHCP enrolled providers for some or all service types, the MCO must state on the list that additional providers from other areas of the State are available and a telephone number to call to find out the names of additional providers the Enrollee may use. This EW list shall be updated annually and shall include a phone number where an Enrollee may call to verify or receive current information. The MCO may choose to include EW service providers in the Provider Directory. See also section 9.3.22, Elderly Waiver Provider Subcontracting..

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

(D) Identification Card.

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

(2) For MSC+, an identification card that conforms to the requirements in Minnesota Statutes, § 62J.60, subd. 3.

(3) MSHO and MSC+ cards must be approved by the STATE prior to printing. The card must identify the Recipient as an MCO Enrollee and contain an MCO telephone number to call regarding coverage, procedures, and Grievances and Appeals. The identification card shall demonstrate that the Enrollee is a Recipient of MHCP, either by printing the Enrollee's STATE PMI number on the card, or by other reasonable

means. The card may include data elements required by CMS for Medicare eligible Enrollees. Additionally, the MCO and/or its Pharmacy Benefit Manager subcontractor must assign a unique BIN/PCN combination that will only be used for MHCP enrollees, including Medical Assistance, MinnesotaCare, and dual eligible integrated programs. The same BIN/PCN combination can be used for all MHCP programs. The MCO and/or PBM must not use the same BIN/PCN combination for its commercial or standalone Medicare Part D enrollees. The MCO must provide the unique BIN/PCN combination numbers to the STATE by March 1, 2014. The revised identification card containing the unique BIN/PCN combination must be distributed to the MCO's Enrollees no later than March 31, 2014.

(E) A website accessible to Potential Enrollees and 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.

3.6.7 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 3.6.6. The MCO must notify the STATE and provide a brief explanation in writing within two (2) working days if the MCO cannot comply with the time frame specified in section 3.6.6.

3.6.8 Primary Care Network List (PCNL).

(A) Specifications. The MCO must supply all Local Agencies within its Service Area with copies of a standardized document (known as a Primary Care Network List, or PCNL) that provides information about the MCO's Medicare and Medicaid Provider network and that includes a description of the essential components of the MCO, to be used by the STATE and Local Agencies to educate consumers. If the MCO also provides its PCNL in alternative format pursuant to section 3.6.9, then the MCO must also supply all Local Agencies within its Service Area with such alternative format. This document must follow the STATE specification as indicated in the STATE model document entitled "*PCNL Guidelines*" posted on the STATE's managed care website and must be prior approved by the STATE in accordance with section 3.6.5(A).

(B) The document must contain the following information:

(1) A list of Participating Providers with summary information, which shall include but is not limited to, addresses and phone numbers including clinics, Primary Care physicians, specialists, hospitals, Nursing Facilities, and Care Systems. The MCO may satisfy or partially satisfy the requirement to list specialists by listing multi-specialty clinics. The PCNL must indicate Providers who speak a non-English language and identify Providers that are not accepting new patients within the Service Area at the time the list is prepared. The MCO must also provide information upon request regarding a specific Provider, including specialists, if the

Provider is not listed in the PCNL. The MCO may list other affiliated Providers and their addresses or provide a toll-free phone number where a Potential Enrollee may call to obtain the specific information. The information required by this section may be posted on the MCO's web site but the MCO must continue to provide paper copies to the STATE and the counties.

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

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

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

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

(6) 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.

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

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

(9) 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 he or she is accepting new patients. This health plan may not cover all your health care costs. Read your contract, or 'Evidence of Coverage,' carefully to find out what is covered."

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

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

(11) 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 PCNL pursuant to the STATE's specifications, in quantities sufficient to meet the STATE's need. If the MCO also provides its PCNL in alternative format pursuant to section 3.6.9, then the MCO must also supply all Local Agencies within its Service Area with such alternative format. This time period may be waived by the STATE for the initial enrollment of current MCO MSC+ Enrollees into the MCO's MSHO product. The MCO must update the PCNL as necessary to maintain accuracy, particularly with regard to the list of Participating Providers, but not less than twice per year. The PCNL and all revisions to the PCNL must be submitted to the STATE along with a cover letter detailing all changes in the PCNL. The PCNL must be approved in writing by the STATE pursuant to section 3.6.3(A)(1). Such approval by the STATE shall not be unreasonably withheld. The MCO shall distribute the PCNLs to the Local Agencies and the STATE in a timely manner. The STATE shall respond to inquiries by the Local Agencies in a timely manner and shall communicate any issues or problems regarding distribution of the PCNLs to the MCO.

3.6.9 Provision of Required Materials in Alternative Formats. The STATE or the MCO may provide in an alternative (other than paper) format enrollment materials such as a PCNL, Provider Directory andEOC, or materials otherwise required to be available in writing under 42 CFR § 438.10, pursuant to Minnesota Statutes, § 256B.69, subd 30. If the MCO provides the materials in an alternative format, the materials must also comply with the accessibility standards of Section 508 of the Rehabilitaiton Act of 1973. See http://www.w3.org/TR/WCAG20/#guidelines.

(A) The STATE or MCO informs the Enrollee that:

(1) an alternative format (other than paper) is available and the Enrollee affirmatively requests of the STATE or MCO that the PCNL, Provider Directory, EOC, or materials be provided in an alternative format; and

(2) a record of the Enrollee request (whether to receive materials in alternative formats or withdraw the request) is retained by the STATE or MCO in the form of written or electronic direction from the Enrollee or a documented telephone call followed by a confirmation letter to the Enrollee from the STATE or MCO that explains that the Enrollee may change the request at any time;

(B) if the materials contain individually identifiable Enrollee data, the materials are sent to a secure electronic mailbox and are made available at a password-protected secure electronic Web site or on a data storage device;

(C) The Enrollee is provided an MCO customer service number on the Enrollee's identification card that may be called to request a paper version of the materials provided in an alternative format; and

(D) The materials provided in an alternative format meets all other requirements of the Contract regarding content, size of the typeface, and any required time frames for distribution.

(E) The MCO may provide in an alternative format its PCNL to the STATE and to Local Agencies within its service area. The STATE or Local Agency, as applicable, shall inform a Potential Enrollee of the availability of an MCO's PCNL in an alternative format. If the Potential Enrollee requests an alternative format of the PCNL, a record of that request shall be retained by the STATE or Local Agency. The Potential Enrollee is permitted to withdraw the request at any time.

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

3.6.11 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.

3.6.12 Additional Information Available to Enrollees. The MCO shall furnish the following information to Potential Enrollees and Enrollees upon request:

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

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

(C) Any 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.

3.6.13 Potential Enrollee and Enrollee Education.

(A) 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, electronic and/or written materials the various MCOs available to Recipients in a particular geographic area and will assist in completing the enrollment process by securing an electronic or written signature of Recipients or their Authorized Representatives on the enrollment form. For MSHO, the MCO also may complete enrollment For Enrollees in MSC+ who are assigned to an MCO, a signature will not be obtained.

(B) Tribal governments may assist the STATE or Local Agency in presenting or developing materials describing the various MCO options for their members. If the tribal government revises any MCO materials, the MCO may review them prior to distribution. If the MCO deems the revisions to be substantial, the MCO shall have thirty (30) days to respond to the tribal government and no MCO materials will be distributed until there is mutual agreement on the revisions.

(C) 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.

(D) This section does not prohibit the MCO or its subcontractors from providing information to Potential Enrollees eligible for MSHO for the purposes of educating them about Provider choices available through the MCO, subject to the limitations in the Marketing Restrictions section.

(E) Local Agency staff and MCO staff shall make available to Recipients the information about Providers as specified in section 3.6.8.

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

(A) Material Modification of Provider Network.

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

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

(a) One of the Primary Care Providers they have used in the past is no longer available and that the Enrollee 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; or

(b) One of the major subcontractors providing a network of Providers, including but not limited to the behavioral health network, pharmacy benefit manager, care system, care coordination/case management entity or dental network will no longer be available in the MCO's network and that access to these services may require that the Enrollee choose a different provider for these services or be assigned a different care coordinator/case manager.

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

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

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

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

3.7 Reporting Requirements.

3.7.1 Encounter Data

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

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

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

(2) The MCO shall submit encounter data that includes all paid lines associated with a claim, and effective with encounter data submissions for March of 2014, include those denied claims and lines for which Medicare or another Third Party has paid in part or in full. No later than August 1, 2014 and continuing thereafter, the MCO will submit all denied claims as defined by the STATE and will work collaboratively with the Encounter Data Quality Unit to ensure compliance with the CMS T-MSIS (Transformed Medicaid Statistical Information System) data project.

(3) Claim-level data must be reported to the STATE using the following claim transaction formats: 1) the X12 837 standard format for physician, professional services, physician-dispensed pharmaceuticals (837P), specified Elderly Waiver Services (837P), inpatient and outpatient hospital services, Nursing Facility services (837I), and dental services that are the responsibility of the MCO (837D); and 2) the

NCPDP Batch 1.2/D.0 pharmacy. The MCO may submit the NCPDP Batch 1.2/D.0 for non-durable medical supplies which have an NDC code.

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

(5) The MCO shall submit on the encounter claim for NCPDP Batch 1.2/D.0, 837P, 837D, and 837I the Provider allowed and paid amounts.

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

(b) For the purposes of this section "paid amount" is defined as the amount paid to the Provider excluding Third Party Liability, Provider withhold and incentives, and Medical Assistance cost-sharing. For the purposes of this section "allowed amount" is defined as the Provider contracted rate prior to any exclusions or add-ons. In accordance with Minnesota Statutes, §256B.69, subd. 9c, (a), the data reported herein is non-public and is defined in Minnesota Statutes, §13.02.

(6) The MCO will submit Medicaid drug information on pharmacy (NCPDP Batch 1.2/D.0), professional (837P) and institutional (837I) encounter claims in accordance with STATE data element specifications related to the collection of drug rebates. These specifications will be outlined in the *Encounter Companion Guides* for the NCPDP Batch 1.2/D.0 Pharmacy, 837 Professional and 837 Institutional encounter claims. The MCO and its subcontractor, if applicable, must comply with these specifications and submit encounter data bi-weekly, every two weeks and no later than 30 days after the MCO (or its subcontractor) adjudicates these outpatient pharmacy and physician-administered drug claims in order for the STATE to comply with 1927(b), 1903m(2)(A) and 1927(j)(1) of the Social Security Act as amended by Section 2501 (c) of the Patient Protection and Affordable Care Act.

(7) The STATE shall provide the MCO with an electronic listing of all enrolled MHCP Providers and their NPI or UMPI numbers on a monthly basis. The MCO must update the Provider identification numbers by submitting, for Providers who are new to the MCO and do not already have a STATE Provider number (UMPI) or NPI, current and complete demographic information about the Provider, on a form approved by the STATE. The MCO shall not require Providers to enroll as an

MHCP FFS Provider. If a Provider will only be serving MCO Enrollees, the MCO shall follow the process established by the STATE for MCO-only Providers.

(8) The MCO shall comply with the applicable provisions of Subtitle F (Administrative Simplification) of the Health Insurance Portability and Accountability Act of 1996 and any regulations promulgated pursuant to its authority, including the 5010 transaction standards. The MCO shall cooperate with the STATE as necessary to ensure compliance.

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

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

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

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

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

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

(15) The MCO should not submit encounters for administrative care coordination. Case management services provided for an Enrollee on EW should be submitted per section 3.7.1(B)(11).

(C) The MCO shall submit all encounter claims no later than thirty (30) days after the date the MCO adjudicates the claim, including submission of all claim adjustments by either submitting a replacement claim or voiding out the original claim and submitting a new claim. The MCO shall make submissions for each transaction format at least bi-weekly. If the MCO is unable to make a submission during a certain month, the MCO shall contact the STATE to notify it of the reason for the delay and the estimated date when the STATE can expect the submission.

(D) For all encounter claims, when the STATE returns or rejects a file of claims, the MCO shall have twenty (20) calendar days from the date the MCO receives the file to resubmit the file with all of the required data elements in the correct file format.

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

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

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

(1) Community Mental Health Clinics;

(2) Physician Clinics;

(3) Dental Clinics;

(4) County Contracted Mental Health Providers;

(5) Indian Health Care Providers, where applicable;

(6) Federally Qualified Health Centers;

(7) Rural Health Clinics;

(8) Chiropractic Clinics;

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

No treating Provider is required for any other claim type.

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

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

(J) Coding Requirements.

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

(a) Diagnosis and inpatient hospital procedure codes obtained from the International Classification of Diseases, Clinical Modification (ICD-9-CM); for dates of service/inpatient discharge dates through September 30, 2014. Effective for dates of service/inpatient discharge dates on October 1, 2014 and thereafter, the MCO must ensure that its providers and the MCO comply with ICD-10-CM/PCS coding requirements on claim and encounter data submissions;

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

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

(d) National Drug Codes;

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

(2) The MCO and its subcontractors must utilize the coding sources as defined in this section and follow the instructions and guidelines set forth in the most current versions of ICD-9-CM for dates of service/inpatient discharge dates through September 30 2014, ICD-10-CM/PCS for dates of service/inpatient discharge dates on October 1, 2014 and thereafter, HCPCS and CPT. The MCO will cooperate with the STATE as necessary, including participating in a workgroup to ensure the MCO will be in compliance with ICD-10 CM/PCS coding requirements when ICD-10 implementation takes effect October 1, 2014. The STATE may request additional information on the MCO's ICD-10 CM/PCS implementation.

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

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

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

(L) 2014 Encounter Data Process. The STATE will be changing the process it uses to collect encounter data to be more consistent with emerging national standards and with other encounter data collection in Minnesota. Although the data elements that are currently required will continue to be required, the field locations could change, and there will be additional data elements to be collected. The data format file (envelope) that transmits the data will change.

(1) The STATE anticipates contracting with a vendor that will assist the STATE with the development and the implementation of a standardized data collection that the STATE anticipates will be operational in 2014. The STATE expects to implement the new data collection process by the summer of 2014. The standardized data collection will allow the STATE to more efficiently and quickly understand healthcare costs, quality and utilization.

(2) The STATE will convene a workgroup with MCO representatives in the beginning of calendar year 2014 to develop a work plan for implementing the new data format file and to incorporate the new data elements and changes to existing data fields. The MCO agrees to work with the STATE to implement the work plan and will have sixty (60) days to make the necessary changes to support the new process of collecting encounter data.

(3) Encounter Data Quality Assurance Program. The MCO shall participate in a quality assurance program that verifies timeliness, completeness, accuracy and consistency of encounter data that is submitted to the STATE. The STATE in consultation with the MCOs has developed quality assurance protocols for the program, which will be evaluated by an independent third party auditor for the capacity to ensure complete and accurate data and to evaluate the STATE's implementation of the protocols. The protocols are available on the DHS web site.

(M) Encounter Data for the Supplemental Recovery Program

(1) The STATE will be using encounter data to implement the Supplemental Recovery Program described in Minnesota Statutes, § 256B.69, subd. 34. The MCO shall work with the DHS Encounter Data Quality Unit to establish the encounter data changes needed to carry out the requirements of the program, and to test system readiness and accuracy of data submitted.

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

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

(B) Service Delivery Plan. Any substantive changes in the Service Delivery Plan previously submitted shall be provided by the MCO to the STATE within thirty (30)

days of the effective date of this Contract and prior to any subsequent changes made by the MCO. The STATE must approve all changes to the MCO's Service Delivery Plan.

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

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

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

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

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

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

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

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

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

(D) Documentation of Care Management/ Case Management/ Care Coordination Plans. The MCO shall maintain documentation sufficient to support its Care Management/ Case Management/ Care Coordination responsibilities set forth in sections 6.1.4 and 6.1.5, and for Elderly Waiver services set forth in section 6.1.13. Upon request of the STATE, the MCO shall provide the STATE or its designee access to a random sampling of Care Management/Case Management/Care Coordination care plans of MCO Enrollees.

(E) Provider Network Information.

(1) The MCO will submit to the STATE a complete listing of its Provider network in accordance with the specifications outlined in the STATE's provider network template posted on the STATE's website. The MCO will submit its entire Provider network February 5, 2014 and the fifth of every month thereafter to the STATE's provider data repository. The MCO will work with the STATE to ensure that its monthly Provider network data submission is complete, accurate, and timely and will resolve any issues necessary to successfully submit the data. For MSHO, contracted Home and Community-Based Services, and Nursing Facility providers; and providers of Medicare and Medicaid services must be included.

(2) The MCO must submit annually, by April 1st of the Contract Year a complete list of all Tier I HCBS, EW and Nursing Facility providers including contracted and open access providers that the MCO has paid in the previous calendar year including the name, address, and type of service provider, in a format specified and provided by the State.

(3) If the MCO has chosen to contract with a specific Tier I EW provider type or Nursing Facility providers through contracting, the MCO must submit geo-mapping of the MCO service area for each contracted provider type in a format specified and provided by the State with input from the MCO. See also section 9.3.22 and Appendix VI, HCBS Tiers.

(4) Upon request by the STATE, the MCO will provide information about the qualifications of mental health and chemical dependency Providers, with at least sixty (60) days' notice.

(F) Financial Information.

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

(2) The MCO shall provide to the STATE the information outlined in Minnesota Statutes, §256B.69, subd. 9c in a format and manner specified by the STATE in accordance with STATE guidelines developed in consultation with the MCO. The MCO will submit the information on a quarterly basis no later than sixty (60) days after the end of the previous quarter, except for the fourth quarter report that shall be submitted by April 1st of each year. The fourth quarter report shall also include audited financial statements, parent company audited financial statements, an income statement reconciliation report, and any other documentation necessary to reconcile the detailed reports to the audited financial statements. The STATE will provide the format by February 10, 2014.

(3) In the event a report is published or released based on data provided under this section, the STATE shall provide the report to the MCO fifteen (15) days prior to the

publication or release of the report. The MCO shall have fifteen days to review the report and provide comments to the STATE.

(G) HCC Risk Adjustment. The MCO SNP will notify the STATE or its actuarial firm of its restated mid-year HCC risk adjustment score and additional HCC Frailty factor score for MSHO. Scores will be from restated data based upon the preceding calendar year as reported by CMS. The MCO SNP will send this information to the STATE, or its actuaries, within thirty (30) days of CMS making it available to the MCO. The actuarial firm may share information about the risk score with the STATE, but the STATE will not receive copies of this information. The MCO must identify this information as trade secret prior to, or at the time of its submission for the STATE to consider classifying it as non-public, as described in section 9.6.

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

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

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

(K) Administration and Subcontracting Information. Information relating to MCO administration and subcontracting arrangements, as specified by the STATE and CMS.

(L) Health Care Home, Alternative Models or Integrated Care System Partnerships.

(1) Reporting for Health Care Homes. The MCO shall require that the Health Care Home provider report data to the Minnesota Department of Health as required in Minnesota Statutes, § 256B.0751, as a condition of contracting between the MCO and Health Care Home. For MSHO and MSC+, the report need not include data on pediatric care coordination.

(2) Reporting Requirement for Health Care Homes under Alternative Payment Arrangements The MCO shall annually provide a description of each comprehensive payment arrangement, and its proposed outcome or performance measures that the MCO will use as an alternative to Health Care Homes payment.

(a) The descriptive report is due July 1 of the Contract Year and shall include the following:

i) Identify each sub-contractor for whom the MCO is paying a comprehensive payment arrangement in lieu of the standard Health Care Home coordination fee, and include:

ii) Identify the number of Enrollees served under each arrangement;

iii) Identify whether the Provider is certified as a Health Care Home or health home;

iv) Describe the payment arrangements

v) Describe the process for tracking total costs of care, if the model includes a TCOC arrangement;

vi) Describe the process for assigning or attributing Enrollees;

vii) Describe the services included in the total cost of care arrangement if the model includes a TCOC arrangement (for example, whether long term care, Medicare and Medicaid costs and chemical, mental and/or behavioral health services are included, and whether any services are carved out of the arrangement);

viii) Describe the MCO's process for overseeing the entities and evaluating their performance;

ix) Describe quality indicators used to measure performance;

x) Describe the benchmarks used to determine whether the Provider entity is within the costs of care expectations.

(b) The summary of the performance measures and outcomes for the previous Contract year is due at the end of the first quarter of the following Contract Year

(3) Reporting Requirement for ICSP. If reporting a subcontracting arrangement under this section, the MCO does not need to report the arrangement in the previous section as a Health Care Home Alternative Payment arrangement. The MCO shall annually provide a description of each ICSP payment arrangement, a brief report of implementation of ICSPs, and ICSP outcome or performance.

(a) The descriptive report is due July 1 of the Contract Year and shall include the following:

i) Identify each subcontractor for whom the MCO is paying an ICSP payment type arrangement including service area, target population and number of enrollees served;

ii) Identify whether the subcontractor is certified as a Health Care Home of Health Home or N/A if not applicable. (If not, please indicate if the provider is in the process of becoming a HCH);

iii) Describe the ICSP payment type, including the identification of which payment type and model option described in Appendix V is being used;

iv) Describe the services included within each identified payment arrangement;

v) Describe the process for assigning or attributing Enrollees;

vi) Describe the process for tracking total costs of care, if the model includes a TCOC arrangement;

vii) Describe the MCO's process for overseeing the subcontractors and evaluating their performance;

(b) The brief ICSP implementation report is due March 30 of the Contract Year and shall include a brief summary of implementation efforts since the previous report.

(c) The summary of the performance measures and outcomes for each ICSP arrangement for the previous Contract Year is due at the end of the third quarter of the Contract Year:

i) Describe quality indicators used to measure performance;

ii) Describe the benchmarks used to determine whether the Provider entity is within the costs of care expectations;

iii) Describe the plan for documenting and reporting progress results for each identified measure including whether the measure was successful or not successful. For measures noted as not successful indicate potential causes, attempted interventions to meet benchmarks and next steps to ensure success going forward;

iv) Identify new measures that need to be initiated and/or measures that need to be discontinued, clearly indicating the reasons for starting or stopping a particular measure.

(M) Third Party Resources. Pursuant to section 10.2, the MCO shall report to the STATE any additional Third Party Resources, including Long Term Care Insurance, except for Medicare.

(N) Third Party Payments. Pursuant to section 10.4 the MCO shall report all recovery and Cost Avoidance amounts on the encounter claim as Third Party Liability payments. For MSC+, Medicare cost avoidance and recovery amounts must include fee-for-service Medicare. For MSHO, the MCO shall also report an estimate of Medicare payment, and may base the estimate on the methodology used for submitting bids to CMS to derive the amount.

(O) Cost Avoidance and Recoveries. Pursuant to section 10.4 and 3.7.2(F), for MSHO, the MCO shall, on a quarterly basis, disclose to the STATE all Cost Avoidance and recovered amounts in a format specified by the STATE. For MSC+, Medicare cost

avoidance and recovery amounts must include fee-for-service Medicare. For MSHO, the MCO shall also report an estimate of Medicare payment, and may base the estimate on the methodology used for submitting bids to CMS to derive the amount.

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

(Q) Disclosure of Ownership and Management Information for the MCO. By September 1st of the Contract Year, the MCO shall report to the STATE full disclosure information in order to assure compliance with 42 CFR § 455.104. The MCO shall also report full disclosure information upon a request from the STATE or within thirty-five (35) days of a change in MCO ownership. The required information includes:

(1) The name, address, date of birth, social security number (in the case of an individual) and tax identification number (in the case of a corporation) of each Person, with an Ownership or Control Interest in the MCO or in any subcontractor in which the MCO has direct or indirect ownership of five percent (5%) or more. The address for corporate entities must include primary business address, every business location and P.O. box address;

(2) A statement as to whether any Person with an Ownership or Control Interest in the MCO or in any subcontractor as identified in section 3.7.2(Q)(1) is related (if an individual) to any other Person with an Ownership or Control interest as a spouse, parent, child, or sibling;

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

(4) The name, address, date of birth, and social security number of any managing employee of the MCO.

(R) Disclosure of Transactions. The MCO must report to the STATE or CMS information related to business transactions in accordance with 42 CFR §455.105(b). The MCO must be able to submit this information within thirty-five (35) days of the date of a written request from the STATE or CMS.

(1) The ownership of any subcontractor (as defined below) with whom the MCO has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12) month period ending on the date of the request; and

(2) Any significant business transactions ($25,000 or five percent (5%) of the MCO's total operating expenses, whichever is less) between the MCO and any wholly owned supplier, or between the MCO and any subcontractor (as defined below), during the five (5) year period ending on the date of the request.

For purposes of section 3.7.2(R)(1) and (2), 42 CFR §455.101 defines subcontractor as an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its Enrollees.

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

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

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

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

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

(T) Health Care Expenditures. Pursuant to Minnesota Statutes, § 16A.725, the MCO shall provide to the STATE, no later than February 1st of the Contract Year, all health care service expenditures for the previous State fiscal year. The report shall include expenditures certified by the MCO paid July 1st through June 30th of the year preceding the Contract Year, combining expenditures under all of the MCO's 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 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, Dental, Home Health, Pharmacy; and Skilled Nursing Facility).

(U) Chemical Dependency Room and Board Services. The MCO will provide a quarterly report to the STATE that identifies the CD room and board services that were authorized in combination with CD treatment pursuant to the Rule 25 assessment criteria. The report will be in accordance with the STATE's specifications and will include only those CD room and board services for which the MCO issued payment and submitted an encounter claim to the STATE. The report will be submitted no later than thirty (30) days following the end of each quarter. The MCO must certify the quarterly report in accordance with section 9.10. As of July 1, 2014, the MCO is not responsible for room and board services provided in residential chemical dependency treatment services and will no longer be required to submit the quarterly report for dates of services on July 1, 2014 and later.

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

(W) Patient-centered Decision-making. In accordance with Minnesota Statutes, §256B.69, subd. 9(c), the MCO shall require its contracted or employed Providers to use patient-centered decision-making tools and/or procedures designed to engage Enrollees early in the decision-making process. The STATE and MCO shall work collaboratively on a process to survey providers on the availability and use of these tools. The MCO will submit a report to the STATE by September 1st of the Contract Year on the extent that these decision-making tools and procedures were used by providers with Enrollees and the steps the MCO took to encourage providers to use the tools and procedures.

(X) Reporting on MSHO Stakeholder Group. For the MCO's local or regional stakeholder group (as required in section 7.4.4) the MCO will submit to the STATE twice per Contract Year, on or before June 15th and December 15th, documentation in the form of stakeholder meeting agendas and meeting minutes that demonstrate the MCO response to significant concerns raised by stakeholder group participants.

3.7.3 Electronic Reporting Data Capability.

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

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

(1) Accept and transmit eligibility transactions;

(2) Accept claims transactions; and

(3) Transmit payment and remittance advice.

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

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

3.9 Special Needs Plan Duties

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

(A) The MCO shall notify the STATE, consistent with section 3.6.14, of any material changes in its contract with CMS as a Special Needs Plan, including but not limited to, termination of the contract by either party.

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

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

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

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

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

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

(F) Dual Demonstration. The MCO agrees to participate in the CMS Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience (Demonstration) as a Fully Integrated Medicare Advantage Dual Eligible Special Needs Plan (FIDE SNP, as defined in 42 CFR § 422.2 and further defined by CMS in the 2014 SNP Application) for MSHO enrollees as outlined in the Memorandum of Understanding between CMS and the STATE. The demonstration's goals will be to improve the integration of Medicare and Medicaid through increased participation of integrated provider health care delivery systems, improve enrollee health outcomes as measured through risk adjusted quality metrics appropriate to the enrolled population, and to align administrative systems to improve efficiency and beneficiary experience.

(1) The STATE will include the MCO in regular calls between CMS and the STATE to work out details of any provisions of the demonstration affecting the MCO's Medicare SNP and Medicaid operations, provider networks, provider contracting and policies.

(2) The STATE will establish a work group for consultation with the MCOs on work plan development and implementation of the demonstration. Topics shall include:

(a) CMS-STATE Contract Management Team, section IV (G) of the MOU;

(b) CMS-STATE Network Adequacy Review Process, section III (a) of the MOU;

(c) MCO's SNP Contract Amendment as proposed by CMS;

(d) Integration of the CAHPS survey to streamline administration, and

(e) Streamlining of quality assurance reporting and testing of potential quality measures; and

(f) Other MOU items as necessary.

(G) Integrated Care System Partnerships.

(1) The MCO shall develop and maintain coordination of care and other arrangements with primary, acute and long term care providers as outlined in Appendix V, Integrated Care System Partnerships.

(2) The MCO will participate in a clinical work group for continuing development of ICSP quality metrics, and reporting for ICSP models.

3.9.2 Communications For Dual Eligible Persons. The MSHO MCO agrees to integrate all Medicare (including Part D) and Medicaid materials provided to Enrollees and Potential Enrollees to the extent allowed by CMS and the STATE. The STATE and the MCO will develop model materials for this purpose through the collaborative MSHO Plan Member Materials Workgroup per section 3.6.4(C) above . The MCO will work with the STATE to assure that where CMS language misrepresents, or does not cover information about all Medicare and Medicaid benefits available to Duals, clarifying language is included.

3.9.3 Continued Integration of Medicare and Medicaid Benefits under MSHO and MOU. The MCO will cooperate with the STATE and CMS under the terms of this Contract and the MOU to promote the continued integration of Medicare and Medicaid benefits for MSHO Enrollees. The MCO shall respond to reasonable requests from the STATE for SNP operational, benefit, network, financial and oversight information that directly impacts the continued integration of Medicare and Medicaid benefits in order to maintain a seamless service delivery of Medicare and Medicaid benefits to Enrollees. The MCO shall notify the STATE of significant changes in Medicare information to beneficiaries, benefits, networks, service delivery, oversight results or policy that are likely to impact the continued integration of Medicare and Medicaid benefits under this contract. The STATE shall notify the MCO of Medicaid changes that are likely to affect its CMS SNP contract.

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

3.9.5 SNP Participation Requirement for MSHO; Medicare Savings.

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

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

3.9.6 Medicare Medication Therapy Management Programs. The MCO will provide the STATE with an update of its current Medicare Medication Therapy Management programs and protocols upon request of the STATE.

Article. 4 Payment.

4.1 Payment of Capitation.

4.1.1 Payment. Except as noted below in section 4.1.2, on the STATE's first warrant date or the 14th day of each month, whichever is earlier, the STATE agrees to pay the MCO the following rates as specified in the Payment Appendices attached hereto, per month, per Enrollee enrolled with the MCO as full compensation for Medical Assistance 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.

4.1.2 Exceptions to Payment Schedules. Section 4.1.1 does not apply to:

(A) Capitation Payments for services provided in the month of June, for which payment shall be made no earlier than the first day of each July, pursuant to Minnesota Statutes, § 256B.69, subd. 5d; and

(B) With thirty (30) days advance notice, at the request of the office of Minnesota Management and Budget for purposes of managing the state's cash flow, the STATE may delay the capitation payment for up to two full warrant cycles twice during the course of this Contract. One delay may take place between January 1 and April 30 of the Contract Year. A second delay may take place between August 1 and December 31 of the Contract Year.

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

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

(E) Return of Withheld Funds. As required by Minnesota Statutes, § 256B.69, subd. 5a:

(1) The Non-Performance-Based Total 47.37% (4.5 / 9.5 x 100) of the withheld funds shall be returned with no consideration of performance, no sooner than July 1st and no later than July 31st of the subsequent Contract Year.

(2) The Performance-based Withhold will also be returned as required by Minnesota Statutes, § 256B.69, subd. 5a.

(F) Payments to the MCOs for the services in section 4.2.12, Payments for Services Furnished by Certain Primary Care Physicians in Calendar Years 2013 and 2014. shall be paid as one or more additional payments separate and apart from capitation payments to the MCO. MCO claims not consistent with encounter data held by the STATE cannot be paid until verified.

(1) Retrospective payment, for the sole use of complying with Section 1202 of the ACA, for claims made and paid in 2013 shall be made by the STATE no later than the end of the first quarter of 2014.

(2) Retrospective payment, for the sole use of complying with Section 1202 of the ACA, for claims made and paid in 2014 shall be made by the STATE on a quarterly basis.

4.2 Medicaid Capitation Payment. The STATE will pay to the MCO a Medicaid Capitation Payment for each Enrollee in accordance with Article 4 for the month in which coverage becomes effective and thereafter until termination of Enrollee coverage pursuant to section 3.2 becomes effective.

4.2.1 Medicare:

(A) For MSHO Enrollees with only Part A or Part B, the STATE will pay the Medicaid capitation until the Enrollee is disenrolled from MSHO.

(B) During periods when an Enrollee with only one part of Medicare is enrolled in MSHO, the MCO or its subcontractors may bill Medicare fee-for-service for services covered by Medicare.

4.2.2 Description of Rate Cell Category Components.

(A) For MSHO.

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

(a) Medicaid Institutional Basic Care rate.

(2) The MSHO Community EW Rate Cell Category includes the following components, which are adjusted for age, sex and county or region:

(a) Medicaid Non-Institutional Basic Care rate.

(b) Elderly Waiver Add-On.

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

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

(a) Medicaid Non-Institutional Basic Care rate.

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

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

(a) Medicaid Non-Institutional Basic Care rate.

(5) The MSHO Community EW Hospice Rate Cell Category includes the following components, which are adjusted for age, sex and county or region:

(a) Medicaid Non-Institutional Basic Care rate.

(b) 50% of the Elderly Waiver Add-On.

(B) For MSC+.

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

(a) Medicaid Institutional Basic Care payment rate.

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

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

(b) EW Waiver Add-On.

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

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

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

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

4.2.3 Assignment of Rate Cells. Assignment of Rate Cells may be made based on:

(A) Information on the STATE MMIS,

(B) Information entered into MMIS by the MCO,

(C) Information contained on the MCO Enrollment Form,

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

(E) As specified by the STATE and CMS.

4.2.4 Requirements for Assignment of Rate Cell Categories for MSHO

(A) For MSHO:

(1) Categories. Rate Cell Categories shall be assigned by the STATE upon receipt of the required information as specified in this section and section 3.1.5 above. Rate Cell Categories shall be assigned prospectively for the next available month.

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

(3) Post-Cut-Off Changes. When a Rate Cell Category change has been entered in the STATE MMIS after the enrollment Cut-Off Date, the MCO will be paid at the rate corresponding to the new Rate Cell Category at the time of the MCO's next Capitation Payment, unless the requirements provided for in section 4.2.8 are met.

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

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

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

(5) Community Elderly Waiver (Rate Cell Category "B" and "C"):

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

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

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

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

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

(d) EW services must be delivered to Enrollees who meet the EW Level of Care criteria based on demonstrated need, and are eligible for payment of LTC services.

MCOs are responsible for delivery of EW services even if the EW Rate Cell component was not paid in a given month.

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

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

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

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

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

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

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

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

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

4.2.6 Requirements for Assignment of Rate Cell Categories for MSC+.

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

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

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

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

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

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

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

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

(5) Institutionalized Rate Cell.

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

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

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

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

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

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

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(A) The STATE shall make payments to the MERC Trust Fund on behalf of the MCO up to the aggregate dollar amount carved out of the Medical Assistance capitation rates and paid to the MERC Trust Fund in state fiscal year 2009 (the baseline year for MERC funds), consistent with Minnesota Statutes, § 256B.69, subdivision 5c.

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

4.2.11 Contingent Reduction in Health Care Access Tax. The Commissioner of Management and Budget shall, by December 1 of the Contract Year, determine the projected balance in the Health Care Access Fund. If the projected balance for the biennium reflects a ratio of revenues to expenditures and transfers greater than one-hundred and twenty-five percent (125%) and if the actual cash balance in the Fund is adequate, the Commissioner of Management and Budget shall reduce the tax rates under subdivisions 1, 1a, 2, 3, and 4 of Minnesota Statutes, § 295.52, for the subsequent calendar year sufficient to reduce the structural balance in the Fund, as described in Minnesota Statutes, § 295.52, subd. 8. The reduction, if any, shall be included in the rates shown in the Payment Appendices.

4.2.12 Payments for Services Furnished by Certain Primary Care Physicians in Calendar Years 2013 and 2014. Consistent with the requirements of § 1902(a)(13)(C) of the Social Security Act, as amended by the Affordable Care Act of 2010 and published in the Final Rule (FR Vol. 77, No. 215, November 6, 2012, pages 66670-66701), and technical specifications provided by the STATE, the MCO shall:

(A) In regard to the enhanced primary care payment specified by 42 CFR 447, subpart G:

(1) For dates of service in calendar years 2013 and 2014, make payments to eligible primary care physicians as defined in 42 CFR § 447.400 at a rate equal to or greater than the rates specified in 42 CFR § 447.405. For claims already made and paid, "payment" means an additional increment such that the total is equal to or greater than the rates specified in 42 CFR § 447.405.

(2) Pay at the rates in section 4.2.12(A)(1) above all eligible claims that were made and paid in 2013 and 2014 without requiring rebilling or any other effort from the provider, consistent with section II.A.5. (page 66687, col 2) of the Final Rule.

(3) Provide to the STATE by February 17, 2014, a data report listing each claim made and paid in calendar year 2013 that is to be paid at the rates in (1) above, in a format determined by the STATE. For calendar year 2014, the MCO shall provide the data report within thirty (30) days of the end of each quarter. The reports must be certified according to section 9.10 of the Contract. The STATE will review this report and if found reasonable in accordance with specifications established by the STATE, will pay the MCO the verified additional payment in (1) above.

(4) Assure that payment at the rates in (1) above is directed to the individual primary care physicians and advanced practice clinicians under the supervision of the primary care physicians, consistent with section II.A.1.b. (page 66677, col. 2) of the Final Rule. The MCO shall distribute the additional payments as specified in the STATE's data report listing each verified claim accompanying its payment to the MCO. Payment at the rates in (1) above shall be made whether the primary care physicians are in or Out of Plan, consistent with section II.A.1.a. (page 66675, col. 2) of the Final Rule; and shall be made regardless of the structure of the MCO's network, consistent with section II.A.2.a. (page 66680, col. 2) of the Final Rule. Such enhanced payments shall not be made for physician services delivered at RHCs and FQHCs, consistent with section II.A.1.b. (page 66676, col. 1) of the Final Rule.

(5) Make payment at the rates in (1) above on a lump sum basis no longer than thirty (30) days after receipt of the funds from the STATE.

(6) Reimburse for services not covered by Medicare at the rates specified by CMS, consistent with section II.A.2.b. (page 66681, col. 3) of the Final Rule.

(7) Promptly make available to the STATE related documentation, including but not limited to reports, encounter claims and physician self-attestations, to enable the STATE to verify the payments at the rates in (1) above as well as to audit or reconcile the payment, consistent with section II.A.5. (page 66688, col. 2) of the Final Rule. Such data must be certified according to section 9.10 of this Contract.

(8) Conduct an annual review of physician self-attestations for only those attestations which the MCO collected and reviewed, and provide to the STATE a letter of assurance that such physician self-attestations have been sampled and found valid, consistent with section II.A.1.a. (page 66675, col. 3) of the Final Rule.

(B) In regard to the enhanced vaccine administration payment specified by 42 CFR 441, subpart L, if applicable:

(1) The MCO shall make payment for eligible vaccine administration services consistent with 42 CFR § 441.615, not to exceed the state's regional maximum administration fee consistent with page 66690 of the Final Rule. Payment from the STATE to the MCO for eligible vaccine administration services will be included in the payment referred to in section 4.1.2(F), and MCOs must follow the same process outlined in section 4.2.12(A)(1) through (5) above.

4.2.13 Risk Adjusted Payment for Long Term Care Elderly Waiver Services.

(A) Risk Adjustment Methodology. To account for variation in risk for the costs of EW services among Enrollees, the STATE will calculate an MCO-specific risk score for the EW add-on rate in section 4.2.13 on an annual basis. The STATE agrees not to rebase the base rates for risk adjustment during the term of this Contract.

(1) Development of Factors. The State has developed risk factors using individual data on costs provided by the MCOs and characteristics of EW recipients from the

data available in the STATE's MMIS system including LTCC screening document data submitted by MCOs and demographic information. See Appendix IV, Long Term Care Elderly Waiver Risk Adjusted Payment System.

(2) Calculation of Annual MCO Elderly Waiver Risk Scores

(a) The MCO's risk score for the Contract Year is based on an Enrollee roster derived from paid MCO capitation claims for the month of November of the previous Contract Year. Area, Age Group, and ADL Group factors for each EW recipient are derived from the MMIS Data Warehouse claims and LTCC Screening document tables as of the first data update in November of the year prior to the start of the Contract Year. Elderly Waiver Enrollees without a valid and current LTCC Screening document are excluded from the calculation. CL/CFC percentages, rankings, and risk factors are derived from the previous calendar year's encounter data.

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

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

4.2.14 EW Risk Adjustment Appeals. The MCO may appeal to the STATE the following year's risk factors. Any appeal of risk factors must be filed with the STATE within six weeks of notification of the 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 3.7.1.

(A) If the MCO appeals under this section, the STATE shall continue to pay the MCO the MCO'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.

4.2.15 Elderly Waiver Payment Adjustment for MSHO and MSC+. The STATE shall deduct from the MCO's warrant an amount equal to all monthly Elderly Waiver Capitation Payments made in the calendar year prior to the current Contract Year after an MSHO/MSC+ Enrollee has been Institutionalized for sixty (60) days, or upon the prior year's Care Plan audit in section 7.8.3 findings that an Enrollee was in an inappropriate Rate Cell. The STATE shall calculate the amount and notify the MCO at least ninety (90) days prior to the adjustment of the warrant.

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

4.2.17 Basic Care Rates for Seniors. For the Contract Year, monthly payments paid by the STATE to the MCO for Basic Care services for MSC+ and MSHO Enrollees shall be shown in the column titled, "*CY 2014 Plan Rate*" in the Payment Appendix. These payments shall be 100% demographically based for all Enrollees. The total Capitation Payment to the MCO is identified in the Payment Appendix.

4.2.18 Nursing Facility Add-on Rates for Seniors. Monthly payments paid by the STATE to the MCO for Nursing Facility services as described in section 4.9.2 shall be those identified in the Payment Appendix.

4.2.19 Elderly Waiver Add-on Rates for Seniors. Monthly payments for Elderly Waiver services shall be made by the STATE to the MCO as shown in the Payment Appendix, as applicable.

4.3 Compliance Related to Capitation Payments.

4.3.1 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. The STATE's contracted actuary must meet the independence requirements under the professional code for fellows in the Society of Actuaries and must not have provided actuarial services to a MCO during the period in which the actuarial services are being provided to the STATE. The certification and attestation of actuarial soundness provided by the actuary must be auditable.

4.3.2 Financial Audit. As outlined in Minnesota Statutes, § 256B.69, subd. 9d, the Office of the Legislative Auditor (OLA) will contract with an audit firm to conduct an independent third-party financial audit of the MCO's information identified in Minnesota Statutes, §256B.69, subd. 9c(b). The audit firm will have the same investigative power as the OLA, as outlined in Minnesota Statutes, § 256B.69, subd. 9d, and will perform the audit every two years beginning January 2014. Additionally, the auditor will be required to determine compliance with the Medicaid managed care rate certification process, and whether the administrative expenses and investment income reported by the MCO are compliant with state and federal law. The audit shall be conducted in accordance with generally accepted government auditing standards issued by the United States Government Accountability Office and the audit firm shall meet the requirements outlined in Minnesota Statutes, §256B.69, subd. 9d(b). The MCO shall submit to and fully cooperate with the independent third-party audit and provide the STATE and the contracted audit firm access to all data required to complete the audit.

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

STATE's specifications, including providing a data certification in accordance with section 9.10 of this Contract.

4.3.4 Renegotiation of Prepaid Capitation Rates. The prepaid capitation rates for Enrollees enrolled in the MCO shall be subject to renegotiation not more than annually unless required by State or federal law, regulation or directive, or necessary due to changes in eligibility or benefits. .

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

4.4 Medical Assistance Cost-Sharing for MSHO and MSC+. Except as noted in section 4.4.1, Medical Assistance Enrollees must pay cost-sharing for the services described in section 4.4.2.

4.4.1 Exceptions. The following Enrollees or services are exempt from cost-sharing:

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

(B) Enrollees receiving Hospice care;

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

(D) Emergency Services;

(E) Family Planning;

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

(G) Copayments that exceed one per day per Provider for non-preventive visits, and non-emergency visits to a hospital-based emergency department; and

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

4.4.2 Medicaid Cost-Sharing Amounts.

(1) Except for anti-psychotic drugs for which no copayment is required, Enrollees shall pay copayments of three dollars ($3) per prescription for brand name drugs, and one dollar ($1) per prescription for generic drugs, with a maximum of twelve dollars ($12.00) per month.

(2) Except for mental health services which are exempt from this copayment, Enrollees shall pay a copayment of three dollars ($3) per non-preventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required

because of an Enrollee's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(3) Enrollees shall have a copayment for non-emergency use of the emergency department of three dollars and fifty cents ($3.50) per visit.

(4) The MCO agrees to waive the monthly family deductible of two dollars and seventy-five cents ($2.75) or as updated by CMS. This waiver applies to both MSHO and MSC+. The MCO must track the amounts for reporting under section 9.10.3.

(5) Cost-sharing and Family Income. For MSC+ only, individuals identified by the commissioner with income at or below one hundred percent (100%) of the federal poverty guidelines, total monthly cost-sharing must not exceed five percent (5%) of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on cost-sharing as authorized by Minnesota Statutes, § 256B.0631, subd. 1, (a)(6).

4.4.3 Cost-Sharing and Residents of Nursing Facility. For MSC+ Enrollees, upon notification to the MCO that a Medical Assistance Enrollee has been a resident of a Nursing Facility for thirty (30) days or more, the MCO shall ensure that its Providers do not require the Enrollee to pay any cost-sharing, and shall reimburse its Providers any cost-sharing amount paid. The MCO may submit an invoice and a data certification to the STATE for all cost-sharing the MCO has reimbursed to its Providers in the previous quarter, no more often than quarterly. The STATE shall verify the Medical Assistance Enrollee's living arrangement, and date of service on the encounter claim, prior to payment to the MCO for the amounts the MCO claims to have reimbursed to its Providers.

4.4.4 Collection of Cost-Sharing. The MCO may delegate to the Providers of these services the responsibility to collect the copayment.

4.4.5 Inability to Pay Cost-Sharing. The MCO must ensure that no Provider denies Covered Services to an Enrollee because of the Enrollee's inability to pay cost-sharing pursuant to 42 CFR §447.53. The MCO must ensure that Enrollees retain the ability to seek services from other Providers.

4.4.6 MCO Waiver of Medicaid Cost-Sharing for MSHO Community Enrollees. The MCO has chosen to waive Medicaid cost-sharing for MSHO community Enrollees for the term of this Contract. The MCO shall have a uniform policy to assure that the same amounts of cost-sharing for the same types of services are waived for all MSHO community Enrollees. Copays for the following services will be waived for MSHO community Enrollees for the cost-sharing in section 4.4 above:

(A) Medicaid prescription drugs (those prescription drugs covered by Medicaid rather than Medicare for dually eligible Medicare Enrollees);

(B) Nonpreventive visit;

(C) Non-emergency use of the emergency department;

(D) Family Deductible.

4.4.7 Notification to Enrollees of Cost-Sharing. The MCO shall explain the cost-sharing policy in the MCO's Evidence of Coverage and other materials for Enrollees. The MCO shall not offer waiver of cost-sharing as an inducement to enroll for MSHO unless CMS has approved waiver of payment of cost-sharing by the MCO as an additional benefit in the MCO's Medicare bid process, and such waiver cannot be described in any of the MCO's Marketing Material.

4.4.8 Payment for Medicaid Covered Medicare Cost-Sharing. The MCO is responsible for payment of Medicaid covered Medicare cost-sharing where applicable. Medicaid covered Medicare cost-sharing is included in the rates in section 4.2.16. Except as provided in section 4.2.12, the MCO may limit its payment to the provider (for Medicare Part B cost-sharing) to the amount included in the rates paid to the MCO, consistent with Minnesota Statutes, § 256B.0625, subd. 57.

4.5 EW Waiver Obligations. Duties of the STATE and the MCO include:

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

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

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

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

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

4.6 Medicaid Managed Care Withhold. For Capitation Payments made on or after January 1, 2012, the STATE shall withhold nine point five percent (9.5%) from the Basic Care Rate portion of the MCS+ and MSHO rates of the MCO's payments. MSHO and MSC+ Medicaid Nursing Facility, and Home and Community Based Services, payments are excluded from the withhold provision.

4.6.1 Return of Withhold Based on Performance. Of the total in section 4.6, 52.63% (5.0 / 9.5 x 100) of the withheld funds shall be returned no sooner than July 1st and no later than July 31st of the year subsequent to the Contract Year only if, in the judgment of the STATE, performance targets in section 4.6.2 are achieved.

4.6.2 Withhold Return Scoring for the 2014 Contract Year.

(A) The withheld funds will be returned to the MCO for the Contract Year based on the following performance targets and assigned points:

(1) Repeat Deficiencies on the MDH QA Examination for MHCP, ten (10) points.

(2) Completion of and submission to STATE of the Care Plan audit in section 7.8.3, following the care planning audit data abstraction protocol developed by the Care Plan audit work group, shall be worth ten (10) points; and

(3) Initial Health Risk Screening or Assessment. Completion of initial health risk screening or assessments per the formula in section 4.6.3(C) below shall be worth twenty (20) points. The State will provide two mid-year MCO interim progress reports in regard to this measure.

(4) Stakeholder Group Reporting. Maintaining a local or regional stakeholders group as required in section 7.4.4, ten (10) points. The MCO will submit documentation that demonstrates the MCO responds to significant concerns raised by stakeholder group participants.

(B) The percentage of the MCO's withheld funds to be returned shall be calculated by summing all earned points, dividing the sum by fifty (50) and converting to a percentage. For this Contract, no partial whole number of points will be assigned if the MCO fails to completely meet performance targets. This percentage is referred to as the Withhold Score.

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

(D) All measures in section 4.6.2, except for the Repeat Deficiencies on the MDH QA Examination, will be calculated from: 1) encounter data submitted pursuant to section

3.7.1 no later than May 31st of the year subsequent to the Contract Year by the MCO to the STATE; 2) additional data sources approved by the STATE and in the STATE's possession; or 3) as otherwise stated below.

(E) The STATE shall provide data (number of tests/ visits/ admissions/ member months) and rates to the MCO on withhold measures in section 4.6.3.

(1) Data will be provided four (4) times per year in:

(a) January, 2014 for the entire Contract Year of 2013

(b) April, for the previous calendar year's data;

(c) July, for the first six months of the Contract Year;

(d) October, for the first nine months of the Contract Year; and

(2) These reports contain measurement estimates and are not the final rates that will be used to determine if the MCO achieved its performance targets. The STATE provides these estimates only to aid the MCO's compliance efforts.

(3) The reports will be based on data in the STATE's possession at the time of the report.

4.6.3 Administrative and Access/Clinical Performance Targets for MSHO and MSC+.

(A) Repeat Deficiencies on the MDH QA Examination.

(1) Comply with the MDH licensing requirements and have no repeated deficiencies related to MHCP that remain after the MCO's corrective action(s) that initially resulted from the MCO's MDH QA Examination.

(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.

(B) Care Plan Audit. Completion of and submittal to the STATE of the Care Plan audit in section 7.8.3, following the care planning audit data abstraction protocol developed by the Care Plan audit work group.

(C) Initial Health Risk Screening or Assessment. The MCO shall conduct an initial risk screening or assessment of each new MSHO and MSC+ non-EW community Enrollee's health needs in accordance with sections 6.1.4(A)(1) and 6.1.5(A)(1) of this contract. The State will then calculate the timeliness of the assessment by using the following formulas:

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

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

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

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

(c) To qualify for the ten (10) points allotted to this performance measure, the MCO must show that combined, initial health risk screenings or assessments were completed in a timely manner for seventy percent (70%) of MSHO and MSC+ new Enrollees.

(d) Transition plans submitted by the MCO and approved by the State under 6.1.4(A)(1)(a) and 6.1.5(A)(1)(a) will be accounted for in the calculation.

(D) MCO Stakeholder Group for MSHO/MSC+. The MCO will maintain a local or regional stakeholder group as required in section 7.4.4. In order to qualify for the withhold, the stakeholder group will meet at least twice per Contract Year. The MCO will submit to the STATE twice per Contract Year, on or before December 15th, documentation in the form of stakeholder meeting agendas and meeting minutes that demonstrate the MCO response to significant concerns raised by stakeholder group participants.

4.6.4 Return of Withheld Funds for Contract Year 2014. For this Contract the funds available to be returned (the Withheld Total) shall be calculated as the difference between:

(1) The total Contract Year 2014 Basic Care Rate portion of the MSHO Capitation Payments and the total Contract Year 2014 MSC+ Capitation payments made to the MCO, (as of May 31st of the year subsequent to the Contract Year), divided by 0.905 (90.5%); and

(2) The total Contract Year 2014 Basic Care Rate portion of the MSHO Capitation Payments and the total Contract Year 2014 MSC+ Capitation Payments made to the MCO (as of May 31 of the year subsequent to the Contract Year).

(3) This amount has been reduced to reflect removal of the MERC funding (for MSC+).

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

(1) The Withheld Total shall be multiplied by 0.5263 (5.0 / 9.5) or 52.63% to determine the Performance-Based Total.

(2) The Performance-Based Total shall be multiplied by the Withhold Score, subject to the Loss Limit in 4.6.4(B)(3) below.

(3) The difference between 4.6.4(B)(1) and 4.6.4(B)(2), the Loss Limit or amount of the unreturned funds that are kept by the STATE, shall not exceed five percent (5%) of the Performance-Based Total.

(4) The Withheld Total shall be multiplied by 0.4737 (4.5 / 9.5) or 47.37% to determine the Non-Performance-Based Total..

(5) The resulting amount from adding the Performance-Based Total and Non-Performance-Based Total will be returned to the MCO according to section 4.1.1.

4.7 Payment Errors

4.7.1 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.

(A) 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.

(1) 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.

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

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

(4) 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.

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

(C) Two Year Limit to Assert Claim.

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

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

(3) Payment Offset. When possible, these payments shall be offset against or added to future payments made according to this Article.

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

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

(A) One Year Limit to Assert Claim.

(1) The STATE shall not assert any claim for or seek the reimbursement of or make any adjustment for any alleged overpayment made by the STATE to the MCO under this section more than one year after the date such payment was actually received by the MCO from the STATE. This one year limitation, along with the notice requirement described in section 4.7.1(C)(4), does not apply to duplicate payments made because of multiple identification numbers for the same Enrollee, payments for full months for a Medical Assistance Enrollee who is incarcerated in a facility, and payments for full months after the death of the Enrollee.

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

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

4.8 Compliance Related to All Payments

4.8.1 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 section 4.7 of this Contract.

4.8.2 CMS Approval of Contract. Approval of the Contract by CMS is a condition for Federal Financial Participation. If CMS disapproves the rates in the Payment Appendices, and CMS and the STATE subsequently agree upon revised rates that are actuarially sound:

(A) The STATE shall adjust MCO payments to bring previous payments in line with rates agreed upon by the STATE and CMS. 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.

(B) For the remainder of the contract term the contract shall be amended, with rates agreed upon by the STATE and CMS, pursuant to Article. 19 of this Contract.

4.8.3 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 42 USC § 1395(h)(c)(2); 42 USC § 1395u(c)(2)); and 42 USC § 1396a (a)(37) , 42 CFR Parts 447.45 and 447.46, and Minnesota Statutes, § 256B.69, subd. 6, clause (b), § 16A.124, and § 62Q.75.

4.9 Non-Capitated Payments.

4.9.1 Payment for CD Room and Board. The STATE will reimburse the MCO for room and board costs associated with CD treatment when such treatment is required by the Rule 25 assessment criteria. The STATE will not pay more than the rate specified in the Consolidated Chemical Dependency Treatment Fund (CCDTF) rates database in effect at the time the service was rendered. The STATE will make a warrant request within thirty (30) days of receipt of the MCO's quarterly report. Effective for dates of service on July 1, 2014 and going forward, the MCO shall not be responsible for the payment of room and board services provided by residential chemical dependency treatment providers.

4.9.2 Payment for Skilled Nursing Facility/Nursing Facility Benefit.

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

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

period may be applied to an Enrollee more than once if the requirements of the one hundred and eighty (180) day Separation Period are met as specified in section 4.9.2(E). The MSHO MCO is responsible for services covered under the Medicare Advantage SNF benefit regardless of whether NF liability is indicated on the STATE's Medical Assistance file.

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

(a) Medicare SNF days. Medicare SNF days incurred during the 180 day period may count towards the 180-day benefit period.

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

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

(3) The MCO may not accrue the following types of days toward the cumulative 180-day benefit period for MSHO:

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

(b) Respite days do not count towards the Medicaid benefit period or Medicare Benefit Period.

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

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

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

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

(6) The MCO remains liable for the 180-day SNF/NF benefit across Contract Years.

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

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

(2) Internal patient account summaries;

(3) Service Authorizations if used by the MCO;

(4) Claim denials for any days billed after the MCO'S 180-day benefit period has ended; or

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

(C) Responsibility for Payment of Medicare SNF Days. After the one hundred and eighty (180) day benefit period for MSHO is expended, the MCO shall retain responsibility for Medicare SNF days according to Medicare SNF benefit policy.

(D) Responsibility for Payment of Medical Assistance NF days. After the 180-day benefit period for MSHO is expended, the STATE shall assume responsibility for Medical Assistance Nursing Facility days.

(E) 180-Day Separation Period for MSHO.

(1) Continuous Separation Period.

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

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

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

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

(4) The STATE enrollment data will contain information indicating the MCO's Nursing Facility benefit period.

(F) 180 Day SNF/NF Benefit for MSC+.

(1) For any Recipient who is enrolled into MSC+ while in a community setting (i.e. Community EW and Community Non-EW payment categories), the MCO shall have financial responsibility for Nursing Facility services for one hundred eighty (180) days. The 180 days begin at the time of the MSC+ Enrollee's date of admission to a Skilled Nursing Facility (SNF) or Nursing Facility (NF) on or after the first effective date of enrollment. Both Medical Assistance and Medicare covered days shall be counted toward the 180-day benefit period, except that the MCO shall not pay for Nursing Facility services for new admits to a facility that occurs during Denial of Payment for New Admissions (DOPNA) violation periods, since these days are not covered under the STATE's fee-for-service program. The 180 days shall be counted cumulatively. The MCO shall be responsible for paying any coinsurance for Medicare covered days during the 180-day benefit period. The 180-day benefit period may be applied to an Enrollee more than once if the requirements of the 180-day Separation Period are met as specified in section 4.9.2

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

(a) Medicare SNF days;

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

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

(3) The MCO may not accrue the following types of days toward the cumulative one 180-day benefit period for MSC+:

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

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

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

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

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

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

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

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

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

(3) Internal patient account summaries;

(4) Service Authorizations if used by the MCO;

(5) Claim denials for any days billed after the MCO'S 180-day benefit period has ended; or

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

(H) Responsibility for Payment of Medical Assistance NF Days. After the 180-day benefit period is expended for MSC+, the STATE shall assume responsibility for Medical Assistance Nursing Facility Days.

(I) 180-Day Separation Period for MSC+.

(1) Continuous Separation Period

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

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

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

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

(4) The STATE enrollment data will contain information indicating the MCO's Nursing Facility benefit period

(J) Non-Medicare Certified Nursing Facilities. Pursuant to Minnesota Statutes, section 256B.48, subd. 6 (as amended by Laws of Minnesota, Ch. 247, Art. 4, sec. 33),

Enrollees may be admitted for Medicaid-covered services to nursing facilities that do not participate in or accept assignment from Medicare. The STATE will audit such facilities and, if an admission would otherwise have been a Medicare-qualifying stay, the STATE will notify the MCO by e-mail. The MCO will assure that no payment is made to the facility for the first twenty (20) days of such an admission.

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

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

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

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

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

(2) If a clinic or clinician is a certified Health Care Home and the MCO has an alternative comprehensive payment arrangement that includes care coordination and is tied to outcome measures related to patient health, patient experience and cost effectiveness with that clinic or clinician, then upon documentation in accordance with section 3.7.2(L) of the alternative comprehensive payment arrangement and its proposed performance and outcome measures, the STATE will provide a variance from the stratified fee schedule in 4.12(A) above and from any additional Health Care Home care coordination fee.

(3) The MCO is not required to pay both a Health Care Home care coordination fee and a fee based on a more comprehensive payment arrangement.

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

4.13 Incentive Payments. The STATE may make payments for certain incentive programs pursuant to section 7.14.

4.14 Contract Year Legislative Changes. The MCO shall comply with the following provisions of Minnesota Statutes:

(A) Minnesota Statutes, § 256B.764, as amended by Minnesota Laws 2013, Ch. 108, Article 6, Section 29, regarding family planning payment, effective July 1, 2013. The MCO shall pass on the full amount of the rate increase to eligible community clinics, in the form of higher payment rates for family planning services.

(B) Minnesota Statutes, § 256B.5012, as amended by 2011 First Special Session Laws of Minnesota, chapter 9, article 7, sections 44 and 51, regarding payment for certain continuing care providers, effective July 1, 2013.

(C) Minnesota Statutes, § 256B.434, subd. 19a, and Minnesota Statutes, § 256B.441, subd. 46b, regarding nursing facility payment, effective September 1, 2013.

(D) Rate Increase for Dental Services. Effective January 1, 2014 payment rates for dental services shall be increased by five percent (5%) from the rates in effect on December 31, 2013 pursuant to Minnesota Statutes, § 256B.76, subd. 2, (j).

4.15 Home and Community-Based Services Performance-based Incentive Payment Program. As a part of the Home and Community-Based Services Performance-based Incentive Payment Program (HCBS PIPP), the MCO shall provide a temporary rate increase for participating EW providers participating in the HCBS PIPP, in a process mutually agreed upon by the MCO and STATE and after the participating EW providers have been identified by the STATE. The temporary rate increases are scheduled to begin on or after April 1, 2014 and end on or before June 30, 2015.

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Article. 5 Term, Termination and Breach.

5.1 Term. The term of this Contract shall be Contract Year from **January 1, 2014** (Effective Date) through **December 31, 2014**, (Termination Date). Coverage will begin at 12:00 a.m. on January 1st and end at 11:59:59 p.m. (Central Standard Time) on December 31st unless this Contract is: 1) terminated earlier pursuant to section 5.2; or 2) extended through: a) an amendment pursuant to Article 19.1, or b) automatic renewal pursuant to section 5.1.1; or 3) replaced by a Renewal Contract pursuant to section 5.1.2.

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

5.1.2 Renewal Contract. The Commissioner of Human Services shall have the option to either provide the MCO with a notice of non-renewal, or to offer to enter into negotiations for a renewal of this Contract on an annual basis, upon no less than one hundred and twenty (120) days' written notice to the MCO. The MCO has the right to decline the offer to renew this Contract. If the MCO declines this offer, this Contract will automatically renew in accordance with section 5.1.1 unless the MCO or the STATE provides notice of termination or non-renewal. If the Parties negotiate and execute a Renewal Contract with the intent that it take effect upon the termination of this Contract on its original or modified Termination Date, this Contract will so terminate and the Renewal Contract will replace it upon the Renewal Contract's effective date.

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

5.1.4 Notice of Service Area Reduction. The MCO shall provide the STATE with at least one hundred and fifty (150) days written notice prior to withdrawing services from a county; this period may be less by mutual agreement.

5.1.5 Notice of Other MCO Termination or Service Area Reduction. In the event that any other MCO under contract with the STATE for the provision of services to Enrollees similar to those covered by this Contract either 1) terminates its Contract with the STATE, or 2) reduces its Service Area in a way that impacts the MCO's Service Area, the STATE shall provide the MCO with written notice within five working days of receipt by the STATE of termination notice or notice of reduction of the Service Area (as described above) from any other such MCO. This paragraph does not apply to procurement decisions.

5.2 Contract Non-Renewal and Termination.

5.2.1 Notice of Non-Renewal

(A) 150 or More Days Prior to the End of the Contract. The MCO shall provide the STATE with at least one hundred and fifty (150) days written notice prior to the end of the contract term if the MCO chooses not to renew or extend this Contract at the end of the contract term. If the MCO provides the STATE with such notice, the Contract will end on the Termination Date.

(B) Less Than 150 Days Prior to the End of the Contract. If the MCO provides the STATE written notice prior to the end of the contract term but less than one hundred and fifty (150) days prior to, the Contract will end at 11:59:59 p.m. on the last day of the month which falls one hundred and fifty (150) days from the date the notice is given, unless the parties agree in writing to a different date.

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

5.2.3 Termination for Cause.

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

(B) By the STATE.

(1) The STATE may terminate this Contract for any material breach by the MCO after one hundred and fifty (150) days from the date the STATE provides the MCO notice of termination. The MCO may request, and must receive if requested, a hearing before the mediation panel described in section 5.9, prior to termination.

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

(a) Fraudulent action by the MCO;

(b) Criminal action by the MCO;

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

(d) For County Based Purchasing MCOs, a determination by MDH that the MCO no longer satisfies the requirements for assurance of consumer protection, provider protection, and fiscal solvency of chapter 62D, applicable to health maintenance

organizations, as stated in Minnesota Statutes, § 256B.692, subd. 2(b), or otherwise results in a determination that the CBP is no longer authorized to operate; or

(e) Loss of Medicare contractual agreement with CMS.

(C) Legislative Appropriation. Continuation of this Contract is contingent upon continued legislative appropriation of funds for the purpose of this Contract. If these funds are not appropriated, the STATE will immediately notify the MCO in writing and the Contract will terminate as of 11:59 p.m. on June 30th of the Contract Year.

5.2.4 Contract Termination Procedures. If the Contract is terminated:

(A) Both parties shall cooperate in notifying all MCO Enrollees covered under this Contract in writing of the date of termination and the process by which those Enrollees will continue to receive medical care, at least sixty (60) days in advance of the termination, or immediately as determined by the STATE, if termination is for a material breach listed in section 5.2.3(B)(2). Such notice must be approved by the STATE and CMS.

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

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

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

(E) Written notice shall be sent by the parties via 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 this Article shall be effective on the last day of the calendar month in which the notice becomes effective. Payment shall continue and services shall continue to be provided during that calendar month.

5.3 Deficiencies. 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 or sanctions listed in section 5.6 or 5.7, 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. Nothing in this article shall be construed as relieving the MCO from performing any contractual duties.

5.3.1 Quality of Services. If the STATE or CMS finds that the quality of care or services offered by the MCO is materially deficient, the STATE has the right to terminate this Contract pursuant to section 5.2.3(B)(1), or to enforce remedies pursuant to section 5.6.

5.3.2 Failure to Provide Services. The MCO shall be subject to one of the remedies listed in section 5.6 or 5.7 if a) the MCO fails substantially to provide Medically Necessary items and services that are required to be provided to an Enrollee covered under this Contract, and b) the failure has adversely affected or has a substantial likelihood of adversely affecting the Enrollee.

5.4 Considerations in Determination of Remedy. In determining the remedy or sanction, the STATE may consider as mitigating factors, as appropriate, any of the following:

(A) The nature and magnitude of the violation, as it relates to this Contract;

(B) The number of Potential Enrollees or Enrollees, if any, affected by the breach;

(C) The effect of the breach on Enrollees' due process rights under this Contract, or Potential Enrollees' or Enrollees' health or access to health services;

(D) If only one Enrollee or Recipient is affected, the effect of the breach on that Potential Enrollee's or Enrollee's health;

(E) Whether the breach is an isolated incident or there are repeated breaches of or deficiencies under the Contract;

(F) Whether and to what extent the MCO has attempted to correct previous breaches or deficiencies; and

(G) The economic benefits, if any, derived by the MCO by virtue of the breach or deficiency.

5.5 Notice; Opportunity to Cure. The STATE shall give the MCO reasonable written notice of a breach or deficiency by the MCO prior to imposing a remedy or sanction under this section. The MCO shall have sixty (60) days to cure the breach or deficiency from the date it receives the notice of breach or deficiency, unless a longer period 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. The STATE has determined the deficiencies in section 5.6(D) below cannot be cured.

5.6 Remedies or Sanctions for Breach. If the STATE determines that the MCO failed to cure the breach within the time period specified in section 5.5, the STATE may enforce one or more of the following remedies or sanctions, which shall be consistent with the factors specified in section 5.4. The STATE may impose sanctions until such time as a breach is corrected, or the time period the correction should have been made until the time when notification by the MCO is actually made or the correction is made. The MCO reserves all of its legal and equitable remedies to contest the imposition of a remedy or sanction under this Contract.

(A) Withhold Medical Assistance capitation payments or a portion thereof until such time as the breach or deficiency is corrected to the satisfaction of the STATE.

(B) Monetary payments from the MCO to the STATE in the following amounts, offset against payments due the MCO by the STATE or as a direct payment to the STATE, at the STATE's discretion, until such time as the breach is corrected to the satisfaction of the STATE.

(C) Sanctions in General. The STATE may impose sanctions at the STATE's discretion, in an amount of

(1) up to five thousand dollars ($5,000) per day; and/or

(2) the direct and indirect costs to the STATE of an incident or incidents, caused by the MCO or its subcontractor(s), not to exceed two hundred and fifty thousand dollars ($250,000).

(D) Sanctions for Due Process Noncompliance: The STATE may impose a sanction of up to $15,000 for each determination of a deficiency by MDH during the triennial Quality Assurance Exam or if a deficiency persists at the time of the MDH Mid-cycle Review, for violations of Enrollee rights or due process. For the purposes of this section, violation of due process includes but is not limited to:

(1) Failure to provide an Enrollee under this Contract with timely notice of disposition of a Grievance and/or timely written notice of the resolution of a Standard or Expedited Appeal;

(2) Failure to provide an Enrollee under this Contract with a timely DTR (Notice of Action) for denial of a Standard or Expedited Service Authorization.

(E) Suspension of all new enrollment including default enrollment after the effective date of the sanction.

(F) If the MCO does not comply with the MSHO Marketing requirements specified in section 3.6 of this Contract, the STATE may require the MCO to cease all MSHO Marketing activities until such time as the MCO has complied with section 3.6 as defined by the STATE.

(G) Payments provided for under the Contract will be denied for new Enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements in 42 CFR §438.730.

5.7 Temporary Management. In addition to the remedies listed in section 5.6, the STATE shall impose temporary management of the MCO pursuant to 42 CFR §438.706(b) if the STATE finds that the MCO has repeatedly failed to meet the substantive requirements of §1903(m) or §1932 of the Social Security Act. When imposing this sanction the STATE shall:

(A) Allow Enrollees the right to terminate enrollment without cause and notify the affected Enrollees of their right to disenroll;

(B) Not delay the imposition of temporary management to provide a hearing; and

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

5.8 Notice. If the STATE enforces a remedy under this section, the STATE shall provide the MCO written notice of the remedy to be imposed.

5.9 Mediation Panel. The MCO may request the recommendation of a three- (3) person mediation panel within three business days of receiving notice of a remedy or sanction, a one hundred and fifty (150) day notice of termination, or notice of non-renewal from the STATE. The mediation panel shall meet, accept both written and oral argument as requested, and make its recommendation within fifteen (15) days of receiving the request for recommendation unless the parties mutually agree to a longer time period. The Commissioner shall resolve all disputes after taking into account the recommendations of the mediation panel and within three (3) business days after receiving the recommendation of the mediation panel.

(A) For non-CBP MCOs, the panel shall be composed of one designee of the Minnesota Council of Health Plans, one designee of the Commissioner of Human Services, and one designee of the Commissioner of Health.

(B) For CBP MCOs, the three-person mediation panel shall be composed of one designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one person selected jointly by the designee of the commissioner of human services and the designee of the Association of Minnesota Counties. The State shall not require that contractual disputes between county-based purchasing entities and the State be mediated by a panel that includes a representative of the Minnesota Council of Health Plans pursuant to Minnesota Statutes, § 256B.69, subd. 3a(d) and (f).

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Article. 6 Benefit Design and Administration. All terms of Article 6 apply to MSHO and MSC+, unless otherwise stated. Medicare Services provided by the MCO must comply with the requirements of this Article.

6.1 Covered Services. The MCO shall provide, or arrange to have provided to Enrollees comprehensive preventive, diagnostic, therapeutic and rehabilitative and long term care health care services as defined in Minnesota Statutes, § 256B.0625 and corresponding Minnesota Rules, Parts 9505.0170 to 9505.0475, and, for MSHO and MSC+, Elderly Waiver services pursuant to §1915(c) of the Social Security Act, 42 USC §1396 and Minnesota Statutes, §256B.0915.

Except for sections 6.1.32 (Prescription Drugs and Over-the-Counter Drugs.) and 6.1.43 (Transplants.), or as otherwise specified in the Contract, these services shall be provided to the extent that the above law and rules were in effect on the Effective Date of this Contract. Services in sections 6.1.32 and 6.1.43 shall be provided to the extent that the above law and rules are in effect.

The MCO shall also provide, or arrange to have provided to MSHO Enrollees Medicare benefits as provided pursuant to 42 USC §1395, and specialized Medicare Advantage plans for Special Needs Enrollees, known as Special Needs Plans (SNPs), established by the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, pursuant to the MCO's MA/SNP contract with CMS.

All covered benefits, except for Home and Community Based Services and services mandated by STATE or federal law, are subject to determination by the MCO of Medical Necessity, as defined in section 2.86. For purposes of this paragraph, mandated services do not include the benefits described in Minnesota Statutes, Chapter 256B.

Consistent with 42 CFR 438.206(b)(4) if the MCO's Provider network is unable to provide necessary medical services covered under the Contract to a particular Enrollee, the MCO must adequately and timely cover these services Out of Plan for the Enrollee.

The MCO shall provide services that shall include but are not limited to the following:

6.1.1 Acupuncture Services. Acupuncture services are covered when provided by a licensed acupuncturist or by another Minnesota licensed practitioner for whom acupuncture is within the practitioner's scope of practice and who has specific acupuncture training or credentialing.

6.1.2 Advanced Practice Nurse Services. Advanced Practice Nurse Services provided by nurse practitioners, nurse anesthetists, nurse midwives and clinical nurse specialists are covered.

6.1.3 Cancer Clinical Trials. Routine care that is provided through the administration or performance of items or services that are 1) required as part of the protocol treatment in a high-quality cancer Clinical Trial, 2) usual, customary and appropriate to the Enrollee's condition and 3) would be typically provided to that Enrollee when cared for outside of a Clinical Trial, including those items or services needed for the prevention, diagnosis or treatment of adverse effects and complications of the protocol treatment are covered.

6.1.4 Care Coordination Services for MSHO. The MCO must provide Care Coordination/Case Management services that are designed to ensure access and integrate the delivery of all Medicare and Medicaid preventive, primary, acute, post-acute, rehabilitation, and long term care services, including State Plan Home Care Services under section 6.1.17, and Elderly Waiver services to MSHO Enrollees. The MCO shall also coordinate the services it furnishes to its Enrollees with the services an Enrollee receives from any other MCO. The MCO shall develop and maintain written descriptions as provided in section 3.7.2(C), and policies and procedures for operation of the Care Coordination/Case Management system in accordance with this section that shall be made available as part of an EQRO review, and for CMS EW waiver reviews. The Care Coordination Workgroup will create a template that MCOs may use to create a training plan for when the MCO contracts with new entities providing Care Coordination. The training plan must include provisions for assuring the training of individuals who will be providing Care Coordination. The training plan will be made available to the State upon request.

(A) MSHO Care Coordination Components. The Care Coordination system must be designed to ensure communication and coordination of an Enrollee's care across the Medicare and Medicaid network Provider types and settings, to ensure smooth transitions for Enrollees who move among various settings in which care may be provided over time, and to strive to facilitate and maximize the level of Enrollee self-determination and Enrollee choice of services, Providers and living arrangements. The Care Coordination system should provide each Enrollee with a primary contact person who will assist the Enrollee in simplifying access to services and information. The system must be designed to promote and assure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, culturally appropriate care and fiscal and professional accountability. The system may differ for Institutional, Community NHC and community members but at a minimum, the Care Coordination system must incorporate the following elements for all MSHO Enrollees:

(1) Comprehensive Assessment. Within thirty (30) calendar days of enrollment, and annually thereafter, the MCO shall make a best effort to conduct a health risk assessment of each Enrollee's health needs. All assessments or a summary of the assessments shall be kept as a part of the individual Enrollee health record at the MCO, care system or county care coordination system. The assessment should address medical, social and environmental and mental health factors, including the physical, psychosocial, and functional needs of the Enrollee. MCOs must integrate required Medicare assessments, LTCC assessments under section 6.1.22 and any additional comprehensive assessments being conducted for enrollees to the extent possible. LTCC assessments and reassessments to determine access to home and community based services and/or home care services performed as part of this assessment process must meet requirements outlined in 6.1.22. Use of the Health Risk Assessment component of the State's process outlined in 6.1.22 by the MCO will meet the requirements of this section.

(a) In the event of a large transfer of enrollees into the MCO with the same initial enrollment date and if the MCO determines that meeting the timelines indicated in this section cannot be met, the MCO may submit a transition plan to DHS, for

review and approval, indicating the timeline in which they expect to be able to conduct this initial assessment required for new enrollees.

(b) For Nursing Facility Enrollees, the MCO may use the MDS collected by the nursing facility to meet this requirement as long as the MCO has access to the information collected.

(c) For community Enrollees, Activities of Daily Living (ADLs) should be included in the assessment. The MCO shall enter the ADL information collected during the assessment into MMIS according to section 3.1.3(A).until such time the State notifies the MCO that a new process for reporting this information is available through the State's assessment process outlined in 6.1.22.

(d) For community non-EW Enrollees, if the comprehensive assessment results in a referral for the LTCC, then the LTCC assessment must be completed within in accordance with the timeframe in section 6.1.22(A)(9) below. If the LTCC does not indicate level of care needs for EW eligibility, the Enrollee will be provided with a copy of the Community Support Plan produced by the State's assessment process.

(2) Comprehensive Care Plan Development. A comprehensive Care Plan shall be developed within thirty (30) days from the completion of the health risk assessment based on available information including but not limited to issues or needs identified by risk and comprehensive assessments, medical records and/or previous utilization to the extent records are available, and Enrollee and/or family input. In addition for Nursing Facility Enrollees, information located at the Nursing Facility should be considered. If the comprehensive assessment was not conducted face-to-face, a face to-face-visit must be offered to non-EW Enrollees as a part of the care planning development process. A face-to-face visit must occur as a part of the care planning development for Enrollees receiving EW services. The Care Plan should incorporate an interdisciplinary/holistic and preventive focus and include advance directive planning and Enrollee participation. For Elderly Waiver Enrollees, the comprehensive Care Plan shall also meet the specifications for the Care Plan pursuant to section 6.1.13(B).

(a) Interdisciplinary/Holistic Focus. The Care Plan shall employ an interdisciplinary and holistic approach by incorporating the unique primary care, acute care, long term care, mental health and social service needs of each Enrollee with appropriate coordination and communication across all Providers. For Nursing Facility Enrollees this includes review of the Nursing Facility chart, gathering input from Nursing Facility staff, participating in facility meetings and family conferences and communication and coordination with other Providers. For community and Community NHC Enrollees this includes appropriate written or verbal communication with physician or other Providers, attending appointments with Enrollees as needed and involving family members as appropriate in the care planning process and visits.

(b) Preventive Focus. For Nursing Facility Enrollees a preventive focus may include but is not limited to a medical history review for immunization status and health risks, prevention of wounds and wound care management when necessary and appropriate interventions and preventive activities to maintain or improve functioning. For community and Community NHC Enrollees a preventive focus may include but is not limited to written and verbal reminders about immunizations, tobacco and alcohol use, fall risk, medications and nutrition. Identification of selected diseases and adoption of protocols and best practices for prevention of deterioration and maintaining functioning are encouraged. The Care Plan must include identification of any risks to health and safety and plans for addressing these risks, including Informed Choices made by Enrollees to manage their own risk, and back-up plans for emergency situations.

(c) Advance Directive Planning. For all Enrollees, advance directive planning shall be an ongoing process based on individual Enrollee needs and cultural considerations. Discussion shall be initiated with the Enrollee and/or authorized family member or guardian if appropriate, when the lack of a documented Advance Directive is identified through the assessment process. For Nursing Facility Enrollees, advance directives may be addressed at Nursing Facility care conferences. For community and Community NHC members, a best effort must be made to document advance directive information in the Enrollee record and communication must be made with the physician.

(d) MSHO Enrollee Participation. The MCO shall ensure that the care coordinator works in partnership with the Enrollee and/or authorized family members, responsible parties or guardians and the Primary Care physician, and in consultation with any specialists caring for the Enrollee. The care coordinator shall cooperate with the Enrollee in developing, coordinating and, in some instances, providing supports and services identified in the Enrollee's Care Plan and obtaining consent to the medical treatment or service. Care Coordination is provided at a level of involvement based on the needs and choices made by the Enrollee and/or authorized family members or guardian, and as appropriate to implement and monitor the Care Plan.

(3) Care Plan Implementation. For each Enrollee, a Care Plan is implemented based on the needs assessment, the establishment of goals and objectives, the monitoring of outcomes through regular follow up, and a process to ensure that Care Plans are revised as necessary. These plans must be designed to accommodate the specific cultural and linguistic needs of MSHO Enrollees. For Nursing Facility residents, Care Coordination communication with facility staff and Primary Care as part of an interdisciplinary team must be established to address risk areas and manage services as needed. For Community NHC members and community members, services shall be coordinated with Providers based on the results of the assessment and with input from the Enrollee, family members as appropriate, Primary Care and the Care System team. Primary Care for Enrollees who have not had access to these services in the past must be arranged.

(4) Care Plan Evaluation. For Nursing Facility Enrollees, routine Care Plan evaluations shall be conducted to support a proactive, preventive approach. More extensive evaluations may be required based on clinical needs or changes in condition. For Community NHC Enrollees, a comprehensive reassessment shall be conducted annually or upon change of condition. For community members, risk assessments shall be conducted annually or upon change in condition followed by a comprehensive assessment as needed based on identified risk. A schedule for regular contact with the Enrollees by the care coordinator shall be established in order to identify and monitor changes in condition.

(5) Care Coordinator Caseload Ratios. The MCO shall establish policies and criteria for Care Coordination case load ratios for care coordinators serving all MSHO Enrollees. The MCO will submit these policies and procedures to the STATE for review. Criteria used to develop ratios will include but not be limited to: 1) low English proficiency or need for translation; 2) case mix; 3) Rate Cell designation; 4) need for high intensity acute Care Coordination; 5) mental health status; 6) travel time; and 7) lack of family or informal supports. The MCO will follow their established and submitted policy in assigning caseloads to case coordinators or include them in their Care System contracts for the following year. Audits of these criteria will become a part of the Care System audit required in section 9.3.9.

(6) Evaluation of Care Coordinator Performance. The MCO shall have a process to evaluate the performance of individual care coordinators including Enrollee input. As a part of this process, the MCO must also have a process on how Enrollees can request and be offered a different care coordinator. These processes should be described in the Care Coordination System description required in section 3.7.2(C). If the process includes the use of subcontractors, the process should be reviewed as a part of the review in section 9.3.9.

(B) Care Coordinator Responsibilities for MSHO. The MCO shall designate a care coordinator and/or nurse practitioner who shall have lead responsibility for creating and implementing the Care Plan unless otherwise designated by the MCO or Care System. The care coordinator or nurse practitioner shall perform the activities as specified below:

(1) Conduct the initial assessment, and periodic reassessment as necessary, of supports and services based on the Enrollee's strengths, needs, choices and preferences in life domain areas;

(2) Facilitate annual physician visits for primary and preventive care.

(3) Develop and update the Enrollee's Care Plan based on relevant ongoing assessment;

(4) Arrange and/or coordinate the provision of supports and services identified in the Enrollee's Care Plan, including knowledgeable and skilled specialty services and prevention, early intervention, and all medically necessary services listed in section

6.1, 6.2, 6.3, and 6.4, whether authorized by the Care Coordinator, Local Agency, or other delegated party;

(5) Assist the Enrollee and his or her legal representatives, if any, to maximize Informed Choices of services and control over services and supports;

(6) Monitor the progress toward achieving the Enrollee's outcomes in order to evaluate and adjust the timeliness and adequacy of services;

(7) Coordinate with Local Agency case managers, financial workers and other staff, as necessary, including use of the DHS form "Case Managers/Financial Worker Communication," Form # 5181 as provided by the STATE.

(8) The MCO will communicate with lead agencies on the authorization of medical assistance home care services using the DHS form "Managed Care Organization/Lead Agency Communication Form - Recommendation for Authorization of MA Home Care Services State Plan Home Care Services, DHS-5841 as provided by the STATE.

(9) Communications include the transfer of an Enrollee from one MCO to another MCO or Local Agency in the event an Enrollee is disenrolled from the MCO, using the "Lead Agency HCBS Case Management Transfer Form", DHS-6037 as provided by the STATE;

(10) Solicit and analyze relevant information;

(11) Communicate effectively with the Enrollee and with other individuals participating in the Enrollee's Care Plan;

(12) Educate and communicate to the Enrollee about good health care practices and behaviors which prevent putting the Enrollee's health at risk;

(13) Be informed of basic Enrollee protection requirements, including data privacy; and

(14) Inform, educate, and assist the Enrollee in identifying available services Providers and accessing needed resources and services beyond the limitations of the Medical Assistance and Medicare Benefit sets.

(C) Other Care Coordination/Case Management Requirements for MSHO. The MCO shall provide the following:

(1) Rehabilitative Services. Services include procedures for promoting rehabilitation of Enrollees following acute events, and for ensuring smooth transitions and coordination of information between acute, subacute, rehabilitation, Nursing Facilities, and Home and Community Based Services settings.

(2) Range of Choices. Procedures for ensuring access to an adequate range of Elderly Waiver and Nursing Facility Services and for providing appropriate choices among Nursing Facilities and/or Elderly Waiver services to meet the individual needs of Enrollees who are found to require a Nursing Facility Level of Care. These procedures must include methods for supporting and coordinating services with informal support systems provided by families, friends and other community resources. These procedures must also include strategies for identifying Institutionalized Enrollees whose needs could be met as well or better in non-Institutional settings and methods for meeting those needs, and assisting the Institutionalized Enrollee in leaving the Nursing Facility. For purposes of this section, the word "assisting" includes, but is not limited to, discharge planning and care management responsibilities described in section 6.1.4(A)(2).

(3) Coordination with Social Service Needs. A method for coordinating the medical needs of an Enrollee with his/her social service needs including coordination with social service staff and other community resources such as Area Agencies on Aging. Coordination with Local Agency social service staff is required when an Enrollee is in need of the following services:

(a) Pre-petition Screening;

(b) OBRA Level II Screening for Mental Health and Developmental Disability;

(c) Spousal Impoverishment Assessments;

(d) Adult Foster Care;

(e) Group Residential Housing Room and Board Payments;

(f) Chemical Dependency room and board services covered by the Consolidated Chemical Dependency Treatment Fund; or

(g) Adult Protection.

(h) The MCO shall coordinate with Local Human Service Agencies for assessment and evaluation related to judicial proceedings.

(4) Notification of Care Coordinator/Case Manager.

(a) The MCO or its subcontractor must provide the name and telephone number of the care coordinator/Case Manager assigned to the Enrollee within ten (10) days of the initial assessment, new assignment or change in case manager.

(b) For new Enrollees, if the name of the care coordinator/case manager is not included in the new member materials, the MCO must include in those materials a phone number that an Enrollee can call for care coordination assistance prior to the assignment and notification of the care coordinator/Case Manager required in (a) above.

(c) The MCO will have a process in place which assists providers, county staff, family members or others who are calling the MCO requesting the identification of a member's current care coordinator and contact information. This process must be efficient and not require callers to make multiple phone calls to find the requested information.

(5) Coordination with Veterans Administration. The MCO shall make reasonable efforts to coordinate with services and supports provided by the Veterans Administration for Enrollees eligible for VA services.

(6) Referrals to Specialists. Procedures and criteria for making referrals to specialists and sub-specialists including those with geriatric expertise when appropriate.

(7) Identification of Special Needs. Capacity to implement and coordinate with when indicated, other Care Management and risk assessment functions conducted by appropriate professionals, including Long Term Care Consultation and other screenings to identify special needs such as common geriatric medical conditions, functional problems, difficulty living independently, polypharmacy problems, health and long term care risks due to lack of social supports; mental and/or chemical dependency problems; mental retardation; high risk health conditions; and language or comprehension barriers. The MCO shall share with other MCOs serving the Enrollee with special health care needs the results of its identification and assessment of that Enrollee's needs to prevent duplication of those activities.

(8) Reporting Requirements. The MCO shall meet the reporting requirements specified in section 3.7.

6.1.5 Case Management for MSC+. The MCO shall have in place processes and procedures for coordinating services provided by the MCO/MSC+ with Medicare services provided through Medicare Part D and through Medicare fee-for-service. The MCO shall also coordinate the services it furnishes to its Enrollees with the services an Enrollee receives from any other MCO. The MCO shall develop and maintain written descriptions as provided in section 3.7.2(C) including policies and procedures for the operation of the Case Management system in accordance with this section that shall be made available as part of an EQRO review, and for CMS EW waiver reviews. The Care Coordination Workgroup will create a template that MCOs may use to create a training plan for when the MCO contracts with new entities providing Care Coordination. The training plan must include provisions for assuring the training of individuals who will be providing Care Coordination. The training plan will be made available to the STATE upon request.

(A) Case Management for Community Non-Elderly Waiver MSC+ Enrollees: The Case Management system must incorporate the following elements for all Community non-EW MSC+ Enrollees:

(1) Risk Screening and Assessment. Within sixty (60) calendar days of enrollment for new Enrollees and annually for all Enrollees, the MCO shall conduct an initial

risk screening or assessment of each Enrollee's health needs. The screening may be conducted by phone, mail or face-to-face. The screening should address medical, social, environmental, and mental health factors. A risk assessment tool may be used with follow-up assessments conducted based on level of risk. Use of the Health Risk Assessment component of the State's process outlined in section by the MCO will meet the requirements of this section. LTCC assessments and reassessments to determine access to home and community based services and/or home care services performed as part of this assessment process must meet requirements outlined in 6.1.22 below.

(a) In the event of a large transfer of enrollees into the MCO with the same initial enrollment date and if the MCO determines that meeting the timelines indicated in this section cannot be met, the MCO may submit a transition plan to DHS for review and approval indicating the timeline in which they expect to be able to conduct this initial risk assessment required for new enrollees.

(b) All screening and assessments or a summary of each screening or assessment shall be kept as a part of the individual Enrollee health record at the MCO or its designee. Activities of Daily Living (ADLs) should be included in the assessment. The MCO shall enter the ADL information collected during the assessment into MMIS according to section 3.1.3(A) until such time the State notifies the MCO that a new process for reporting this information is available through the State's assessment process outlined in 6.1.22.

(c) If the comprehensive assessment results in a referral for the LTCC, then the LTCC assessment must be completed within the timeframe and process of, and must meet all applicable requirements outlined in section 6.1.22. If the LTCC does not indicate level of care needs for EW eligibility, the Enrollee will be provided with a copy of the Community Support Plan produced by the State's assessment process. If the comprehensive assessment was not conducted face-to-face, a face-to-face visit must be offered as a part of the care planning development process.

(2) The MCO Case Management system will encourage that each Enrollee has an established relationship with a Primary Care Physician or clinic. The MCO Case Management system will develop and employ protocols to facilitate annual physician visits for primary and preventive care.

(3) The MCO Case Management system will establish a communication system of significant health events between Primary Care and the MCO or its designees, such as case managers who coordinate other plan services that may include home care services. Significant health events include, but are not limited to, Emergency Room use, hospital or Nursing Facility admissions.

(B) Case Management System for Community Elderly Waiver MSC+ Enrollees. The MCO must provide Case Management services that are designed to ensure access to, and coordinate the delivery of preventive, primary, acute, post-acute and rehabilitation

services. The Case Management system must incorporate the following elements for all Community EW MSC+ Enrollees:

(1) Risk Screening and Assessment. Within thirty (30) calendar days of enrollment for new Enrollees and annually for all Enrollees, the MCO shall conduct an initial risk screening or assessment of each Enrollee's health needs. The screening may be conducted by phone, mail or face-to-face. The screening should address medical, social, environmental, and mental health factors. A risk assessment tool may be used with follow-up assessments conducted based on level of risk. Use of the Health Risk Assessment component of the State's process outlined in 6.1.22 by the MCO will meet the requirements of this section. All screening and assessments or a summary of screening and assessments shall be kept as a part of the individual Enrollee health record at the MCO or its designee. ADLs should be included in the assessment. The MCO shall enter the ADL information collected during the assessment into MMIS according to section 3.1.3(A) until such time the State notifies the MCO that a new process for reporting this information is available through the State's LTCC assessment process outlined in 6.1.22. LTCC assessments and reassessments to determine access to Home and Community Based Services and/or Home Care services performed as part of this assessment process must meet requirements outlined in section 6.1.22. If the LTCC reassessment does not indicate level of care needs for EW eligibility, the Enrollee will be provided with a copy of the Community Support Plan produced by the State's assessment process. For an Enrollee on EW, a face-to-face visit must occur as a part of the care planning development process.

(a) In the event of a large transfer of Enrollees into the MCO with the same initial enrollment date, and the MCO determines that meeting the timelines indicated in this section cannot be met, the MCO may submit a transition plan to DHS for review and approval indicating the timeline in which they expect to be able to conduct this initial risk assessment required for new Enrollees.

(2) MCOs will provide case management as required by the STATE's Home and Community-Based Waiver.

(3) Each Community Elderly Waiver Enrollee will be assigned a case manager to assist with coordination of Elderly Waiver services, State Plan Home Care Services and other informal or formal services.

(4) For MSC+ Elderly Waiver Enrollees, a Care Plan shall be developed in accordance with the specifications for the Elderly Waiver Care Plan pursuant to section 6.1.13(B) based on a face-to-face needs assessment according to the specifications provided in section 6.1.22. The Care Plan should incorporate an interdisciplinary, holistic and preventive focus and include advance directive planning and Enrollee/family participation.

(5) Care plans must be maintained and updated as required under section 6.1.13, and must be maintained in a clearly identifiable manner by the MCO or its designee for a minimum of three (3) years.

(6) The MCO will establish a written triage protocol and will follow that protocol in assuring a regular schedule of case management contacts with each Community Elderly Waiver Enrollee based on health, and long term care needs.

(7) Annual face-to-face reassessments must be conducted according to section 6.1.13(C).

(8) The MCO case management system must provide for communication of the Care Plan to the Primary Care Physician.

(9) The MCO must establish a system of communication of significant health events including, Emergency Room use, hospital and Nursing Facility admissions between Primary Care and Elderly Waiver case managers.

(10) The case management system must include procedures for promoting rehabilitation of Enrollees following acute events and for ensuring smooth transitions and coordination of information and services between acute, subacute, rehabilitation and Nursing Facilities and Home and Community Based Services settings.

(11) Case management must facilitate consumer and family involvement in care planning and must preserve consumer choices as required under section 6.1.13(A).

(12) The case management system must provide care giver supports and facilitation of care giver respite to assist Enrollees to remain at home.

(13) The case management system must continue to facilitate and coordinate with informal supports and address preservation of community relationships.

(14) The case management system must provide that consumer directed options such as PCA Choice and consumer directed consumer supports waiver services are offered and facilitated at the consumer's choice.

(15) Care Plans must be designed to identify, address and accommodate the specific cultural and linguistic needs of MSC+ Enrollees.

(16) The MCO shall designate a case manager who shall have lead responsibility for creating and implementing the Care Plan unless otherwise designated by the MCO. The Case Manager shall perform the activities as specified below:

(a) Conduct the initial assessment, and periodic reassessment as necessary, of supports and services based on the Enrollee's strengths, needs, choices and preferences in life domain areas;

(b) Develop and update the Enrollee's Care Plan based on relevant ongoing assessment;

(c) Arrange and/or coordinate the provision of supports and services identified in the Enrollee's Care Plan, including knowledgeable and skilled specialty services and prevention and early intervention services that include the facilitation of annual physician visits for primary and preventive care, and all medically necessary services listed in section 6.1, 6.2, 6.3, and 6.4, whether authorized by the Care Coordinator, Local Agency, or other delegated party;

(d) Assist the Enrollee and their legal representatives, if any, to maximize Informed Choices of services and control over services and supports;

(e) Monitor the progress toward achieving the Enrollee's outcomes in order to evaluate and adjust the timeliness and adequacy of services;

(f) Coordinate with Local Agency case managers, financial workers and other staff, as necessary using use of the DHS form "Case Managers/ Financial Worker Communication," #DHS-5181, as provided by the STATE.

(g) The MCO will communicate with lead agencies on the authorization of medical assistance home care services using the DHS form "Managed Care Organization/Lead Agency Communication Form - Recommendation for State Plan Home Care Services, Form# DHS-5841 as provided by the STATE.

(h) Communications include the transfer of an Enrollee from one MCO to another MCO or Local Agency in the event an Enrollee is disenrolled from the MCO, using the Lead Agency HCBS Case Management Transfer Form, DHS-6037 as provided by the STATE;

(i) Solicit and analyze relevant information;

(j) Communicate effectively with the Enrollee and with other individuals participating in the Enrollee's Care Plan;

(k) Educate and communicate to the Enrollee about good health care practices and behaviors which prevent putting the Enrollee's health at risk;

(l) Be informed of basic Enrollee protection requirements, including data privacy; and

(m) Inform, educate, and assist the Enrollee in identifying available services, Providers, and accessing needed resources and services beyond the limitations of the Medical Assistance and Medicare Benefit sets.

(17) Evaluation of Case Manager Performance for MSC+ EW Case Management. The MCO shall have a process to evaluate the performance of individual case managers including Enrollee input. As a part of this process, the MCO must also

have a process on how Enrollees can request and be offered a different case manager. These processes should be described in the Case Manager System description required in section 3.7.2(C). If the process includes the use of subcontractors, the process should be reviewed as a part of the review in section 9.3.9.

(C) Case Management for MSC+ Nursing Facility Residents. The Case Management system must incorporate the following elements for Nursing Facility residents:

(1) The case management system must assist with transition during placement of Enrollees in Nursing Facilities and with discharges back to the community.

(2) For Enrollees placed in the Nursing Facility under MCO payment responsibilities, the case management system must establish a periodic review to determine whether discharge to the community is feasible.

(3) The MCO must provide Relocation Targeted Case Management services for any Nursing Facility resident Enrollee who is planning to return to the community and who requires support services to do so. This can be a part of the case management system indicated above in (2).

(D) Other Case Management Requirements. The MCO shall provide the following:

(1) Case Management Caseload Ratios. The MCO shall establish policies and criteria for case management case load ratios for case managers serving MSC+ Enrollees receiving Elderly Waiver services and will submit this to the STATE for review. Criteria used to develop ratios will include but not be limited to: non-English speaking or need for translation, case mix, Rate Cell designation, care management needs related to chronic condition, mental health status, travel time, and lack of family or informal supports. The MCO will follow this policy in assigning caseloads to case managers. MCO case load policies will be shared with the EQRO and the EQRO will review periodically to determine whether the MCO is following their policy.

(2) The MCO shall meet the reporting requirements specified in section 3.7.

(E) Range of Choices. Procedures for ensuring access to an adequate range of Elderly Waiver and Nursing Facility Services and for providing appropriate choices among Nursing Facilities and/or Elderly Waiver services to meet the individual needs of MSC+ Enrollees who are found to require a Nursing Facility Level of Care. These procedures must include methods for supporting and coordinating services with informal support systems provided by families, friends and other community resources. These procedures must also include strategies for identifying Institutionalized Enrollees whose needs could be met as well or better in non-Institutional settings and methods for meeting those needs, and assisting the Institutionalized Enrollee in leaving the Nursing Facility. For purposes of this section, the word “assisting” includes, but is not limited to, discharge planning and care management responsibilities described in section 6.1.4(A)(2).

(F) Coordination with Social Service Needs. A method for coordinating the medical needs of a MSC+ Enrollee with his/her social service needs including coordination with social service staff and other community resources such as Area Agencies on Aging. Coordination with Local Agency social service staff is required when an Enrollee is in need of the following services:

(1) Pre-petition Screening;

(2) OBRA Level II Screening for Mental Health and Developmental Disability;

(3) Spousal Impoverishment Assessments;

(4) Adult Foster Care;

(5) Group Residential Housing Room and Board Payments; or

(6) Chemical Dependency room and board Services covered by the Consolidated Chemical Dependency Treatment Fund, and;

(7) Adult protection.

(8) The MCO shall coordinate with Local Human Service Agencies for assessment and evaluation related to judicial proceedings.

(G) Notification of Case Manager.

(1) The MCO or its subcontractor must provide to the Enrollee the name and telephone number of the Case Manager assigned to the Enrollee within ten (10) days of a new assignment or change in case manager.

(2) For new Enrollees, if the name of the Case Manager is not provided upon initial enrollment, the MCO must provide each Enrollee with a phone number of a person who is knowledgeable about the MSHO/MSC+ program, that a member can call for case management assistance prior to the assignment and notification of the Case Manager required in (1) above.

(3) The MCO will have a process in place which assists providers, county staff, family members or others who are calling the MCO requesting the identification of an Enrollee's current Case Manager and contact information. This process must be efficient and not require the callers to make multiple phone calls to find the requested information.

(H) Coordination with Veterans Administration. The MCO shall make reasonable efforts to coordinate with services and supports provided by the Veterans Administration, for Enrollees eligible for VA services.

(I) Referrals to Specialists. Procedures and criteria for making referrals to specialists and sub-specialists, including those with geriatric expertise when appropriate.

(J) Identification of Special Needs. Capacity to implement and coordinate with when indicated, other Care Management and risk assessment functions conducted by appropriate professionals.

(K) Screening. Long Term Care Consultation in accordance with section 6.1.22 and other screenings to identify special needs such as common geriatric medical conditions, functional problems, difficulty living independently, polypharmacy problems, health and long term care risks due to lack of social supports; mental and/or chemical dependency problems; mental retardation; high risk health conditions; and language or comprehension barriers. Upon request, the MCO shall share with other MCOs serving the Enrollee with special health care needs the results of its identification and assessment of that Enrollee's needs to prevent duplication of those activities.

(L) Reporting Requirements. The MCO shall meet the reporting requirements specified in section 3.7.

6.1.6 Care Management Services for All Enrollees. The MCO shall be responsible for the Care Management of all Enrollees. The MCO's Care Management system for Enrollees must be designed to coordinate the provision of Primary Care and all other Covered Services to its Enrollees and must promote and assure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, the provision of culturally appropriate care, and fiscal and professional accountability. At a minimum, the MCO's Care Management system for Enrollees must incorporate the following elements:

(A) Procedures for the provision of an individual needs assessment, diagnostic assessment, the development of an individual treatment plan as necessary based on the needs assessment, the establishment of treatment objectives, the monitoring of outcomes, and a process to ensure that treatment plans are revised as necessary. These procedures must be designed to accommodate the specific cultural and linguistic needs of the MCO's Enrollees.

(B) Protocols to facilitate annual physician visits for primary and preventive care.

(C) A strategy to ensure that all Enrollees and/or authorized family members or guardians are involved in treatment planning and consent to the medical treatment.

(D) A method for coordinating the medical needs of an Enrollee with his 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;

(2) Case Management for pre-petition screening;

(3) Court ordered treatment, developmental disabilities, assessment of medical barriers to employment; or

(4) A State medical review team (SMRT) or social security disability determination.

(5) Services offered through social service staff or county attorney staff, for Enrollees who are the victims or perpetrators in criminal cases.

(6) If the MCO determines that an assessment is required in order for the Enrollee to receive Covered Services related to these conditions, the MCO is responsible for payment of the assessments, unless the requested assessment has been paid for by an MCO within the previous one hundred and eighty (180) days.

(E) Procedures and criteria for making referrals to specialists and sub-specialists.

(F) Capacity to implement, when indicated, Care Management functions such as 1) individual needs assessment, including screening for special needs (e.g. mental health and/or chemical dependency problems, developmental disability, high risk health problems, difficulty living independently, functional problems, language or comprehension barriers); 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.

(G) Procedures for coordinating care for American Indian Enrollees.

(H) Hospital In-reach Community-based Service Coordination (IRSC). The MCO will provide in-reach community-based service coordination that is performed through a hospital emergency department for an Enrollee who has frequented a hospital emergency department for services three or more times in the previous four consecutive months. The in-reach service coordination will include performing an assessment to address an Enrollee's mental health, chemical health, social, economic, and housing needs, or any other activities targeted at reducing the incidence of emergency room and other non-medically necessary health care utilization and to provide navigation and coordination for accessing the continuum of services to address the Enrollee's needs. In-reach community based service coordination shall seek to connect frequent users with existing covered services including but not limited to, targeted case management, waiver case management, Care Coordination or care coordination in a health care home.

6.1.7 Chemical Dependency (CD) Treatment Services. CD treatment services do not include detoxification (unless it is required for medical treatment). The MCO is responsible for all CD treatment services including room and board as determined necessary by the assessment. identified in Minnesota Rules, Part 9530.6615. Effective for dates of service on July 1, 2014 and going forward, the MCO shall not be responsible for the payment of room and board services provided by residential chemical dependency treatment providers.

Notwithstanding section 6.22.2(B), CD treatment services shall be provided in accordance with 42 CFR §8.12, and Minnesota Statutes § § 254B.04, subd. 2a and 254B.05, subd. 1.

(A) Chemical Dependency services will include utilization, in primary care clinics, of a valid and reliable tool approved by the STATE, for Screening and Brief Intervention (SBI) to identify unhealthy substance use, and to provide a brief intervention, when indicated.

(B) In addition, when patient screens are positive for substance abuse or dependence, the MCO agrees to provide Screening Brief Intervention and/or Referral to Treatment (SBIRT) in primary care clinics. Clinics will utilize valid and reliable tools, approved by the STATE, and resources to provide immediate treatment options, which may include pharmacotherapy options and/or referral to specialized treatment.

6.1.8 Chiropractic Services. Chiropractic services are covered.

6.1.9 Clinic Services. Clinic services are covered.

6.1.10 Community Health Worker Services. CHW services are covered.

6.1.11 Community Paramedics. Pursuant to Minnesota Statutes, §256B.0625, subd. 60, community paramedic services include health assessments, chronic disease monitoring and education, medication compliance, immunizations and vaccinations, laboratory specimen collection, hospital discharge follow-up care, and minor medical procedures approved by the ambulance medical director. Services provided by community paramedics must be a part of a care plan ordered by a Primary Care Provider in consultation with the ambulance medical director. The care plan must ensure that the services provided by the community paramedics are coordinated with other community health providers and local public health agencies, and are not duplicate services, including home health and waiver services. Community paramedics providing services to enrollees receiving care coordination must be in consultation with the providers of the care coordination.

6.1.12 Dental Services. Pursuant to Minnesota Statutes, § 256B.0625, subd. 9, dental services include the following.

(A) Services for adults who are not pregnant are limited to the following services:

(1) comprehensive exams, limited to once every five years;

(2) periodic exams, limited to one per year;

(3) limited exams;

(4) bitewing x-rays, limited to one per year;

(5) periapical x-rays;

(6) panoramic x-rays, limited to one every five years except (1) when medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma, or (2) once every two years for patients who cannot cooperate for intraoral

film due to a developmental disability or medical condition that does not allow for intraoral film placement;

(7) prophylaxis, limited to one per year;

(8) application of fluoride varnish, limited to one per year;

(9) posterior fillings, all at the amalgam rate;

(10) anterior fillings;

(11) endodontics, limited to root canals on the anterior and premolars only;

(12) removable prostheses, each dental arch limited to one every six years;

(13) replacement of removable prostheses if misplaced, stolen or damaged due to circumstances beyond the Enrollee's control;

(14) replacement of a partial prosthesis if the existing prosthesis cannot be modified or altered to meet the Enrollee's dental needs;

(15) reline, rebase or repair of removable prostheses (dentures and partials);

(16) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;

(17) palliative treatment and sedative fillings for relief of pain; and

(18) full-mouth debridement, limited to one every five years.

(B) In addition to the services specified in (A) above, Medical Assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:

(1) periodontics, limited to periodontal scaling and root planing once every two years;

(2) general anesthesia; and

(3) full-mouth survey once every five years.

(C) In addition to the services specified in 6.1.12(A) and (B), the following services for adults are covered effective July 1, 2013:

(1) House calls or extended care facility calls for on-site delivery of covered services;

(2) Behavioral management when additional staff time is required to accommodate behavioral challenges and sedation is not used;

(3) Oral or IV sedation, if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center; and

(4) Prophylaxis, in accordance with an appropriate individualized treatment plan, but no more than four times per year.

(D) Services provided by advanced dental therapists and dental therapists when provided within the scope of practice identified in Minnesota Statutes, §§ 150A.105 and 150A.106 are covered.

6.1.13 Elderly Waiver Services for MSHO and MSC+.

(A) Authority and Purpose. Elderly Waiver services, also known as Home and Community-Based Services (HCBS), are authorized under §1915(c) of the Social Security Act and federal waivers under 42 USC §1396n, and Minnesota Statutes, § 256B.0915 and shall be provided pursuant to the current waiver plan approved by CMS when necessary to prevent or avoid Institutional placement to community Enrollees who have received a Long Term Care Consultation and who but for the provision of such services, would require a Nursing Facility (NF) Level of Care, the cost of which could be reimbursed under the Medicaid State Plan. STATE's authority to develop Elderly Waiver services includes subd. 9 of Minnesota Statutes, § 256B.0915 authorizing tribal management of Elderly Waiver Services. See section 6.26. Waiver requirements include:

(1) An individual written Care Plan must be developed for each Enrollee as specified in this contract. Services included in the Care Plan must be necessary to meet a need identified in the enrollee's assessment and be for the sole benefit of the Enrollee and related to the Enrollee's condition.

(2) The waiver shall cover only those goods and services authorized in the Care Plan that collectively represent a feasible alternative to institutional care. Services not included in the Care Plan are not covered by Elderly Waiver.

(B) Care Plan. For each MSC+ or MSHO Enrollee who is assessed and determined to require Elderly Waiver services, the MCO shall develop a Care Plan in accordance with section 6.1.4(A)(2) for MSHO Enrollees and 6.1.5 for MSC+ Enrollees. Care Plans for EW Enrollees shall meet the following requirements:

(1) The Care Plan shall include the Community Support Plan, or all elements thereof in Minnesota Statutes, § 256B.0915, subd. 6, based on a face-to-face needs assessment. The Community Support Plan includes a section titled Community Services and Support, that authorizes EW services and contains at minimum; services to be furnished, the amount, frequency and duration of each service, and the type of Provider furnishing each service, including non-paid caregivers and other informal community supports or community resources.

(2) The Care Plan for EW Enrollees shall be completed and implemented within thirty (30) days of LTCC assessment.

(3) The Care Plan shall involve the Enrollee and/or authorized representative, and requires that an explanation of home and community-based and consumer directed support services be provided to the Enrollee or authorized representative, in order for Enrollee to make Informed Choices as required by the Social Security Act, § 1929(f)(2)(A), 42 CFR § 441.353 subpart (d), and Minnesota Statutes § 256B.0911 subd. 3a, (e).

(4) The Care Plan shall include consultation with the Enrollee's family, primary care-givers and other care disciplines as appropriate.

(5) The Enrollee or Authorized Representative must sign a summary of the Care Plan that contains at a minimum, the Community Support Plan or all elements thereof.

(6) The MCO shall provide a copy of the summary of the Care Plan to the Enrollee.

(7) The MCO shall provide a copy of the Care Plan to the STATE upon request.

(C) Reassessment. The MCO shall provide a face-to-face re-evaluation of the Enrollee's Elderly Waiver services Level of Care, eligibility for Elderly Waiver services and care needs at least every twelve (12) months after Elderly Waiver services have begun. Reassessment must be conducted in a manner and frequency to ensure that the services furnished are consistent with the nature of the Enrollee's needs. Re-evaluations are conducted using the forms designated by the STATE. A summary of the Long Term Care Consultation information must be maintained in the Enrollee's record along with the Plan of Care. When a reassessment is conducted, the MCO must enter the information into MMIS within thirty (30) days of the reassessment.

(D) OBRA (Omnibus Budget Reconciliation Act) Screening. The Long Term Care Consultation shall include the completion of the questions on the OBRA Level I screening form. If mental health (MH) or developmentally disability (DD) diagnoses are indicated and the Enrollee is to be admitted to the NF, the MCO must refer the Enrollee to the Local Agency for further OBRA Level II screening prior to the NF admission.

(E) Tribal Assessments and Care Plans. The MCO will accept the results of EW assessments, reassessments and the resulting care plans developed by tribal assessors for Tribal Community Members as determined by the tribe. Referrals to non-tribal providers for services resulting from the assessments must be made to providers within the MCO's network. This applies to services requested by Tribal Community Members residing on or off the reservation.

(F) Spousal Impoverishment. Any married Enrollee who becomes a Recipient of Elderly Waiver services or is admitted to a certified Nursing Facility must be referred

by the MCO to the appropriate Local Agency Medical Assistance Eligibility office for an asset assessment.

(G) Eligibility and Limitations. The MCO shall provide Elderly Waiver services necessary to prevent or avoid Nursing Facility placement to community Enrollees who have received a Long Term Care Consultation and who have been determined to meet Nursing Facility Level of Care Criteria as documented on forms designated by the STATE, and for whom it has been determined that but for the provision of waiver services, would require a Nursing Facility.

(1) To be eligible for EW the Enrollee must receive Case Management, and have authorized and delivered at least one additional formal waiver service as documented in the community support plan.

(2) The MCO must determine whether or not the Enrollee's needs can safely be met through the provision of Elderly Waiver services and develop and implement a Plan of Care based on information in the Long Term Care Consultation assessment in the least restrictive alternative in a community-based setting.

(H) Conversions. Elderly Waiver services shall also be provided to convert Enrollees residing in the Nursing Facility to allow them to return to a community setting pursuant to Minnesota Statutes, § 256B.0915, subd. 3b. The MCO shall provide transitional services to assist the Enrollee in returning to a community setting as described in section 6.1.13(K)(18). MCOs will approve conversion budget limits and Customized Living including 24 hour Customized Living limits for members authorized for adult foster care, Customized Living including 24 hour customized living. Limits will be based on budgets documented using the Customized Living Tool and submitted electronically to DHS per section 9.3.22(E)(3).

(I) Money Follows the Person Rebalancing Demonstration (MFP; or Moving Home Minnesota). The MCO will work with the STATE to identify Enrollees who could benefit from the MFP demonstration and are eligible for MFP services, pursuant to Minnesota Statutes 256B.04, subdivision 20.

(1) The MCO must use operational protocols provided by the STATE. The STATE will inform the MCO of the specific services available under MFP.

(2) The MCO is responsible to notify the STATE of Enrollees who will benefit from the MFP demonstration using a process determined by the STATE to enable the Enrollee to be placed in the MFP MSHO Rate Cell Category or MSC+ program type for tracking purposes.

(3) Timelines.

(a) If the Enrollee chooses to not utilize MFP, the MCO must notify the STATE timely so the Enrollee can be moved to the appropriate MSHO Rate Cell Category or MSC+ program type. If an Enrollee who was enrolled in the MFP returns to an institutional placement for thirty (30) days, the MCO must notify the STATE.

(b) Within one year from first receiving MFP, Enrollees must be transitioned to Elderly Waiver services without MFP services. The STATE will notify the MCO of Enrollees no longer eligible for MFP due to the one year limit, prior to the end of the one year limit. The MCO must assist in transitioning these Enrollees to other available services.

(4) Eligibility. To be eligible for MFP an enrollee must be

(a) Medicaid eligible;

(b) reside or have resided for at least ninety (90) days excluding Medicare rehabilitation days in a qualified institution of which at least one day has been paid by Medical Assistance;

(c) meet the criteria for EW; and

(d) be moving to a qualified residence.

i) Qualified institutions include hospitals, nursing facilities, intermediate care facilities and institutions for mental disease.

ii) Qualified residences are include: a home owned or leased by the individual or the individual's family member, an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the individual or the individual's family has domain and control; or a residence, in a community-based residential setting, in which no more than four (4) unrelated individuals reside.

(J) EW Cost. The MCO may refuse to offer Elderly Waiver services to any Enrollee for whom it can reasonably be expected that the cost of Elderly Waiver services furnished to that Enrollee would exceed the cost of Nursing Facility Level of Care. For conversions, the MCO must calculate a monthly conversion limit for the cost of Elderly Waiver services for those Enrollees who are residing in a Nursing Facility for at least thirty (30) days and who wish to return to a community setting pursuant to Minnesota Statutes, § 256B.0915, subd. 3b. Conversion rates must be approved by the MCO. Conversion rates may be extended and reauthorized annually if required to maintain a community placement. Elderly Waiver services will not be furnished to an Enrollee while the Enrollee is an inpatient of a hospital, NF or ICF/DD, except for respite care as provided for in section 6.1.13(K)(2). The MCO may limit the amounts of services provided under Home and Community Based Services (HCBS) to the limits specified in the MHCP manual.

(K) Elderly Waiver Covered Services. Elderly Waiver services include the services listed below. Current Elderly Waiver service definitions and provider standards are available on the STATE's website at the MHCP Provider Manual, in the EW and AC section at: http://www.dhs.state.mn.us/main/id_056766The STATE will provide notice to the MCO when waiver amendments are approved by CMS.

(1) Homemaker services

(2) Respite care services (In Home and Out of Home)

(3) Adult day services (ADS)

(4) Adult companion services

(5) Specialized medical supplies and equipment

(6) Extended State Plan home health care services, including home health aide and skilled nursing services

(7) Extended State Plan Private Duty Nursing

(8) Extended State Plan PCA services

(9) Family and care giver training and education services.

(10) Home delivered meals;

(11) Residential care services

(12) Customized Living, including 24-Hour Customized Living services

(13) Adult Foster Care services (Corporate and Family)

(14) Environmental accessibility adaptations

(15) Chore services

(16) Consumer directed community supports

(17) Transportation

(18) Transitional supports services

(19) Adult Day Service Bath.

(20) Community Emergency Respite Services.

(21) Individual Community Living Support Services. Pending federal approval, individual community living support will be added to the Elderly Waiver. MCOs will use the electronic ICLS service planning and rate-setting tool established by the Commissioner and will submit tools electronically to DHS. The State will consult with the MCO in the development of the service planning and rate-setting tool through the MCO EW Services Workgroup.

(L) Choice of EW Providers. MCO EW networks must make a best effort to offer a choice of EW Providers within each of the EW service and support categories required to be provided. The MCO shall report where they have identified little or no availability of EW providers through the gap analysis process described in 6.13.

6.1.14 Treatment of End Stage Renal Disease (ESRD).

6.1.15 Family Planning Services. Family planning services are covered.

(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 services prescribed by Minnesota Statutes, § 62Q.14.

(B) The MCO may not restrict the choice of an Enrollee as to where the Enrollee receives the following services, pursuant to Minnesota Statutes, § 62Q.14:

(1) Voluntary planning of the conception and bearing of children, provided that this clause does not refer to abortion services;

(2) Diagnosis of infertility, including counseling and services related to the diagnosis (e.g., Provider visit(s) and test(s) necessary to make a diagnosis of infertility and to inform the Enrollee of the results);

(3) Testing and treatment of a sexually-transmitted disease; 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) Medical Care other than Family Planning Services;

(4) Genetic testing; and

(5) HIV treatment.

(D) Pursuant to 42 CFR § 433.116(f)(2) the MCO shall not specify confidential services, as defined by the STATE, in any Notices sent to the Enrollee including but not limited to Explanation of Benefit and/or Explanation of Medical Benefit Notices.

6.1.16 Health Care Home. Enrollees with complex or chronic health conditions may access services through a Health Care Home that meets the certification criteria listed in Minnesota Rules, parts 4764.0010 through 4764.0070.

6.1.17 Home Care Services. Services covered under Minnesota Statutes, § 256B.0625, subds. 6a, 7 and 19a and c, §§ 256B.0651; 256B.0653; 256B.0654; 256B.0655, and § 1861(m) of the Social Security Act.

(A) Home Care Services include:

(1) Skilled Nursing visits provided by a certified home health care agency, up to the service limit described in Minnesota Statutes, § 256B.0653, subd. 4, including telehomecare skilled nurse visits.

(2) Home Health Aide services provided by a certified Home Health Care Agency, for Medical Assistance, up to the service limit described in Minnesota Statutes, § 256B.0651, subd. 6(b), and § 256B.053, subd. 3, and for MSHO, for Medicare, as long as the Enrollee meets Medicare criteria.

(3) Personal Care Assistance Services (PCA) services as specified in Minnesota Statutes § 256B.0659, subdivisions (1) through (30) and below, except subdivisions (5)(c), (d), and (e).

(a) PCA Assessment/ LTCC Assessment. The MCO must provide assessments for PCA services as required under § 256B.0659 subd. 3a, as amended, or for MCOs who are lead agencies, under § 256B.0911, as amended, and must authorize home care services utilizing the home care rating criteria, service amounts and limits under § 256B.0659, subd. 4. An in-person assessment must occur at least annually or when there is a significant change in the enrollee's condition or when there is a change in the need for PCA services. A service update may substitute for an in-person assessment when there is no significant change in the Enrollee's condition or a change in the need for PCA services.

(b) PCA services for Enrollees with one dependency in ADLs or Level I behavior shall be provided consistent with Minnesota Statutes, § 256B.0652, subd. 6.

(c) Personal Care Assessment and Service Plan. Pursuant to Minnesota Statutes, § 256B.0659, subd. 6, the MCO must require that the service plan be completed by the assessor with the Enrollee and responsible party, on a form provided by the STATE. The PCA Assessment and Service Plan must include a summary of the assessment with a description of the need and authorized amount of personal care assistance services. The Enrollee and the provider must be given a copy of the completed PCA Assessment and Service Plan within ten (10) working days of the date of the home visit for the assessment. The Enrollee must also be given information by the assessor about the options in the personal care assistance program to allow for review and decision making. The MCO must ensure that an Enrollee who appeals a reduction in previously authorized home care services has been provided the most recent PCA Assessment and Service Plan with an explanation of the ADL, complex health-related needs and behavior areas that have changed since the last assessment, including notice of the amount of time per

day reduced, and the reasons for the reduction in the Enrollee's Notice of Denial, Termination or Reduction.

(d) Personal Care Assistance Care Plan. The MCO must require that the provider and the QP working for the PCPA provide each enrollee with a current Personal Care Assistance plan consistent with the service plan. The care plan must meet the requirements of Minnesota Statutes, § 256B.0659 subd. 7 and 7a, and must be completed by the QP and the Enrollee or responsible party based on the service plan.

i) The provider plan of care must be completed within seven (7) calendar days of the receipt of the PCA Assessment and Service Plan referenced in paragraph 6.1.17(A)(3)(c) above after the start of services with a PCPA and must be updated as needed when there is a change in need for PCA services.

ii) A new provider plan of care is required annually at the time of reassessment.

iii) A copy of the provider plan of care must be kept in the Enrollee's home and in the Enrollee's file at the PCA agency. The provider plan of care must include provisions for measures to address identified health and safety and vulnerability issues, including a backup staffing plan, the responsible party and instructions for contact, a description of the Enrollee's needs for assistance with activities of daily living, instrumental activities of daily living, health related tasks and behaviors, and must be signed and dated by the Enrollee or responsible party, and QP. The provider plan of care must also include instructions and comments about the Enrollee's needs for assistance and any special instructions or procedures required. The month-to-month plan for the use of PCA services is part of the provider plan of care

(e) Disenrollment or Change in MCO. The MCO will comply with Minnesota Statutes, § 256B.0651, subd. 7(b), which provides that the amount and type of PCA services based on the assessment and service plan must remain in effect for the one year period of the most recent valid assessment for the Enrollee whether the Enrollee chooses a different provider or enrolls or disenrolls from an MCO under Minnesota Statutes, § 256B.0659, unless the service needs of the Enrollee change and a new assessment is warranted under 6.1.17(A)(3)(a) above.

(f) MCO Authorization of PCA Services. The MCO is responsible for reviewing the PCA Assessment and Service Plan, and authorizing the amount, duration and frequency of the PCA services, as determined by the Assessment.

i) If the MCO authorization requires changes to the PCA Assessment and Service Plan due to a required reassessment, to avoid duplication of services or due to an Enrollee's request, the MCO is responsible for ensuring the PCA provider, Primary Care Physician and Enrollee are notified of this change in writing. The MCO must assure that the provider and the Enrollee

are notified in writing of the updated written service plan, including reasons for any changes.

ii) The MCO shall direct the provider to adjust the care plan to reflect the changes in i) above and to provide an updated care plan to the Enrollee.

(g) MCO Authorizations Continue after Disenrollment. The MCO must cooperate with provisions under Minnesota Statutes, § 256B.06512, Subd 14, paragraph (5) for extension of authorizations of PCA services for enrollees who are temporarily disenrolled from the MCO and enrollees who return to the MCO.

i) If a Recipient enrolled in managed care experiences a temporary disenrollment from the MCO, the STATE FFS system shall accept the current MCO authorization for up to sixty (60) days, provided the request is received within the first thirty (30) days of disenrollment.

ii) If the Recipient's re-enrollment in managed care is after sixty (60) days and before ninety (90) days, the PCA provider must request an additional thirty (30) day extension of the current MCO authorization,

iii) An MCO authorization is valid in the FFS system for a total limit of ninety (90) days from the date of disenrollment.

(h) The MCO will participate in the MCO Personal Care Assistance (PCA) workgroup to develop additional implementation plans for the processes as specified in Minnesota Statutes, § 256B.69, subd. 5a, if required.

(i) PCA Services Notice. An Enrollee whose PCA services will be reduced or terminated due to the requirements of Minnesota Statutes, § 256B.0659 may request continued services pending appeal within ten (10) days after the notice is sent, or before the effective date of the action, whichever is later. The Enrollee may request a copy of the care plan and/or authorization document from the MCO or its subcontractor for PCA hours of service at the previously authorized level, if the Enrollee has requested services pending an appeal.

(j) Foster Care. The MCO shall not authorize PCA services in a housing setting where the foster care license holder is also the PCA provider or personal care assistant unless the foster home is the licensed provider's primary residence as defined in Minnesota Statutes, § 256B.0625, subdivision 19a, (c). The MCO must ensure that PCA Providers keep specific documentation on file for each Enrollee, pursuant to § 256B.0659, subds. 12 and 28, including but not limited to a service plan, care plan and timesheets.

(k) PCA services are not covered when the owner of a PCPA who is not related by blood, marriage or adoptions owns or otherwise controls the living arrangement, pursuant to Minnesota statute, § 256B.0659, subdivisions 3b and 29.

i) Provider owned or controlled housing includes but is not limited to Corporate Foster Care, Assisted Living, Housing with services and other models where there is an expectation that services are included with housing.

ii) The STATE considers a living arrangement to be controlled by a provider if any of the following are true:

1. Entity that controls the living arrangement is using PCAs as shift staff. This includes unlicensed group residences, corporate foster care, assisted living and any other model with an expectation that PCA services are included with the housing;

2. Landlord actively markets one or more PCA providers to its residents;

3. Landlord places any restrictions on residents based on their MHCP enrollment status, amount of service authorized or the PCA provider used;

4. Landlords provide incentives, such as discounts in rent or higher personal needs allowances, to recipients of one or more PCA services;

5. Living arrangement is made contingent upon the need for or authorization of PCA services, or

6. Recipient needs to move in order to choose a new PCA provider.

(l) PCA Options. The MCO shall ensure that the flexible use, shared and PCA choice options are provided in accordance with Minnesota Statutes, § 256B.06595, subds 15, 16 and 18 through 20, including but not limited to the limitations and Service Authorization for the option for flexible use of PCA hours and as described on the DHS PCA Portal at http://www.dhs.state.mn.us/main/dhs16_145201#

(m) Responsible Party. The MCO must have mechanisms in place to ensure that PCA providers require that responsible parties meet the definitions outlined in Minnesota Statutes, § 256B.0659, subd. 9, as amended, and that they carry out their duties as required under § 256B.0659, subd. 10, including that the responsible party enter into a written agreement with the PCPA, using the "PCA Program Responsible Party Agreement and Plan," (DHS form #5856) provided by the STATE.

(n) Ineligible PCAs. If the STATE provides the MCO notice that an individual is ineligible to participate as a PCA in the Minnesota Health Care Programs, the MCO will ensure that funds received by the MCO from the STATE are not used to pay the individual for PCA services.

(o) PCA Qualifications. MCOs must make reasonable efforts to assure that PCAs are in compliance with Minnesota Statutes, § 256B.0659, subd. 11, as amended. This compliance includes but is not limited to the PCA being:

i) employed by a personal care assistance provider agency, with completion of a background study according to Minnesota Statutes, § 245C;

ii) supervised by a QP according to section 6.1.17(A)(4) below; and

iii) limited to providing and being paid for up to two hundred and seventy-five (275) hours per month of PCA services regardless of the number of Enrollees being served or the number of PCPAs the PCA is enrolled with. The STATE shall provide to the MCO on a monthly basis a report identifying an individual PCA who has exceeded the monthly 275 hour limit. The report will provide how many units of service exceeded 275 hours for that PCA in that month. The MCO must reprocess the original claim and take back the reimbursement for service provided above the 275 hour limit. The MCO will also submit either a void or replacement encounter claim for action taken on the original claim.

(p) PCPA Qualifications; Enrollee Right to Choose. MCOs must make reasonable efforts to assure that PCPAs are in compliance with Minnesota Statutes, § 256B.0659, subdivision 21. This compliance includes (but is not limited to) assurance by the MCO that the PCPA does not limit Enrollees' right to choose service providers. This includes that the PCPA may not require its PCAs to

i) Agree not to work with any particular Enrollee, nor

ii) Agree not to work for another PCPA, after leaving the PCPA.

iii) The MCO must assure that the PCPA is not taking action on any such agreements or requirements regardless of the date signed.

(q) Requests for Assessments by PCA Providers. PCPA and individual PCAs may not request initial PCA assessments. An Enrollee, a person with the authority to act on behalf of the Enrollee, or a Health Care Professional can request an initial assessment when there have been no PCA services provided or there has been a break in PCA services (for example, service agreement/authorization ended or there is a change in circumstances).

(4) Qualified Professional (QP) supervision of PCA Services as described in Minnesota Statutes, § 256B.0659, subds. 13 and 14. All personal care assistants must be supervised by a QP. The QP is responsible for assisting the enrollee in developing a plan for use of the PCA time authorized and will assure how those hours are used throughout the month.

(5) Private Duty Nursing Services, for Medical Assistance, up to the limits established in Minnesota Statutes, § 256B.0654, subd. 2 and 2b, and § 256B.0652.

The MCO shall also use the criteria established in Minnesota Statutes, § 256B.0654, subd. 4, to determine whether or not to grant a hardship waiver for these services to an Enrollee's parent, spouse, legal guardian, or family foster care parent.

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

(7) Medical Equipment and Supplies, pursuant to section 6.1.24.

(B) Home care policy is in the Community-Based Services Manual (CBSM). The CBSM is the primary source of information related to home care services at http://www.dhs.state.mn.us/main/id_000402#

(C) For Enrollees who are ventilator-dependent, limits described in section 6.1.17(A) above do not apply; the limits for these Enrollees are as described in Minnesota Statutes, § 256B.0652, subd. 7.

(D) Nursing Facility Certifiable: Those Enrollees in MSHO and MSC+ who are NHC shall also receive Elderly Waiver services from the MCO, as needed.

(E) Service Authorization: If the MCO requires Service Authorization for Home Care Services, it shall comply with section 6.21.

(1) The MCO's authorization process and criteria for any Home Care Services must be in a format specified by the STATE, and made available on the MCO's website with a corresponding link on the DHS public website so it is accessible to Providers and Enrollees.

(2) Care Coordinators or case managers must be made aware of all services authorized under this section, consistent with the responsibilities in section 6.1.4(B)(4) or section 6.1.5(B)(16)(c).

(F) Tribal Assessments and Service Plans. The MCO will accept the results of home care assessments, reassessments and the resulting service plans developed by tribal assessors for Tribal Community Members as determined by the tribe. Referrals to non-tribal providers for home care services resulting from the assessments must be made to providers within the MCO's network. This applies to home care services requested by Tribal Community Members residing on or off the reservation.

(G) Use of Certified Assessors and Assessment. By a date determined by the STATE and with at least ninety (90) days' notice, and provided required training has been made available to those the MCO has designated, the MCO is required to utilize DHS certified assessors and the STATE-approved assessment system for home care services as provided in Minnesota Statutes, § 256B.0911, subds. 2b and 2c.

(H) Sanctioned Home Health Care Agencies.

(1) In the event of a termination due to sanction under Minnesota Statutes, § 256B.064 or an MCO Action, the MCO must make reasonable efforts to assure that home health care agencies will provide or have provided each Enrollee with a copy of the home care bill of rights under MS § 144A.44 at least thirty (30) days before terminating services to an Enrollee.

(2) If a home health care agency determines it is unable to continue providing services to an Enrollee because of any action under Minnesota Statutes, § 256B.064, the agency must notify the MCO, the Enrollee, the Enrollee's responsible party if applicable, and the STATE thirty (30) days prior to terminating services to the Enrollee. The MCO and home health care agency must cooperate in supporting the Enrollee in transitioning to another home health care provider of the Enrollee's choice within the MCO's network .

(3) In the event of a sanction of a home health care agency, a suspension of participation, or a termination of participation of a home health care agency under § 256B.064 or from the MCO, the MCO must inform the Office of the Ombudsman for Managed Care for all Enrollees with care plans with the home health care agency. The MCO must contact Enrollees to ensure that the Enrollees are continuing to receive needed care, and that the Enrollees have been given choice of provider (within the MCO's network) if they transfer to another home health care agency.

6.1.18 Hospice Services. Hospice services include services provided by a Medicare certified hospice agency or, when a Medicare certified hospice agency is not available, services that are equivalent to those provided in a Medicare certified hospice agency. For purposes of this section, "equivalent" means that the Enrollee: will be provided with a hospice election process that is similar to the hospice election process used by a Medicare certified hospice agency; and will be provided with the same choice and amount of services that would be available through a Medicare certified hospice agency.

6.1.19 Inpatient Hospital Services. Coverage for Inpatient Hospitalization shall not exceed the actual semi-private room rate, unless a private room is determined to be Medically Necessary by the MCO.

6.1.20 Interpreter Services. The MCO shall provide sign and spoken language interpreter services that assist Enrollees in obtaining services covered under this Contract, 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 responsible to provide interpreter services for services provided through fee-for-service.

(A) Coverage for face-to-face oral language interpreter services shall be provided only if the oral language interpreter used by the MCO is listed in the registry or roster established under Minnesota Statutes, § 144.058.

(B) The MCO is not required to provide an interpreter for activities of daily living in residential facilities. The MCO is responsible to provide an interpreter for medical services provided by the MCO outside of residential facilities and the per diem institutional facilities under this Contract.

6.1.21 Laboratory, Diagnostic and Radiological Services.

6.1.22 Long Term Care Consultation

(A) Long Term Care Consultation (LTCC), Assessment and Support Planning Services.

(1) Lead Agency Role: the MCO is the Lead Agency responsible for conducting required pre-admission screenings (PAS) face-to-face assessments and reassessments and support planning services for its Enrollees to determine the need for an institutional level of care and for determination of HCBS waiver service eligibility, including institutional level of care determination as defined under Minnesota Statutes, §§ 256B.0911, subd. 4a, paragraph (d) and 144.0724, subd. 11, and for service eligibility including State Plan home care services identified in Minnesota Statutes, § 256B.0625 subds. 6, 7, and 19, paragraphs (a) and (c). Determinations must be based on assessment and support plan development with appropriate referrals.

(2) The MCO or its subcontractor will perform the Preadmission Screening (PAS) on Enrollees entering NFs who have been identified by the MCO or by a referral from the Senior LinkAge Line. The MCO or its subcontractor will enter the results of the PAS into MMIS according to section 3.5.

(3) The lead agency must provide the STATE with an administrative contact for communication purposes.

(4) Cost Effective Alternatives: Pursuant to § 256B.0911, subd. 1, (b) the MCO providing LTCC services shall offer a variety of cost effective alternatives to institutional care and shall encourage the use of volunteers from families, religious organizations, social clubs and similar civic and service organizations to provide community based services.

(5) Use of Certified Assessors: The MCO must assure that is has sufficient numbers of certified assessors to provide assessment and support planning within the timelines and parameters of the service.

(6) All MCO and subcontractor staff designated to provide the LTCC services defined in 256B.0911, subdivision 1a, must be certified within timelines specified by the Commissioner, but no sooner than six months after statewide availability of the training. These staff will also serve as the on-going care coordinator/case manager of the Enrollees assessed. The Commissioner must establish the timelines for training and certification in a manner that allows MCO to most efficiently adopt the automated process established in 256B.0911, subd. 5.

(7) Certified Assessors: Certified assessors are persons with a minimum of a bachelor's degree in social work, nursing with a public health nursing certificate, or other closely related field with at least one year of home and community based experience, or a registered nurse without public health certification with at least two years of home and community based services experience, who has received training and certification specific to assessment and consultation services for long term care services in Minnesota. Certified assessors shall demonstrate best practices in assessment and support planning including person-centered planning principles and have a common set of skills to ensure consistency and equitable access to services statewide. Assessors must be part of a multidisciplinary team of professionals that includes public health nurses, social workers and other professionals as defined in this section. Certified assessors must be recertified every three years.

(8) For Enrollees with complex health care needs a public health nurse or registered nurse from a multidisciplinary team must be consulted.

(9) Initial evaluation of Level of Care to determine eligibility for Elderly Waiver services must be performed, using the process designated by the STATE, within twenty (20) calendar days after a request for such evaluation by the Enrollee or legal representative, or referral by other competent authority, such as a doctor, discharge planning team or social worker.

(a) Such assessment shall be conducted by a professional as listed in section 2.75 using the process designated by the STATE to determine eligibility for Nursing Facility placement and/or Elderly Waiver services according to the Level of Care criteria, and pursuant to Minnesota Statutes, §§ 256B.0911 or 144.0724, subd. 11.

(b) The MCO shall maintain the assessment information in the Enrollee's medical record for a minimum of three years. When such assessment is completed, the MCO must complete the screening document and enter the screening document into MMIS, according to section 3.5, LTCC Screening Document Entry.

(10) Long Term Care Consultation Audits. As a part of the Care Plan audits required in section 7.8.3, documents will be audited to ensure that the assessment of the Enrollee clearly indicates that he or she meets Level of Care criteria, and to ensure consistency between the Enrollee's Level of Care and the services to be provided. As a part of the STATE's review of the Care Plan audit, if the audit reveals placement of Enrollees in inappropriate Rate Cells, the Rate Cell will be corrected prospectively by the STATE, and any retrospective amounts may be collected by the STATE according to the process in section 4.2.4(A) or 4.2.4(B). All LTCC documents and forms completed under this Contract with a Local Agency will be subject to the same audits or verifications applied by the STATE to LTCC performed outside of the MSHO and MSC+ contract.

(11) When an Enrollee is determined to require a Nursing Facility Level of Care, the Enrollee or his or her legal representative will be:

(a) Informed of feasible alternatives to Nursing Facility care; including a choice of Home and Community-Based Services and consumer directed options and if needs can be met using State Plan services.

(b) Offered a plan of care consistent with the screening assessment which is designed to meet the needs of the Enrollee and protect his or her health and safety;

(c) Informed of the right to Appeal the screening decision as required under Article 8 of this Contract and pursuant to Minnesota Statutes, § 256.045.

(12) In all cases where an Enrollee who previously was determined to meet Nursing Facility Level of Care but upon subsequent assessment is determined to not meet the Nursing Facility Level of Care criteria, the MCO shall have a process for review of these assessment results.

(a) This review shall determine the appropriateness of the reduction of level of care prior to implementation of the change and issuance of a DTR, and will ensure that the revised Care Plan addresses health and safety needs appropriately.

(b) The revised Care Plan will include Essential Community Supports for eligible individuals, pursuant to DHS guidance. The MCO shall submit service agreements for Essential Community Supports to the STATE and shall monitor enrollees' use of Essential Community Supports, in a process provided by the STATE. The MCO remains responsible to provide care coordination services for MSHO enrollees under section 6.1.4 and case management for MSC+ enrollees under section 6.1.5.

(c) Enrollees must also be informed of the right to appeal the screening decision as required under Article 8 of this contract and pursuant to Minnesota Statutes, § 256.045.

(13) In all cases where an Enrollee is determined to not meet the Nursing Facility Level of Care criteria, the MCO shall have a process for review of the assessment results. Enrollees must also be informed of the right to appeal the screening decision as required under Article 8 of this contract and pursuant to Minnesota Statutes, § 256.045. This review shall determine the appropriateness of the reduction of level of care prior to implementation of the change and issuance of a DTR, and will ensure that the revised Care Plan addresses health and safety needs appropriately.

6.1.23 Medical Emergency, Post-Stabilization Care, and Urgent Care Services.

(A) Pursuant to 42 CFR § 438.114, Medical Emergency, Post-Stabilization Care and Urgent Care services must be available twenty four (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 6.22.1.

(B) For Medical Emergency services the MCO shall not:

(1) Require Service Authorization as a condition of providing a Medical Emergency service;

(2) Limit what constitutes a Medical Emergency condition based upon lists of diagnoses or symptoms;

(3) Refuse to cover Medical Emergency services based upon the emergency department Provider, hospital, or fiscal agent not notifying the MCO of an Enrollee's screening and treatment within ten (10) calendar days of the Enrollee requiring Emergency Services.

(4) Hold the Enrollee liable for payment concerning the screening and treatment necessary to diagnose and stabilize the condition; or

(5) Prohibit the treating Provider from determining when the Enrollee is sufficiently stabilized for transfer or discharge. The determination of the treating Provider is binding on the MCO for coverage and payment purposes.

6.1.24 Medical Equipment and Supplies. Medical equipment and supplies includes durable and non-durable medical equipment and supplies that provide a necessary adjunct to direct treatment of the recipient's condition. Supplies and equipment may also include devices, , including electronic tablets used as an augmentative and alternative communication system as defined in Minnesota Statutes, §256B.0625, subd. 31(e), controls, or appliances, which enable the client to increase his or her ability to perform activities of daily living, or to perceive, control, or interact with the environment or communicate with others. This also includes ancillary supplies necessary for the appropriate use of such equipment. All safeguards and provider standards apply.

(A) Covered medical supplies, equipment, and appliances suitable for use in the home are those that are:

(1) Medically necessary;

(2) Ordered by a physician;

(3) Documented in a plan of care that is reviewed and revised as medically necessary by the physician at least once a year; and

(4) Provided to the recipient at the recipient's own place of residence that is a place other than a nursing facility, or intermediate care facility for persons with developmental disability (ICF/DD).

(5) Medical equipment that is not covered in the facility per diem rate, but must be modified for the recipient, or the item is necessary for the continuous care and exclusive use of the recipient to meet the Enrollee's unusual medical need according to the written order of a physician, will be separately reimbursed by the MCO.

(6) Medical equipment includes replacement of lost, stolen or irreparably damaged hearing aids for an Enrollee who is twenty-one (21) years of age or older, but may be limited to two replacements in a five year period.

(7) The MCO must comply with Minnesota Statutes, § 256B.0625, subd. 31 (b) and (c), in assuring that its contracted vendors of durable medical equipment are enrolled as Medicare providers, unless exempted by the STATE pursuant to § 256B.0625, subd. 31 (b) and (c).

6.1.25 Medical Transportation Services. Also see section 6.4 below for Common Carrier Transportation Services. Medical transportation services include:

(A) Ambulance services required for Medical Emergency care, as defined in Minnesota Statutes, § 144E.001, subd. 2. MCOs shall require that providers bill ambulance services according to Medicare Criteria. Nonemergency ambulance services shall not be paid as emergencies, pursuant to Minnesota Statutes 256B.0625, subd. 17a.; and

(B) Special transportation services for Enrollees who are physically or mentally incapable of transport by taxicab or bus.

6.1.26 Mental Health Services. Mental health services shall be provided by qualified Mental Health Professionals. In approving and providing mental health services, the MCO shall use a definition of Medical Necessity that is no more restrictive than the definition of Medical Necessity found in Minnesota Statutes, § 62Q.53 or described in section 2.86. .

(A) Payments for Certain Mental Health Services. Physician assistants under the supervision of a physician certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry, may bill for medication management and evaluation and management services provided to enrollees in inpatient hospital settings consistent within their authorized scope of practice, defined in Minnesota Statutes §147A.09, with the exception of performing psychotherapy, diagnostic assessments, or providing clinical supervision. Payments for these mental health services shall be reimbursed at 80.4 percent of the base rate paid to psychiatrists.

(B) Mental health services should be directed at rehabilitation of the client in the least restrictive clinically appropriate setting. For adult Mental Health Services, services include:

(1) Diagnostic assessment, psychological testing, and an explanation of findings to rule out or establish the appropriate Mental Illness (MI) diagnosis in order to develop the individual treatment plan. All assessments must include the direct assessment of the Enrollee. The MCO will require behavioral health providers performing diagnostic assessments to:

(a) Screen all adult Enrollees upon initial access of behavioral health services for the presence of co-occurring mental illness and substance use disorder using a screening tool of the Providers' choice, but that must meet the following criteria:

i) Reading grade level of no more than 9th grade;

ii) Easily administered and scored by a non-clinician;

iii) Tested in a general population at the national level;

iv) Demonstrated reliability and validity;

v) Documented sensitivity of at least seventy percent (70%) and overall accuracy of at least seventy percent (70%); and

vi) Predicts a range of diagnosable major mental illnesses such as affective disorders, anxiety disorders, personality disorders, and psychoses, if a mental illness screening tool; predicts alcohol disorders and drug disorders, especially dependence, if a substance use screening tool; and both of the above, if a combined screening tool.

(b) Preferred criteria for screening tools, but not required, include:

i) Short duration of screening process taking no more than ten (10) minutes or having ten (10) or fewer items per scale;

ii) Widely used with adults; and

iii) Tool can be used in either interview or self-report format.

(c) The STATE recommends the following nationally recognized assessment tools:

i) "In the mental health service for detecting substance use:" Section 3 (Substance use Disorder Screener) of the Global Assessment of Individual Needs-Short Screener (GAIN-SS) or the CAGE-AID; or

ii) "In the chemical health service for detecting mental health issues;" Sections 1 and 2 (Internalizing Disorder and Externalizing Disorder Screeners) of the Global Assessment of Individual Needs-short Screener (GAIN-SS) or the K 6.

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

(3) Residential and non-residential crisis response and stabilization services as authorized by Minnesota Statutes, § 256B.0624.

(4) Intensive Rehabilitative Mental Health Services (IRTS)provided during a short-term stay in an IRTS setting as authorized by Minnesota Statutes, § 256B.0622.

(5) Assertive Community Treatment (ACT) that is consistent with DHS established standards and protocols (see DHS Bulletin #08-53-01).

(6) Adult Rehabilitative Mental Health Services (ARMHS) as authorized by Minnesota Statutes, § 256B.0623, including parenting skills services;.

(7) Day treatment.

(8) Partial hospitalization.

(9) For IRTS, ACT, ARMHS, Day Treatment and Partial Hospitalization services identified in paragraphs (4) through (8) above, the MCO shall require its providers to use the Level of Care Utilization System (LOCUS) or another level of care tool recognized nationally with prior approval by the STATE. When determining eligibility and making referrals for these services, the LOCUS must be used in conjunction with a completed diagnostic assessment and functional assessment that reflects the Enrollee's current mental health status.

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

(11) Inpatient and outpatient treatment.

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

(13) Neuropsychological assessment.

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

(15) Medication management.

(16) Travel time for mental health Providers, as specified in Minnesota Statutes, § 256B.0625, subd. 43, who provide community-based mental health services covered by the MCO in the community at a place other than their usual place of work.

(17) 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.

(18) Consultation provided by a psychiatrist, a psychologist, or an advanced practice registered nurse certified in psychiatric mental health via telephone, e-mail, facsimile, or other means of communication, to Primary Care Providers. The

consultation must be documented in the patient record maintained by the Primary Care Provider. Consultation provided without the Enrollee being present is subject to federal limitations and data privacy provisions and must have the Enrollee's consent.

(19) Mental health outpatient treatment benefits consistent with DHS guidelines and protocols for dialectical behavior therapy (DBT) for Enrollees who meet the eligibility criteria consistent with DHS guidelines for admission, continued treatment and discharge.

(20) For Enrollees with bipolar disorder or schizophrenia, the STATE recommends use of the "Minnesota 10 x 10" program/tool that coordinates primary care physicians and other health care providers to ensure that annual health screenings are offered, for example chronic disease such as heart disease and diabetes.

(21) Adult Mental Health Targeted Case Management (AMH-TCM). The MCO shall make available to enrollees MH-TCM services that comply with Minnesota Rules, Parts 9520.0900 to 9520.0926 (Rule 79) that establish standards and procedures for providing case management services to adults with Serious and Persistent Mental Illness (SPMI) as authorized by Minnesota Statutes, §§ 245.461 to 245.486.

(a) Upon notification from a mental health crisis response team the MCO shall make available within one business day information on the assigned AMH-TCM provider or entity of an Enrollee receiving services from Crisis Response Services providers within the MCO provider network

(b) The MCO may offer substitute models of AMH-TCM services to Enrollees who meet SPMI criteria with the consent of the Enrollee, if the substitute model includes all four activities that comprise the CMS definition for targeted case management services. These activities include:

i) Comprehensive assessment of the Enrollee to determine the need for any medical, educational, social or other services. The LOCUS is not required in determining eligibility for AMH-TCM. However it is required as part of AMH-TCM services to complete the LOCUS as it relates to the responsibilities of the case manager in assessment, planning, referral and monitoring of all mental health services;

ii) Development of a specific care plan that: is based on the information collected through the assessment; specifies the goals and actions to address the medical, social, educational, and other services needed by the Enrollee; includes activities such as ensuring the active participation of the Enrollee, and working with the Enrollee (or the Enrollee's authorized health care decision maker) and others to develop those goals; and identifies a course of action to respond to the assessed needs of the Enrollee.

iii) Referral and related activities to help the Enrollee obtain needed services including activities that help link the Enrollee with: medical, social, or educational providers; or programs and services capable of providing additional needed services, such as assisting with referrals to Providers for needed services and scheduling appointments for the Enrollee.

iv) Monitoring and follow-up activities, including necessary Enrollee contact to ensure the care plan is implemented and adequately addresses the Enrollee's needs. These activities and contact may be with the Enrollee, his or her family members, Providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met: services are being furnished in accordance with the Enrollee's care plan; services in the care plan are adequate; and if there are changes in the needs or status of the Enrollee, necessary adjustments must be made to the care plan and to service arrangements with Providers.

(c) All AMH-TCM services must meet the following quality standards:

i) Assure adequate access to AMH-TCM for all eligible Enrollees pursuant to Minnesota Rules parts 9520.0900 to 9520.0903.

1. The MCO agrees to work with the STATE to provide adequate access to AMH-TCM. This includes limiting the case manager average caseload as specified in Minnesota Rules, part 9520.0903, subp. 2, in order to attend to the outcomes specified for case management services as specified in Minnesota Rules, Part 9520.0905.

2. The STATE acknowledges that MH-TCM Providers may provide services to Enrollees for multiple MCOs and FFS, and agrees to monitor caseload ratios and provide feedback to the MCO regarding the caseload ratios of all contracted case management Providers.

ii) Provide face-to-face contact with the Enrollee at least once per month, or as appropriate to Enrollee need pursuant to Minnesota Rules 9520.0914, subp. 2.B.

(d) Case Managers for AMH-TCM services must meet the qualifications and supervision requirements listed in Minnesota Statutes, § 245.462, subds. 4 and 4(a), and Minnesota Rules, Part 9520.0912.

(C) The MCO Provider must have a working knowledge of physical, mental health, educational and social service resources that are available in order to assist the enrollee with accessing the most appropriate treatment in the least restrictive setting as determined by clinical need.

(D) Court Ordered Treatment. The following procedures apply to mental health services that are court-ordered.

(1) The MCO must provide all court-ordered mental health services pursuant to Minnesota Statutes, § 62Q.535, subds. 1 and 2, and § 253B.045, subd. 6, which are also covered services under this Contract. The services must have been ordered by a court of competent jurisdiction and based upon a mental health evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist. The MCO shall assume financial liability for the evaluation which includes diagnosis and an individual treatment plan, if the evaluation has been performed by one of the Participating Providers.

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

(3) The MCO's liability for an ongoing mental health inpatient hospital stay at a regional treatment center (RTC) shall end when the medical director of the center or facility or his or her designee, no longer certifies that the Enrollee is in need of continued treatment at a hospital level of care, and the MCO agrees that the Enrollee no longer meets Medical Necessity criteria for continued treatment at a hospital level of care.

(4) The MCO must provide a twenty-four (24)-hour telephone number answered in-person that a Local Agency may call to get an expeditious response to situations involving the MCO's Enrollees where court ordered treatment and disability certification are involved.

(E) Civil Commitment.

(1) The MCO shall:

(a) Work with hospitals in the MCO's network to develop procedures for prompt notification by the hospital to the MCO upon admission of an Enrollee for psychiatric inpatient services;

(b) Work with county pre-petition screening teams to develop procedures for notification within seventy-two (72) hours by the pre-petition screening team to the MCO when an Enrollee is the subject of a pre-petition screening investigation;

(c) Provide expedited determination of eligibility for AMH-TCM for MCO enrollees who are referred to the health plan as potentially eligible for MH-TCM;

(d) Assign mental health case management as court ordered services for Enrollees with MI who are committed, or for Enrollees whose commitment has been stayed or continued;

(2) The MCO Mental Health Targeted Case Manager shall:

(a) Work with hospitals, pre-petition screening teams, family members or representatives, and current Providers, to assess the Enrollee and develop an individual care plan that includes diversion planning and least restrictive alternatives consistent with the Commitment Act. This may include testifying in court, and preparing and providing requested documentation to the court;

(b) Report to the court within the court-required timelines regarding the Enrollee's care plan status and recommendations for continued commitment, including, as needed, requests to the court for revocation of a provisional discharge;

(c) Provide input only for pre-petition screening, court-appointed independent examiners, substitute decision-makers, or court reports for Enrollees who remain in the facility to which they were committed;

(d) Provide mental health case management coverage which includes discharge planning for up to one hundred and eighty (180) days prior to an Enrollee's discharge from an Inpatient Hospitalization in a manner that works with, but does not duplicate, the facility's discharge planning services; and

(e) Ensure continuity of health care and case management coverage for Enrollees in transition due to change in benefits or change in residence.

6.1.27 Nursing Facility (NF) Services. Se**e** section 4.9.2 for SNF/NF benefit description and responsibilities.

6.1.28 Outpatient Hospital Services. Outpatient hospital services are covered and include emergency care.

6.1.29 Personal Care Assistance (PCA) Services. PCA services are covered as specified in section 6.1.17(A)(3).

6.1.30 Physician Services and Telemedicine Consultation. Physician services include Telemedicine Consultations. Coverage of Telemedicine Consultations is limited to three Telemedicine Consultations per Enrollee per week.

6.1.31 Podiatric Services. Podiatric services are covered.

6.1.32 Prescription Drugs and Over-the-Counter Drugs.

(A) Covered prescription and over-the-counter drugs prescribed by 1) a Provider who is licensed to prescribe drugs within the scope of his/her profession; 2) dispensed by a Provider who is licensed to dispense drugs within the scope of his/her profession; and 3) are contained in the Medical Assistance Drug Formulary or that are the therapeutic equivalent to Medical Assistance formulary drugs. Drugs covered under the Medicare Prescription Drug program under Medicare Part D for Medicare eligible Enrollees are not covered under Medicaid.

(B) Pursuant to Minnesota Statutes, § 256B.0625, Subd13(d), the MCO may allow pharmacies to prescribe over-the-counter drugs.

(C) For Dual Eligible Enrollees, the MCO may cover drugs from the drug classes listed in United States Code, title 42, § 1396r-8(d)(2), except that drugs listed in United States Code, title 42, § 1396r-8(d)(2)(E), which are covered by Part D, shall not be covered.

(D) Before January 1, 2015, the MCO shall adopt the minimum requirements for high risk medications universal drug formulary and policies defined in section 2.152 of this Contract that have been recommended by the Universal Pharmacy Workgroup by October 1, 2014. If the MCO chooses to have a drug formulary or policies for drugs which are not included in the Universal Pharmacy Policy definition, which are more restrictive than the STATE's drug formulary or policies, the MCO shall provide any necessary drug at its own cost to Enrollees on behalf of whom the STATE intervenes, following the STATE's review by a pharmacist and physician. If the STATE does such an intervention, it shall also initiate a corrective action plan to the MCO, which the MCO must implement.

(E) Members of the Universal Pharmacy Workgroup will share information on prescribing and dispensing patterns with the goal of identifying inappropriate prescribing and dispensing activities. Using criteria and/or algorithms developed by the Universal Pharmacy Workgroup, the MCO and the STATE will identify prescribers and/or dispensers engaged in potentially inappropriate prescribing and dispensing and will make referrals to the Board of Medicine or the Board of Pharmacy as appropriate.

(F) Upon request of the STATE, the MCO shall submit a copy of the MCO's drug formularies including the SNPs Medicare Part D formulary. The MCO may fulfill this requirement by making the drug formulary available on the MCO's website and providing the link to the STATE.

(G) The MCO agrees to offer SNP formularies appropriately tailored to the special needs of Dual Eligible persons in that the number and types of drugs required to be prior authorized are comparable to that currently required under the STATE's Medicaid program. The STATE may review public information about the MCO SNP Medicare Part D formularies and may discuss problems or concerns with coverage and prior authorization with the MCO.

(H) For MSHO, the MCO agrees to coordinate the provision of both Medicare and Medicaid drug coverage so that coverage is as seamless as possible for the Enrollee. The MCO assures that its Pharmacy Benefit Manager will administer Medicaid drugs according to Medicaid requirements, and that Medicaid drugs are not being confused with Medicare drugs.

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

(J) 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.

(K) The MCO must cover antipsychotic drugs prescribed to treat emotional disturbance or Mental Illness regardless of the MCO's formulary if the prescribing Provider certifies in writing to the MCO that the prescribed drug will best treat the Enrollee's condition, pursuant to Minnesota Statutes, § 62Q.527, subd. 2. The MCO shall not require recertification from the prescribing Provider on prescription refills or renewals, or impose any special payment requirements that the MCO does not apply to other drugs in its drug formulary. If the prescribed drug has been removed from the MCO's formulary due to safety reasons the MCO does not have to provide coverage for the drug.

(L) Subject to conditions specified in Minnesota Statutes, § 62Q.527, subd. 3, the MCO shall allow an Enrollee to continue to receive a prescribed drug to treat a diagnosed Mental Illness or emotional disturbance for up to one year, upon certification by the prescribing Provider that the drug will best treat the Enrollee's condition, and without the MCO imposing special payment requirements. This continuing care benefit is allowed when the MCO changes its drug formulary or when an Enrollee changes MCOs, and must be extended annually if certification is provided to the MCO by the prescribing Provider. The MCO is not required to cover the prescribed drug if it has been removed from the MCO's formulary for safety reasons.

(M) Pursuant to Minnesota Statutes, § 62Q.527, subd. 4, the MCO must promptly grant an exception to its drug formulary when the health care Provider prescribing the drug for an Enrollee indicates to the MCO that:

(1) The formulary drug causes an adverse reaction in the Enrollee;

(2) The formulary drug is contraindicated for the Enrollee; or

(3) The health care Provider demonstrates to the MCO that the prescription drug must be dispensed as written (DAW) to provide maximum medical benefit to the Enrollee.

6.1.33 Medication Therapy Management (MTM) Care Services. Medication Therapy Management (MTM) Care Services are covered pursuant to Minnesota Statute, § 256B.0625, subd. 13h, and the Pharmacy Web page on Medication Therapy Management Services listed on the STATE's MHCP Enrolled Providers website (http://www.dhs.state.mn.us/id_054232; MHCP Provider Update PRX-06-02R. MTM services are covered, except for Enrollees receiving drugs covered by Medicare Part D, for whom MTM services are covered by Medicare. An eligible pharmacist within the MCO's network may provide MTM services via two-way interactive video when there are no pharmacists eligible to provide such services within a reasonable geographic distance of the Enrollee.

6.1.34 Prescribing, Electronic. The MCO shall comply with Minnesota Statutes, § 62J.497 and the applicable standards specified in the statute for electronic prescribing. The MCO shall also ensure that its providers involved in prescribing, filling prescriptions or paying for prescriptions, including communicating or transmitting formulary or benefit information also conform to the electronic prescribing standards for transmitting prescription or prescription-related information.

6.1.35 Prosthetic and Orthotic Devices. Prosthetic and orthotic devises are covered, including related medical supplies.

6.1.36 Public Health Services. Public health clinic services and public health nursing clinic services as they are described in Chapter 8 of the DHS Provider Manual which is incorporated herein by reference and made a part of this Contract, as applicable.

6.1.37 Reconstructive Surgery. As described in Minnesota Statutes, § 62A.25, subd. 2, and the Women's Health and Cancer Rights Act of 1998 (WHCRA), 45 CFR § 146.180.

6.1.38 Rehabilitative and Therapeutic Services. Rehabilitative and therapeutic services (related to evaluation and treatment) are covered and include:

(A) Physical therapy;

(B) Speech therapy;

(C) Occupational therapy;

(D) Audiology; and

(E) Respiratory therapy.

6.1.39 Relocation Targeted Case Management. Relocation targeted case management is covered.

6.1.40 Second Opinion. MCOs must provide, at MCO expense, a second medical opinion within the MCO network upon Enrollee request pursuant to Minnesota Rules, Part 9500.1462, A.

6.1.41 Skilled Nursing Facility (SNF) Services. See section 4.9.2 for SNF/NF benefit.

6.1.42 Specialty Care. Specialty care is covered.

6.1.43 Transplants. Covered transplants are: cornea, heart, kidney, liver, lung, pancreas, heart-lung, intestine, intestine-liver, pancreas-kidney, pancreatic islet cell, stem cell, bone marrow and other transplants that are listed in the Provider Manual, covered by Medicare, or recommended by the STATE's medical review agent. All organ transplants must be performed at transplant centers meeting United Network for Organ Sharing (UNOS) criteria or at Medicare approved organ transplant centers. Stem cell or bone marrow transplant centers must meet the standards established by the Foundation for the Accreditation of Cellular Therapy (FACT).

6.1.44 Tuberculosis Related Services. Tuberculosis related services include Case Management and Directly Observed Therapy (DOT) which consists of direct observation of the intake of drugs prescribed to treat tuberculosis by a nurse or other trained health care provider. The MCO shall make reasonable efforts to contract with and use the Local Public Health Nursing Agency as the Provider for direct observation of the intake of drugs prescribed to treat tuberculosis, and refer for nurse case management, except for persons who are Institutionalized. The MCO shall communicate to medical care Providers that all other tuberculosis patients should be referred to the Local Public Health Agency for DOT and nurse case management services.

6.1.45 Vaccines and Immunizations. Vaccines and immunizations are covered and include but are not limited to, 1) recommendations by the Minnesota Department of Health; 2) Zostavax® for Enrollees age sixty (60) and over, and 3) Varicella immunization.

6.1.46 Vision Care Services. Vision Care services are covered and include vision examinations, eyeglasses, and optician, optometrist and ophthalmologist services. Eyeglasses, sunglasses and contact lenses shall be provided only if prescribed by or through the MCO participating physicians or participating optometrists. The MCO must make available a reasonable selection of eyeglass frames, but is not required to make available an unlimited selection. Replacement of lost, stolen or irreparably damaged eyeglasses, sunglasses, and contact lenses may be covered upon a showing of Medical Necessity and may be limited to the replacement of the same frames.

6.2 Substitute Health Services Permitted. To the extent consistent with Minnesota Statutes, Chapter 256B, the MCO shall have the right, in its discretion, to pay for or provide if such services are, in the judgment of the MCO, medically appropriate and cost-effective.

(A) For MSHO and MSC+ , the MCO shall have a mechanism for timely payment of Substitute Health Services provided in this section, and for consumer directed community support services in section 6.1.13(K)(16).

(B) Substitute Health Services submitted as encounter data will be considered in calculations of MCO costs pursuant to Article 4.

6.3 Additional Services Permitted. The MCO may provide or arrange to have provided services in addition to the services described in Article 6, as permitted by CMS under Title XIX, § 1915 of the Social Security Act, for Enrollees for whom, in the judgment of the MCO's Care Management staff, the provision of such services is Medically Necessary; provided, however, that it is understood that the provision of any such services shall not affect the calculation of capitation rates pursuant to Article 4.

6.4 Common Carrier Transportation Services.

6.4.1 General. In addition to the medical transportation services specified in section 6.1.25, and except for the services described in section 6.4.2, the MCO shall provide Common Carrier Transportation, including Volunteer Drivers when available, to its Enrollees for the purpose of obtaining covered health care services.

6.4.2 Common Carrier Transportation That is Not the Responsibility of the MCO.

(A) The Local Agency shall remain responsible for reimbursing the Enrollee the Enrollee or the Enrollee's driver for mileage to non-Emergency Covered Services, and meals and lodging as necessary.

(B) The MCO shall not be responsible for providing Common Carrier Transportation in any situation where the Enrollee has access to private automobile transportation (not including Volunteer Drivers) to a non-emergency service covered under this Contract.

(C) The MCO shall not be responsible for providing Common Carrier Transportation when an Enrollee chooses a non-emergency Primary Care Provider located more than thirty (30) miles from the Enrollee's home, or when an Enrollee chooses a Specialty Care Provider that is more than sixty (60) miles from the Enrollee's home, unless the MCO approves the travel because the non-emergency primary or specialty care required is not available within the specified distance from the Enrollee's residence.

(D) Providing non-emergency transportation to medical services located outside of Minnesota that has been approved by the MCO is the responsibility of the Local Agency.

6.5 Limitations on MCO Services.

6.5.1 Medical Necessity. Unless otherwise provided in this Contract 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. Home and Community Based Services, and services mandated by state or federal law, are excluded from the MCO's Medical Necessity determination.

6.5.2 Coverage Limited to Program Coverage. Except as otherwise provided under this Contract, or otherwise mandated by state or federal law, all health care services prescribed or recommended by a participating physician, dentist, care manager, or other practitioner, or approved by the MCO, are limited to services covered under Medical Assistance or Medicare.

6.6 Services Not Covered By This Contract. Although the MCO may provide the following services, the prepaid capitation rate does not include payment for the following services, and therefore the MCO is not required to provide them.

6.6.1 Abortion Services. Abortion services are not covered.

6.6.2 Cosmetic Procedures or Treatment. Cosmetic procedures or treatment are not covered, except that the following services are not considered cosmetic and therefore must be covered: services necessary as the result of injury, illness or disease, or for the treatment or repair of birth anomalies.

6.6.3 Experimental or Investigative Services. Experimental or investigative services are not covered.

6.6.4 Federal Institutions. All claims arising from services provided by institutions operated or owned by the federal government, are not covered unless the services are approved by the MCO.

6.6.5 State and Other Institutions. All claims arising from services provided by a state regional treatment center, a State-owned long term care facility, or an institution for mental disease (IMD) are not covered, unless the services are approved by the MCO, or the services are covered by Medicare, or unless the services are court-ordered pursuant to Minnesota Statutes, §§ 62Q.535 and 253B.045, subd. 6.

6.6.6 Fertility Drugs and Procedures. Fertility Drugs are not covered when specifically used to enhance fertility. The following procedures also are not covered: in vitro fertilization, artificial insemination, and reversal of a voluntary sterilization.

6.6.7 Sex Reassignment Surgery. Sex reassignment surgery is not covered.

6.6.8 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.

6.6.9 Certain Mental Health Services. Housing associated with IRTS is not covered.

6.6.10 HIV Case Management Services. HIV case management services are not covered.

6.6.11 Nursing Facility Per Diem Services. Nursing Facility per diem services are not covered, except as provided for in section 4.9.2 for 180 day Nursing Facility coverage.

6.6.12 Out of Country Care. Medicaid payments must not be made:

(A) For services delivered or items supplied outside of the United States; or

(B) To a provider, financial institution, or entity located outside of the United States.

For the purpose of this section, United States includes the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

6.6.13 Drugs covered under the Medicare Prescription Drug Program. Drugs covered under the Medicare Prescription Drug Program are not covered, for Enrollees who are eligible for Medicare.

6.6.14 Additional Exclusions. All other exclusions set forth in Minnesota Statutes, § 256B.0625, Minnesota Statutes, § 256B.69, Minnesota Rules, Part 9505.0170 through 9505.0475, and Minnesota Rules, Part 9500.1450 through 9500.1464 are not covered.

6.7 Enrollee Liability and Limitations.

6.7.1 Medical Assistance Cost-sharing. Enrollees may be liable for Medical Assistance cost-sharing under section 4.4, Medical Assistance Cost-Sharing for MSHO and MSC+.

6.7.2 Limitation. Except for section 4.4, the MCO will not bill or hold the Enrollee responsible in any way for any charges or cost-sharing for Medically Necessary Covered Services or services provided as alternatives to Covered Services as part of the MCO's Care Management Plan, including Medicare cost sharing under section 4.4. Providers may seek payment from an Enrollee for services not otherwise eligible for payment, pursuant to Minnesota Statutes, § 256B.0625, subd. 55. The MCO shall ensure that its subcontractors also do not bill or hold the Enrollee responsible in any way for any charges or cost-sharing for such services. The MCO shall further ensure that an Enrollee will be protected against liability for payment under any of the following circumstances:

(A) The MCO does not receive payment from the STATE for the Covered Services;

(B) A health care Provider under contract or other arrangement with the MCO fails to receive payment for Covered Services from the MCO;

(C) Payments for Covered Services furnished under a contract or other arrangement with the MCO are in excess of the amount that an Enrollee would owe if the MCO had directly provided the services;

(D) A non-Participating Provider does not accept the MCO's payment as payment in full; or

(E) For MSHO Enrollees, if a Provider under contract or other arrangement with the MCO charges an Enrollee cost sharing that would exceed the amounts permitted under Medicaid, if the Dually-eligible Enrollee were enrolled only in Medicaid and Original Medicare rather than the MSHO dual-eligible SNP. Provider contracts shall be consistent with 42 CFR § 422.504 (g)(1)(iii) as published in the Federal Register, Vol. 74, No. 7, January 12, 2010, page 1542.

6.8 Penalty for Illegal Remuneration. If the MCO or its subcontractors violate 42 USC § 1320a-7b(d), the MCO and its subcontractors may be subject to the criminal penalties stated therein.

6.9 No Payments to Enrollees. The MCO shall not make payment to an Enrollee in reimbursement for a service provided under this Contract. (See 42 CFR § 447.25).

6.10 Designated Source of Primary Care. The MCO will provide each Enrollee with a choice of a Primary Care Provider who will supervise and coordinate the Enrollee's care. The MCO shall have written procedures that ensure each Enrollee has an ongoing source of Primary Care appropriate to his or her needs and a Provider formally designated as primarily responsible for coordinating the health care services furnished to the Enrollee.

6.11 Fair Access to Care. The MCO agrees that the health care services listed in Article 6 will be available to Enrollees during normal business hours to the same extent available to the general population.

6.12 Geographic Accessibility of Providers. In accordance with Minnesota Statutes, § 62D.124, the MCO must demonstrate that its Provider network is geographically accessible to Enrollees in its Service Area. In determining the MCO's compliance with the access standards, the STATE may consider an exception granted to the MCO by the Minnesota Department of Health for areas where the MCO cannot meet these standards.

6.13 Gap Analysis for EW Service Providers. If the STATE chooses to conduct a Gaps Analysis in the Contract Year, the MCO shall participate in an analysis of gaps in availability of EW service providers and shall report known gaps in availability in its Service Area in a process determined by the STATE.

6.14 Home and Community-Based Services Critical Access Study. The MCO shall participate in an analysis of gaps in availability of EW services at the local (within county) level by providing input regarding the factors affecting availability of EW services and reviewing data regarding community level service availability in its Service Area.

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

6.15.1 Primary Care.

(A) Distance/Time: No more than thirty (30) miles or thirty (30) minutes distance for all Enrollees, or the STATE's Generally Accepted Community Standards.

(B) Adequate Resources: The MCO shall have available appropriate and sufficient personnel, physical resources, and equipment to meet the projected needs of its Enrollees for covered health care services.

(C) Timely Access: The MCO shall arrange for covered health care services, including referrals to Participating and non-Participating Providers, to be accessible to Enrollees on a timely basis in accordance with medically appropriate guidelines and consistent with Generally Accepted Community Standards. The MCO shall also take into account the urgency of the need for services.

(D) Appointment Times: Not to exceed forty-five (45) days from the date of an Enrollee's request for routine and preventive care and twenty-four (24) hours for Urgent Care.

(E) Tracking: The MCO must have a system in place for confidential exchange of Enrollee information with the Primary Care Provider, if a Provider other than the Primary Care Provider delivers health care services to the Enrollee.

6.15.2 Specialty Care.

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

(B) Appointment/Waiting Time: Appointments for a specialist shall be made in accordance with the time frame appropriate for the needs of the Enrollee, or the Generally Accepted Community Standards.

6.15.3 Emergency Care. All Emergency Care must be provided on an immediate basis, at the nearest equipped facility available, regardless of MCO contract affiliation.

6.15.4 Hospitals. Transport time: Not to exceed thirty (30) minutes, or the STATE's Generally Accepted Community Standards.

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

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

(B) Appointment/Waiting Time: Not to exceed sixty (60) days for regular appointments and forty-eight (48) hours for Urgent Care. For the purposes of this section, regular appointments for dental care means preventive care and/or initial appointments for restorative visits.

6.15.6 Pharmacy Services. Transport Time: Not to exceed sixty (60) minutes, or the STATE's Generally Accepted Community Standards.

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.

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 twenty-four (24) hour, seven-day-per-week basis. The MCO must provide a twenty-four (24) hour, seven day per week MCO telephone number that is answered in-person by the MCO or an agent of the MCO. This telephone number must be provided to the STATE. The MCO is not required to have a dedicated telephone line.

6.17 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.

(A) Persons with Serious and Persistent Mental Illness (SPMI). Services for this group include ongoing medications review and monitoring, day treatment, and other community-based alternatives to conventional therapy, and coordination with the Enrollee's case management service Provider to assure appropriate utilization of all needed psychosocial services.

(B) Persons with a Physical Disability or Chronic Illness. Services for this group include in-home services and neurological assessments.

(C) Abused Adults, Abusive Individuals. Services for this group include comprehensive assessment, diagnostic services and specialized treatment techniques for victims and perpetrators of maltreatment (physical, sexual, emotional).

(D) Enrollees with Language Barriers. Services for this group include interpreter services, bilingual staff, culturally appropriate assessment and treatment. When an individual is enrolled in MSHO, the enrollment form will indicate whether the Enrollee needs the services of an interpreter and what language he or she speaks. Upon receipt of enrollment information indicating interpreter services are needed, the MCO shall contact the Enrollee by phone or mail in the appropriate language to inform the Enrollee how to obtain Primary Care services. In addition, whenever an Enrollee requests an interpreter in order to obtain health care services, the MCO must provide the Enrollee with access to an interpreter, pursuant to section 6.1.20 of this Contract.

(E) Cultural and Racial Minorities. Services for this group include culturally appropriate services rendered by Providers with special expertise in the delivery of health care services to the various cultural and racial minority groups.

(F) Enrollees in Need of Gender-Specific Mental Health and/or CD Treatment. The MCO must provide its Enrollees with an opportunity to receive mental health and/or chemical dependency services from a same-sex therapist and the option of participating in an all-male or all-female group therapy program.

(G) Lesbians, Gay Men, Bisexual and Transgender Persons. Services for this group require sensitivity to critical social and family issues unique to these Enrollees.

(H) Hearing Impaired. Services for this group include access to TDD and hearing-impaired interpreter services.

(I) Persons with a Developmental Disability (DD). Services for this group include specialized mental health and rehabilitative services and other appropriate services covered by Medical Assistance should be designed to maintain or increase function and prevent further deterioration or dependency and should be coordinated with available community resources and support systems including the Enrollee's Local Agency DD case management service provider, families, guardians and residential care Providers. Continuity of care should be a major consideration in the treatment planning process. Referrals to specialists and sub-specialists must be made when medically indicated.

(J) American Indians. Services for this group include culturally appropriate services rendered by Providers with special expertise in the delivery of health care services to the various tribes.

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.

6.19 Direct Access to Obstetricians and Gynecologists. Pursuant to Minnesota Statutes, § 62Q.52, the MCO shall provide Enrollees direct access without a referral or Service Authorization to the following obstetric and gynecologic services: annual preventive health

examinations and any subsequent obstetric or gynecologic visits determined to be Medically Necessary by the examining obstetrician or gynecologist; and evaluation and necessary treatment for acute gynecologic conditions or emergencies. Direct access shall apply to obstetric and gynecologic Providers within the Enrollee's network, including any Providers with whom the MCO has established referral patterns.

6.20 Services Received at Indian Health Care Providers.

6.20.1 Access to Indian Health Care Providers. American Indian Medical Assistance Enrollees, living on or off a reservation, will have direct out-of-network access to IHCPs for services that would otherwise be covered under Minnesota Statutes, § 256B.0625, even if such facilities are not Participating Providers. The MCO shall not require any Service Authorization or impose any condition for an American Indian to access services at such facilities.

6.20.2 Referrals from Indian Health Care Providers.

(A) When a physician in an IHCP facility refers an American Indian PMAP 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.

(B) The Participating Provider to whom the IHCP physician refers the Enrollee may determine that services are not Medically Necessary or not covered.

6.20.3 Home Care Service Assessments. The MCO will comply with section 6.1.17(F) for requirements specific to Tribal Community Members and home care assessments.

6.20.4 Cost-sharing for American Indian Enrollees. The MCO shall cooperate in assuring that the IHCP and Providers providing IHS Contract Health Services (IHS CHS) through referral from IHS Facilities do not charge copayments to American Indians, pursuant to section 4.4.1(C).

6.20.5 STATE Payment for IHS and 638 Facility Services. The STATE shall pay IHS and 638 facilities directly for services provided to American Indian Enrollees under this Contract, including Elderly Waiver services provided by a tribe under contract with the STATE..

(A) 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.

(B) Elderly Waiver Reimbursements. The STATE shall obtain reimbursement from the MCO, on an annual basis and through reasonable means, for payments to Indian Health Care Provider facilities for Elderly Waiver services provided to Enrollees that would be covered under this Contract; however, the financial liability of the MCO for these services, in aggregate for all Enrollees who utilized the Indian Health Care Provider

facilities during the Contract Year, shall be limited to forty percent (40%) of the aggregate annual capitated payment amount for these American Indian Enrollees.

(C) The STATE shall not obtain reimbursement for any quarter in which the STATE failed to provide the electronic quarterly report of all its paid Elderly Waiver encounters on a timely basis.

(D) Upon receipt of the statement of encounters, if the MCO determines that duplicate Elderly Waiver claims have been submitted to both the STATE and the MCO, the MCO shall provide that claim information to the STATE within sixty (60) days, and the STATE shall, at its discretion: 1) recover the STATE payment to the IHS/638 facility and subtract the amount from the MCO's reimbursement owed to the STATE; or 2) recover a portion of the STATE's payment to the IHS or 638 facility that reflects the payment made by the MCO, and adjust the MCO's reimbursement owed to the STATE accordingly.

(E) If a tribe authorizes services covered under the State Plan for Elderly Waiver tribal Enrollees, those State Plan service costs shall not be recovered by the STATE, as they are already taken into consideration and reflected in the current rates paid under this Contract.

6.20.6 Payment for IHCPs That Are Not IHS and 638 Facilities.

(A) Consistent with section 5006(d) of the American Recovery and Reinvestment Act of 2009, MCO must pay an Urban Indian Organization that is an FQHC (but not a Participating Provider with the MCO) for the provision of covered services to an American Indian Enrollee at a rate equal to the amount of payment that the entity would pay an FQHC that is a Participating Provider (but is not an IHCP) for such services.

(B) In the case of an IHCP that is not an IHS or 638 Facility nor FQHC, and for IHS Contract Health Services, the MCO must

(1) Pay for covered services (at Participating or non-Participating Providers) provided to American Indian Enrollees at a rate equal to the rate negotiated between the MCO and the Provider or,

(2) If such a rate has not been negotiated, the MCO must make payment at a rate that is not less than the level and amount of payment which the MCO would make if the services were furnished by a Participating Provider that is not an IHCP; and

(3) The MCO must make payment at a rate that is not less than the State Plan rate for the service.

(4) Pursuant to Section 5006 (c) of the ARRA and 42 CFR 447.57, the MCO must not reduce payments to Indian Health Care Providers or Providers providing IHS Contract Health Services (IHS CHS) for Medicaid cost-sharing amounts not paid by eligible American Indian Enrollees under the exceptions in section 4.4.1(C). The MCO must ensure refunds to Enrollees of cost-sharing collected in error.

6.20.7 Cooperation. The MCO agrees to work cooperatively with the STATE, other MCOs under contract with the STATE, and tribal governments to find mutually agreeable mechanisms to implement this section including, but not limited to, a common notification form by which tribal governments may report referrals to the MCO.

6.21 Service Authorization and Utilization Review.

6.21.1 General Exemption for Medicaid Services. The MCO is exempt from STATE Service Authorization and second surgical opinion procedures at Minnesota Rules, Part 9505.5000 through 9505.5105, and from certification for admission requirements at Minnesota Rules, Part 9505.0500 through 9505.0540.

6.21.2 Medical Necessity Standard. The MCO may require Service Authorization for services, except for Medical Emergency services and other services described in section 6.22.1. Service Authorization shall be based on Medical Necessity, pursuant to section 2.86, and, in the case of mental health services, shall also be based on Minnesota Statutes, § 62Q.53, and for CD services, in Minnesota Rules, Parts 9530.6600 through 9530.6655.

6.21.3 Utilization Review. The MCO, and if applicable its subcontractor, must have in place and follow written policies and procedures for utilization review that: 1) reflect current standards of medical practice in processing requests for initial or continued Service Authorization of services, and 2) meet the requirements specified in Minnesota Statutes, § § 62M.05 and 62M.09. The MCO's policies and procedures shall ensure the following:

(A) Consistent application of review criteria for authorization decisions;

(B) Consultation with the requesting Provider when appropriate;

(C) Decisions to deny an authorization request or authorize it in an amount, duration, or scope that is less than requested be made by a Health Care Professional who has appropriate clinical expertise in treating the Enrollee's health condition; and

(D) Notification to the requesting Provider and written notice to the Enrollee of the MCO's decision to deny or limit the request for services in accordance with section 8.3.

6.21.4 Denials Based Solely on Lack of Service Authorization. Pursuant to Minnesota Statutes, § 62D.12, subd. 19, the MCO shall not deny or limit coverage of a service which the Enrollee has received solely on the basis of lack of Service Authorization, to the extent that the service would otherwise have been covered by the MCO had Service Authorization been obtained.

6.22 Out of Plan and Transition Services.

6.22.1 Out of Plan Services. The MCO shall cover Medically Necessary Out Of Plan or Out of Service Area services received by an Enrollee when one of the following occurs

(A) The Enrollee requires Medical Emergency Services.

(B) The Enrollee requires Post-Stabilization Care Services to maintain, improve or resolve the Enrollee's condition. The MCO shall continue coverage until: 1) an MCO Provider assumes responsibility for the Enrollee's care; 2) the MCO reaches an agreement with the treating Provider concerning the Enrollee's care; 3) the MCO has contacted the treating Provider to arrange for a transfer, or 4) the Enrollee is discharged.

(C) The Enrollee is Out of Service Area and requires Urgent Care; or

(D) The Enrollee is Out of Service Area or Out of Plan 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 6.22.3.

(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 the Medicare or Medical Assistance FFS rate or billed charges, whichever is less, any services provided by non-Participating Providers to the Enrollee during the balance of the month or the month after which the Enrollee has moved and for which the MCO received a Capitation Payment from the STATE. The MCO may condition reimbursement of these Out of Plan services on the Enrollee's requesting MCO approval or Service Authorization to receive such services except for Emergency Care.

6.22.2 Transition Services. The MCO is responsible for care in the following situations.

(A) Services Previously Service Authorized. The MCO shall provide Enrollees Medically Necessary Covered Services and EW covered services that an Out of Plan Provider, another MCO, or the STATE had Service Authorized before enrollment in the MCO. The MCO may require the Enrollee to receive the services by an MCO Provider, if such a transfer would not create undue hardship on the Enrollee, and is clinically appropriate. Transition services relating to mental health services, and chemical dependency services are covered as described in the below paragraphs of this section.

(B) Chemical Dependency (CD) Treatment Services.

(1) The MCO shall be responsible for all CD treatment and treatment-related room and board effective upon the date of the Potential Enrollee's enrollment into the MCO. The MCO shall provide coverage for services that were authorized by the CCDTF or any other STATE contracted MCO prior to the Recipient's enrollment in the MCO, unless the MCO completes a new Rule 25 assessment or assessment update, which identifies a different level of need for services. Whether Potential Enrollees will be enrolled into the MCO is described in section 3.1.5(C). Effective for dates of service on July 1, 2014 and going forward, the MCO shall not be

responsible for the payment of room and board services provided by residential chemical dependency treatment providers.

(C) Mental Health Services. At the time of initial enrollment, the MCO shall consider the individual Enrollee's prior use of mental health services and develop a transitional plan to assist the Enrollee in changing mental health Providers, should this be necessary, and develop a plan to assure continuity of care for any Enrollee or family who is receiving ongoing mental health services.

(D) Enrollee Change of MHCP. The MCO shall continue coverage if: 1) the Enrollee was enrolled with the MCO in the same county, but covered under another STATE-MCO contract; 2) the MCO products do not have the same Participating Providers; and 3) the Enrollee chooses to receive services from the Participating Providers from the prior enrollment with the MCO. The MCO must notify any affected Enrollee of his or her right to choose to remain with the original Participating Providers.

(E) Pharmacy. Upon the Enrollee's enrollment into the MCO, the MCO shall continue payment of all drugs the Enrollee is taking under a current prescription, except for those drugs covered by a Medicare Prescription Drug Program (Part D) for Medicare eligible Enrollees. This payment shall continue until such time as a transition plan can be established by the MCO or ninety (90) days, whichever occurs first, and shall apply to 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.

6.22.3 Reimbursement Rate for Out of Plan or Out of Service Area Care. When the Enrollee is authorized for Out of Plan Care or Out of Service Area care, the MCO shall reimburse the non-Participating Provider for the Out of Plan Care or Out of Service Area Care. Pursuant to § 6085 of the Deficit Reduction Act, the MCO may not reimburse more than the comparable Medical Assistance FFS rate for emergency services furnished by non-Participating Providers. For all other services pursuant to Minnesota Rules, Part 9500.1460, subpart 11a, the MCO is not obligated to reimburse the non-Participating Provider more than the comparable Medical Assistance or Medicare FFS rate or its equivalent (or billed charges, whichever is less), unless another rate is required by law.

6.23 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.

6.24 Timeframe to Evaluate Requests for Services.

6.24.1 General Request for Services. The MCO must evaluate all requests for services, either by Participating Providers or Enrollees within ten (10) business days of receipt of the request for services. The MCO must communicate its decision on all requests for services to the Enrollee or his or her Authorized Representative and the appropriate Provider as expeditiously as the Enrollee's health condition requires, but no later than the evaluation determination.

6.24.2 Request for Urgent Services. If the need is for Urgent Care or for services appropriate 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 seventy-two (72) hours.

6.24.3 Request for Long Term Care Consultation. The MCO must provide for an LTCC within the time frame in section 6.1.12(B)(6).

6.24.4 Request for Mental Health and/or Chemical Dependency Services. The MCO must provide Mental Health and/or CD services in a timely manner. Enrollees requiring CD services or Enrollees needing mental health crisis intervention services should be seen immediately. Other Enrollees in need of mental health and CD services should have an appropriate assessment performed within two (2) weeks.

6.25 Access to Culturally and Linguistically Competent Providers. To the extent possible, the MCO shall provide Enrollees with access to Providers who are culturally and linguistically competent in the language and culture of the Enrollee. For the purpose of this Contract, cultural and linguistic competence includes Providers who serve Enrollees who are deaf and use sign language or an alternative mode of communication.

(A) Providers. The MCO agrees to work towards increasing the Provider pool of culturally and linguistically competent Providers where there is an identified need, including but not limited to, participating in STATE efforts to increase the Provider pool of culturally and linguistically competent Providers, and participating in the STATE's needs assessment process and related planning effort to expand the pool.

(B) Access. Nothing in this section shall obligate an MCO to contract or continue to contract with a Provider if the MCO has determined that it has sufficient access for Enrollees to culturally and linguistically competent Providers and/or if the Provider does not meet the MCO's participation criteria, including credentialing requirements.

6.26 At Risk of Nursing Facility Placement Services. The MCO shall provide Medically Necessary and cost-effective services to the Enrollee and offer Home and Community-Based Services (through the MCO) that are designed to prevent placement of a NHC Enrollee into a Nursing Facility.

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Article. 7 Quality Assessment and Performance Improvement.

7.1 Quality Assessment and Performance Improvement Program. The MCO shall provide a Quality Assessment and Performance Improvement Program consistent with federal requirements under Title XIX of the Social Security Act, 42 CFR Part 438, Subpart D, and as required pursuant to Minnesota Statutes, Chapters 62D, 62M, 62N, 62Q and 256B and related rules, including Minnesota Rules, parts 4685.1105 through 4685.1130, and applicable NCQA "*Standards and Guidelines for the Accreditation of Health Plans*" as specified in this Contract. For MSHO, the Quality Assessment and Performance Improvement Program must also meet the quality review requirements for Medicare Advantage contractors specified in Title XVIII, §1852(e) of the Social Security Act (42 USC § 1395w-22) and the implementing regulations at 42 CFR § § 422.152 through 158.

The MCO must comply with the applicable requirements of CMS' "*Quality Framework*," for EW services.

The MCO shall have an ongoing quality assessment and performance improvement program for the services it furnishes to all Enrollees ensuring the delivery of quality health care.

7.1.1 Scope and Standards. The MCO must incorporate into its quality assessment and improvement program the standards as described in 42 CFR § 438, subpart D (Access, Structure and Operations, and Measurement and Improvement). At least annually, the MCO must assess program standards to determine the quality and appropriateness of care and services furnished to all Enrollees. This assessment must include monitoring and evaluation of compliance with STATE and CMS standards and performance measurement.

7.1.2 Information System. The MCO must operate an information system that supports initial and ongoing operations and quality assessment and performance improvement program. The MCO must maintain a health information system that collects, analyzes, integrates, and reports data, and can achieve the following objectives:

(A) Collect data on Enrollee and Provider characteristics, and on services furnished to Enrollees;

(B) Ensure that data received from Providers is accurate and complete by:

(1) Verifying the accuracy and timeliness of reported data;

(2) Screening or editing the data for completeness, logic, and consistency; and

(3) Collecting service information in standardized formats to the extent feasible and appropriate.

(C) Make all collected data available to the STATE and CMS upon request.

7.1.3 Utilization Management. The MCO shall adopt a utilization management structure consistent with state and federal regulations and current NCQA "*Standards and Guidelines for the Accreditation of Health Plans*." Pursuant to 42 CFR § 438.240(b)(3), this structure must

include an effective mechanism and written description to detect both under- and over-utilization of services.

(A) Ensuring Appropriate Utilization. The MCO shall facilitate the delivery of appropriate care and monitor the impact of its utilization management program to detect and correct potential under- and over-utilization. The MCO shall:

(1) Choose the appropriate number of relevant types of utilization data, including one type related to behavioral health to monitor;

(2) Set thresholds for the selected types of utilization data and annually quantitatively analyze the data against the established thresholds to detect under- and over-utilization;

(3) Examine possible explanations for all data not within thresholds;

(4) Analyze data not within threshold by medical group or practice; and

(5) Take action to address identified problems of under- and over-utilization and measure the effectiveness of its interventions.

7.1.4 Special Health Care Needs. The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs. All Enrollees covered by this Contract are considered to meet the STATE's criteria for special needs.

(A) Identification and Assessment. Pursuant to sections 6.1.4 and 6.1.5 of the Contract, the MCO shall perform a comprehensive assessment or screening on all Enrollees and identify any ongoing special conditions of the Enrollee that may require a course of treatment or regular care monitoring.

(B) Care Plans. For Enrollees with special health care needs as determined through assessment, the MCO shall develop and implement a care plan as required by the Contract in sections 6.1.4, 6.1.5, and 6.1.6. The Care Plan must be:

(1) Developed by the Care Coordinator/Case Manager in conjunction with the Enrollee's Primary Care Provider and with Enrollee participation, and in consultation with any specialists caring for the Enrollee; and

(2) Approved by the MCO in a timely manner, if approval is required by the MCO.

(C) Access to Specialists. If the assessment determines the need for a course of treatment or regular care monitoring the MCO must have a mechanism in place to allow Enrollees to directly access a specialist as appropriate for the Enrollee's condition and identified needs. The MCO's mechanism may be to use a standing referral or an approved number of visits as appropriate for the Enrollee's condition and identified needs.

(D) Items Required for Review and Evaluation by the STATE. The MCO shall submit to the STATE the following items for review and evaluation by the STATE: the Care Plan, Case Management and Care System audit reports and audit protocols as required in sections 7.8.3 and 9.3.9, and the Waiver Quality Assurance Planning Survey, required in section 7.8.4. The MCO must submit to the STATE the written Care Plan, County Case Management and Care System audit reports and audit protocols by September 15th of each Contract Year, and the Waiver Quality Assurance Plan Survey according to the timeframe in section 7.8.4. If there are no changes to a particular report or description, the MCO shall notify the STATE that there are no changes to that item.

7.1.5 Practice Guidelines. The MCO shall adopt preventive and chronic disease practice guidelines appropriate for Enrollees age sixty-five (65) and older, consistent with accepted geriatric practices. The MCO shall adopt, disseminate and apply practice guidelines consistent with current NCQA "*Standards and Guidelines for the Accreditation of Health Plans*" QI 9 Clinical Practice Guidelines, as appropriate.

(A) Adoption of practice guidelines. The MCO shall adopt guidelines that: 1) are based on valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field; 2) consider the needs of the MCO Enrollees; 3) are adopted in consultation with contracting Health Care Professionals: and 4) are reviewed and updated periodically as appropriate.

(B) Dissemination of guidelines. The MCO shall ensure that guidelines are disseminated to all affected Providers and, upon request, to Enrollees and Potential Enrollees.

(C) Application of guidelines. The MCO shall ensure that these guidelines are applied to decisions for utilization management, Enrollee education, coverage of services, and other areas to which there is application and consistency with the guidelines.

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 and Guidelines for the Accreditation of Health Plans*." For organizational Providers, including nursing facilities, hospitals, and Medicare certified home health care agencies; the MCO shall adopt a uniform credentialing and recredentialing process and comply with that process consistent with State regulations.

(A) Waiver service Providers and PCPAs are exempt from this requirement.

(B) Selection and Retention of Providers. The MCO must implement written policies and procedures for the selection and retention of Providers.

(C) Process for Credentialing and Recredentialing. The MCO must follow a documented process for credentialing and recredentialing of those Providers who are subject to the credentialing and recredentialing process and have signed contracts or participation agreements with the MCO.

(D) Discrimination Against Providers Serving High-Risk Populations. The MCO is prohibited from discriminating against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

(E) Sanction Review. The MCO shall ensure prior to entering into or renewing an agreement with a Provider, that the Provider:

(1) Has not been sanctioned for fraudulent use of federal or state funds by the U.S. Department of Health and Human Services, pursuant to 42 USC §1320 a-7(a) or by the State of Minnesota; or

(2) Is not debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 (51 FR 6370, February 18, 1986) or under guidelines interpreting such order, or

(3) Is not an affiliate of such a Provider.

(4) The MCO shall not knowingly contract with such a Provider.

(F) Restricting Financial Incentive. The MCO may not give any financial incentive to a health care Provider or individual who performs utilization review based solely on the number of services denied or referrals not authorized by the Provider, pursuant to Minnesota Statutes, §§ 72A.20, subd. 33 and 62M.12; and as required under 42 CFR §417.479 and for MSHO, 42 CFR §422.208.

(G) Provider Discrimination. The MCO shall not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of the Provider's license or certification under applicable State law, solely on the basis of such license or certification. This section shall not be construed to prohibit the MCO from including Providers only to the extent necessary to meet the needs of the MCO's Enrollees or from establishing any measure designated to maintain quality and control costs consistent with the responsibilities of the MCO. If the MCO declines to include individuals or groups of Providers in its network, it must give the affected Providers written notice of the reason for its decision.

(H) Contracted Provider Access Standards. The MCO shall require its contracted Providers to meet the access standards required by section 0, and applicable state and federal laws. The MCO shall monitor, on a periodic or continuous basis, but no less than every twelve (12) months, the Providers' adherence to these standards.

7.1.7 Annual Quality Assurance Work Plan. On or before May 1st of the Contract Year, the MCO shall provide the STATE an annual written work plan that details the MCO's proposed quality assurance and performance improvement projects for the year. This report shall follow the guidelines and specifications contained in Minnesota Rules, Part 4685.1130, subpart 2, and current NCQA "*Standards and Guidelines for the Accreditation of Health Plans*." If the MCO chooses to substantively amend, modify or update its work plan at any time during the year, it

shall provide the STATE with material amendments, modifications or updates in a timely manner.

(A) The work plan must include specific references to activities that are to be conducted during the year and affect the MSHO and MSC+ population.

(B) MSHO MCO SNPs may combine their Medicare and Medicaid Quality Assurance Work Plans to the extent specifically applicable to the MSHO population and to the extent the combined plan meets the STATE's requirements. If the MSHO Dual Eligible MCO SNP submits a separate work plan to CMS, the MCO will provide a timely copy to the STATE.

7.1.8 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, including the CMS "*Quality Framework for the Elderly Waiver*" and current NCQA "*Standards and Guidelines for the Accreditation of Health Plans*." This evaluation must review the impact and effectiveness of the MCO's quality assessment and performance improvement program including performance on standard measures and MCO's performance improvement projects. The MCO must submit the written evaluation to the STATE by May 1st of the Contract Year.

(A) The evaluation must also include an analysis on the impact and effectiveness of MSHO Care Coordination activities.

(B) For MSHO SNPs, this evaluation may be combined with the required Medicare evaluation, provided it is conducted at the Dual Eligible SNP plan level; is applicable to the MSHO population; and meets the above criteria.

7.2 Performance Improvement Projects (PIPs). The MCO may use its Medicare Quality Improvement Project (QIP) to meet the Medicaid Performance Improvement Project (PIP) requirements for both MSHO and MSC+. This includes using Medicare's measurement standards and reporting timelines and templates.

7.2.1 New Performance Improvement Project Proposal. . CMS will work with the State and MCO to have input into topics selected. The MCO must submit to the STATE for review and approval a written description of the PIP the MCO proposes including interventions being proposed, prior to submission to CMS.

7.2.2 Annual QIP Status Reports. The MCO shall submit written QIP status report within 15 days of submission to CMS. Final QIP Report. The MCO will provide the STATE with copies of the final QIP proposal and reports submitted to CMS within fifteen (15) days of submission.

7.2.4 Current PIPs. The MCO shall submit to the STATE by July 1, 2014, a final PIP status report for those current PIPs being conducted that have not been completed by January 2, 2014.

7.2.5 Performance Improvement Project PIP/QIP Categories. The MCO agrees to work with the STATE on developing PIP/QIPs for Seniors. Topics should address the full spectrum of clinical and nonclinical areas associated with the MCO and not consistently eliminate any particular subset of Enrollees or topics when viewed over multiple years.

7.2.6 PIP/QIP Collaborative for SNPs. The MCO is encouraged to continue participation in PIP/QIP Collaborative initiatives that coordinate topics and designs between SNPs.

7.3 Disease Management Program. The MCO shall make available a Disease Management Program for its Enrollees with diabetes and heart disease. These programs shall be tailored to meet the appropriate clinical needs of Enrollees under this contract. The MCO shall provide information to the State on how the disease management program has been tailored to meet to meet these needs in the annual evaluation, and within thirty (30) days of adoption of any new DM programs applicable to Enrollees under this contract.

(A) The MCO may request the STATE to approve an alternative Disease Management Program topic other than diabetes or heart disease. The MCO must submit to the STATE appropriate justification for the MCO's request.

(B) Disease Management Program Standards. The MCO's Disease Management Program shall be consistent with current NCQA "*Standards and Guidelines for the Accreditation of Health Plans*" pursuant to the QI Standard for Disease Management.

(C) Waiver of Disease Management Program Requirement. If the MCO is able to demonstrate that a Disease Management Program: 1) is not effective based upon Provider satisfaction, and is unable to achieve meaningful outcomes; or 2) would have a negative financial return on investment, then the MCO may request that the STATE waive this requirement for the remainder of the Contract Year.

7.4 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.

7.4.1 MSC+ Disenrollment Survey. For MSC+ only, Enrollee disenrollment is measured by an ongoing survey conducted by the STATE or its designee in the manner required in Minnesota Statutes, Chapter 62J. The MCO shall cooperate with the STATE or its designee in collection activities as directed by the STATE. If the MCO or any of its contracted Care Systems conduct an Enrollee disenrollment survey that involves MSHO Enrollees, the MCO must provide the STATE with a copy of the survey results in a timely manner.

7.4.2 Elderly Waiver Consumer Survey. The MCO agrees to work with the STATE, as necessary, for the STATE's survey of Elderly Waiver consumers. The STATE will consult with the MCO on the survey tool.

7.4.3 Additional Satisfaction Surveys. If the MCO or any of its contracted Care Systems conduct an Enrollee satisfaction survey that involves MSC+ or MSHO Enrollees, including the Medicare Consumer Assessment of Health Plan Satisfaction (CAHPS), the MCO must provide the STATE with a copy of the survey results in a timely manner. For the CAHPS survey that the

MCO conducts to meet Medicare requirements, the MCO will report results at the PBP level per the MOU.

7.4.4 Stakeholder Group. The MCO will establish and maintain a local or regional stakeholders group to consider issue for the senior population group, and obtain periodic feedback from members on satisfaction with care, problem identification, and suggestions for improving the delivery system. This stakeholder group will meet at least twice per year. This process must include a way to use this information to improve access to, and quality of, the care delivered to MSHO/MSC+ Enrollees. Results of consumer feedback activity mechanisms shall be shared with the STATE as described in section 3.7.2(X).

7.5 External Quality Review Organization (EQRO) Study. 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 USC §1396a(a)(30), and 42 CFR Part 438, subpart E. Such cooperation shall include, but is not limited to 1) meeting with the entity and responding to questions, 2) providing requested medical records and other data in the requested format; and 3) providing copies of MCO policies and procedures, and other records, reports and/or data necessary for the external review.

7.5.1 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, when the following required terms are met:

(A) Complies with federal requirements (42 CFR §438.360);

(B) CMS or accrediting standards are comparable to standards established by the STATE and identified in the STATE's Quality Strategy;

(C) MCOs must have received an NCQA accreditation rating of excellent, commendable, or accredited; and

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

7.5.2 Exemption from EQR. The MCO may request from the STATE an exemption to the EQR, if the MCO meets federal requirements (42 CFR §438.362) and is approved by the STATE and CMS.

7.5.3 Review of EQRO Annual Technical Report Prior to Publication. The STATE shall allow the MCO to review a final draft copy of the EQRO Annual Technical Report prior to the date of publication. The MCO shall provide the STATE any written comments about the report, including comments on its scientific soundness or statistical validity, within thirty (30) days of receipt of the final draft report. The STATE shall include a summary of the MCO's written comments in the final publication of the report, and may limit the MCO's comments to the report's scientific soundness and/or statistical validity. The STATE will make available the audit reports to the MCO as they become available.

7.5.4 EQRO Recommendation for Compliance. Pursuant to 42 CFR §438.364(a)(5), the MCO shall effectively address recommendations for improving the quality of health care services made by EQRO in the Annual Technical Report for obligations under this Contract.

7.6 Delegation of Quality Improvement Program Activities. The MCO shall meet the requirements for delegation for any delegated activities related to quality improvement. Reviews of Care Systems shall be conducted according to the annual Care System review described in section 9.3.9.

7.7 Annual Performance Measures.

(A) The MCO will provide the STATE the following within thirty (30) days of submission to NCQA: 1) HEDIS report submitted to CMS for MSHO in an Excel spreadsheet format; and 2) upon request, the documentation submitted to CMS for the MSHO Structure and Process Measures.

(B) The MCO will provide the STATE the following within thirty (30) days of receipt from CMS: the summarized results of the MSHO Structure and Process Measures reported by NCQA.

7.8 Care Coordination and Case Management Documentation.

7.8.1 MCO Collaboration. The MCO shall collaborate with the STATE and other MCOs to promote Care Coordination and Case Management efforts and measure its effectiveness through an intervention on a mutually agreed upon topic by the STATE, the MCO and the other MCOs.

7.8.2 MCO Cooperation. The MCO will cooperate with any research or evaluation of Care Coordination and/or Case Management conducted by the STATE, CMS or their contractors.

7.8.3 Care Plan Audits. The MCO shall audit a sample of Care Plans for EW Enrollees. The sample must follow appropriate sampling methodology. The MCO must use a protocol submitted to and approved by the STATE that follows the Care Planning audit data abstraction protocol developed by the Care Plan audit work group. This protocol incorporates requirements for EW services and Case Management as appropriate for the Enrollee. Audit results must be submitted to the STATE along with any Care System and/or Care Plan audits as required under section 9.3.9, by September 15th of each year. A summary of the audit results shall be submitted in a form and manner determined by the STATE. MDH will audit a sample of care plans for EW Enrollees from each MCO during its triennial compliance audit.

7.8.4 Waiver Quality Assurance Plan Survey. The MCO will submit the Waiver Quality Assurance Plan Survey, using the tool designated by the STATE, at the STATE's request with a ninety (90) day notice.

7.9 Enrollment Data by Care System. Upon request, the MCO shall submit to the STATE enrollment data for each delegated Care System by Rate Cell Category and Care System within thirty (30) days of the request.

7.10 Cooperation with Independent Assessment. The MCO will cooperate with any independent assessment of the MSHO program or of the MSC+ 1915(b)(c) waivers conducted by the STATE, its contractors, or CMS.

7.11 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.

7.12 Workgroup Participation. The MCO is encouraged to appoint representatives to participate in the STATE's workgroups as follows:

(A) Care Coordination; and

(B) Clinical Practice and Performance Measurement. This group will provide input on geriatric clinical practice that includes implementing practice models based on Medical Home concepts, identifying best clinical practices and related performance measurement, and integration of new Medicare SNP measures and protocol requirements.

(C) Quality Technical Committee covering EQR activities, surveys, Quality Strategy,

(D) The STATE and MCO agree to convene a workgroup to develop strategies for the alignment of measurable quality improvement across MHCP populations. Considerations of the workgroup shall include alignment of federal and state quality standards and other quality improvement initiatives and activities, with particular focus on improving health outcomes.

7.13 Quality Program Transparency and Accountability. Annually, the MCO shall demonstrate how the MCO's Quality Improvement Program identifies, monitors and works to improve service and clinical quality issues relevant to the MHCP Enrollees.

(A) The MCO shall submit, on or before May 1st of the Contract Year, a written summary in a format determined by the STATE describing quality improvement activities that have resulted in measurable, meaningful and sustained improved health care outcomes for the contracted populations. The MCO will describe the quality strategies, including quantitative evidence of improvements lessons learned, and how the quality improvement outcomes will influence future activities.

(B) The MCO must provide the report in electronic format that complies with the accessibility standards of section 508 of the Rehabilitation Act of 1973. See http://www.w3.org/TR/WCAG20/#guidelines.

(C) The STATE will publish the annual MCO written summary on the STATE's public website and public comments will be requested. The MCO will respond to public comments received.

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7.14 Financial Performance Incentives.

7.14.1 Compliance and Limits. Incentives, if any, must comply with the federal managed care incentive arrangement requirements pursuant to 42 CFR § 438.6(c)(1)(iv); (2)(i); (4)(ii) and (iv); (5)(iii) and (iv) and the State Medicaid Manual (SMM) 2089.3, and to the extent that funds are available.

7.14.2 Federal Limit. The total of all payments paid to the MCO under this Contract shall not exceed one hundred and five percent (105%) of the Capitation Payments, pursuant to 42 CFR § 438.6(c)(5)(iii), as applicable to each group of Rate Cells covered under the incentive arrangement. If the incentive applies to the entire population covered under the Contract, the limit will apply in aggregate.

7.14.3 Collaboration. MCOs are encouraged to join with other MCOs in collaborative initiatives to expand these preventive services.

7.14.4 Pay for Performance. The MCO shall cooperate with the STATE to develop and implement a pay-for-performance model for rewarding Providers for chronic disease care.

(A) The STATE, as a member of the guiding coalition for the Minnesota Bridges to Excellence (BTE) health care quality initiative, has contracted with the Minnesota Health Action Group (MHAG) to implement the pay-for-performance BTE program. All private payers and the STATE participating in the pay-for-performance program contribute incentive payments based on the payer's proportionate share of enrollees served by the clinics or medical groups.

(B) MHAG calculates the incentive payment annually, and provides a report to the MCOs and the State. As a participant in the program, the STATE pays the incentive reward payments to the MCO based on criteria established by MHAG. The MCOs pay to MHAG the same incentive reward payment. MHAG then distributes the appropriate payment to the eligible clinics or medical groups based on their performance level of providing optimal chronic disease care.

(C) In order to receive the annual pay-for-performance reward, the MCO contracted clinic or medical group must have achieved optimal chronic disease care for a designated percentage of its patients, as determined by MHAG. The pay-for-performance projects are limited to Diabetes Care, and Vascular Care.

7.14.5 Critical Access Dental Payment.

(A) The MCO shall participate in a dental access initiative whereby the MCO agrees to provide increased reimbursement to designated dentists for services for Medical Assistance in accordance with the following:

(1) Designation of Critical Access Dental Providers. The STATE shall provide to the MCO a list of designated dental Providers for the Critical Access dental payment quarterly at the end of February, May, August and November.

(2) Quarterly Reporting of MCO's Dental Payments to Designated Critical Access Dental Providers. The MCO shall provide for each quarter no later than the 20th 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. For each Provider listed, the MCO shall report payments for the major programs Medical Assistance and MinnesotaCare separately. The report must be certified in accordance with section 9.10.

(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 schedule that will identify the amount of critical access dental payment to be paid to each designated Provider, pursuant to specifications.

(b) For Medical Assistance, this amount shall be thirty-five percent (35%) more than the amount that was reported by the MCO on its quarterly report, consistent with Minnesota Statutes, § 256B, subd. 4.

(c) The STATE will issue a gross payment adjustment to the MCO that will be the sum of the Critical Access dental payment amounts for the Providers identified in the quarterly report. The MCO shall distribute the Critical Access dental payments as specified in the STATE's payment schedule.

(d) In the event that a designated dental provider provides notice to the STATE that a payment by the MCO is incorrect, the MCO remains responsible for the payment after verification of the correct payment.

7.15 Minnesota Community Measurement. The STATE will work with MDH and the marketplace of purchasers and Providers on the development and application of the MN Community Measurement programs supporting MHCP. The MCOs shall retain and apply the race and ethnicity data supplied by the STATE when needed for MNCM programs supporting MHCP.

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Article. 8 The Grievance System: Grievances, Notices of Action (DTR), Appeals, and State Fair Hearings.

8.1 General Requirements.

8.1.1 Components of Grievance System. The MCO must have a Grievance System in place that includes a Grievance process, an Appeal process, and access to the State Fair Hearing system. For MSHO the system must:

(A) Assure compliance with Medicare and Medicaid requirements; and

(B) Preserve MSHO Enrollees' access to all appropriate levels of Medicare and Medicaid appeals; and

(C) Integrate both processes to make the system easier to navigate for the MSHO Enrollee.

8.1.2 Timeframes for Disposition. The MCO must dispose of each Grievance, resolve each Appeal, and provide notice as expeditiously as the Enrollee's health condition requires, but no later than timeframes set forth in this Article. For MSHO, in instances where the MCO's integrated system described in section 8.1.1 creates timeline conflicts, the MCO must apply the timeline that benefits the Enrollee to the greatest extent.

8.1.3 Legal Requirements. The Grievance System must meet the requirements of Minnesota Statutes, § § 62M.06, 256.045, subd. 3a; (excluding the reference to Minnesota Statutes, §62D.11) and 42 CFR § 438, Subpart F. For MSHO as a Medicare integrated product, the Grievance and Appeals system must also meet the requirements of 42 CFR § 422, Subpart M.

8.1.4 STATE Approval Required. The MCO's Grievance System is subject to approval by the STATE. This requires that:

(A) Any proposed changes to the Grievance System must be approved by the STATE prior to implementation;

(B) The MCO must send written notice to Enrollees of significant changes to the Grievance System at least thirty (30) days prior to implementation;

(C) The MCO must provide information specified in 42 CFR § 438.10(g)(1) about the Grievance System to Providers and subcontractors at the time they enter into a contract; and

(D) Within sixty (60) days after the execution of a contract with a Provider (e.g. hospitals, individual Providers, and clinics), the MCO must inform the Provider of the programs under this Contract, and specifically provide an explanation of the Notice of Rights and Responsibilities, and Grievance, Appeal and State Fair Hearing rights of Enrollees and Providers under this Contract.

8.1.5 Response to Investigation. Pursuant to Minnesota Statutes, § 256B.69, subd. 3a, the MCO must respond directly to county advocates, established under Minnesota Statutes, § 256B.69, subd. 21, and the STATE Ombudsman, established under Minnesota Statutes, § 256B.69, subd. 20, regarding service delivery.

8.2 MCO Grievance Process Requirements

8.2.1 Filing Requirements. The Enrollee, or the Provider acting on behalf of the Enrollee with the Enrollee's written consent, may file a Grievance within ninety (90) days of a matter regarding an Enrollee's dissatisfaction about any matter other than an MCO Action. Examples include the quality of care or services provided, rudeness of a Provider or employee, or failure to respect the Enrollee's rights. A Grievance may be filed orally or in writing.

8.2.2 Timeframe for Resolution of a Grievance.

(A) Oral Grievances must be resolved within ten (10) days of receipt.

(B) Written Grievances must be resolved within thirty (30) days of receipt.

(C) Oral Grievances may be resolved through oral communication, but the MCO must send the Enrollee a written decision for written Grievances.

8.2.3 Timeframe for Extension of Grievance Resolution. The MCO may extend the timeframe for resolution of a Grievance by an additional fourteen (14) days if the Enrollee or the Provider requests the extension, or if the MCO justifies that the extension is in the Enrollee's best interest (for example, due to a need for additional information). The MCO must provide written notice to the Enrollee of the reason for the decision to extend the timeframe if the MCO determines that an extension is necessary. The MCO must issue a notice of resolution no later than the date the extension expires. The STATE may review the MCO's justification upon request.

8.2.4 Handling of Grievances.

(A) The MCO must mail a written acknowledgment to the Enrollee or Provider acting on behalf of the Enrollee, within ten (10) days of receiving a written Grievance, and may combine it with the MCO's notice of resolution if a decision is made within the ten (10) days.

(B) The MCO must maintain a log of all Grievances, oral and written.

(C) The MCO must not require submission of a written Grievance as a condition of the MCO taking 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.

8.2.5 Notice of Disposition of a Grievance.

(A) Oral grievances may be resolved through oral communication. If the disposition, as determined by the Enrollee, is partially or wholly adverse to the Enrollee, or the oral grievance is not resolved to the satisfaction of the Enrollee, the MCO must inform the enrollee that the grievance may be submitted in writing. The MCO must also offer to provide the Enrollee with any assistance needed to submit a written Grievance, including an offer to complete the Grievance form, and promptly mail the completed form to the enrollee for his/her signature pursuant to Minnesota Statutes § 62Q.69, subd. 2. Oral resolution must include the results of the MCO investigation and actions related to the Grievance, and the MCO must inform the enrollee of options for further assistance through the Managed Care Ombudsman and/or review by MDH.

(B) When a grievance is filed in writing, the MCO must notify the enrollee in writing of its disposition. The written notice must include the results of the MCO investigation, MCO actions relative to the grievance, and options for further review through the Managed Care Ombudsman and MDH.

8.3 Denial, Termination, or Reduction (DTR) Notice of Action to Enrollees. If the MCO denies, reduces or terminates services or claims that are: 1) requested by an Enrollee; 2) ordered by a Participating Provider; 3) ordered by an approved, non-Participating Provider; 4) ordered by a care manager; or 5) ordered by a court, the MCO must send a DTR notice to the Enrollee that meets the requirements of this section. For MSHO, the MCO will work with the State to modify form CMS 10003-NDMCP for use for all services denied, terminated or reduced by the MCO.

8.3.1 General DTR Notice of Action Requirements.

(A) Written Notice. The DTR must meet the language requirements of 42 CFR § 438.10(c). The DTR must also:

(1) Be understandable to a person who reads at the 7th grade reading level;

(2) Be available in alternative formats as required by section 3.6.2(B);

(3) Be approved in writing by the STATE, pursuant to section 3.6;

(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); and

(5) Be sent to the Enrollee. The MCO may have its subcontractor send the DTR to the Enrollee only if MCO has received prior written approval by the STATE. The MCO must submit in advance for STATE approval any DTR notification and member rights form that will be used by the subcontractor.

(B) Content of the DTR Notice of Action. The DTR must include:

(1) The Action that the MCO has taken or intends to take;

(2) The type of service or claim that is being denied, terminated, or reduced;

(3) A clear detailed description in plain language of the reasons for the Action;

(4) The specific federal or state regulations that support or require the Action, whichever applies. Nothing in this section prevents the MCO from providing more specific information;

(5) The date the DTR was issued;

(6) The effective date of the Action if it results in a reduction or termination of ongoing or previously authorized services;

(7) The date the MCO received the request for Service Authorization if the Action is for a denial, limited authorization, termination or reduction of a requested service;

(8) The first date of service, if the Action is for denial, in whole or in part, of payment for a service;

(9) The STATE's language block with an MCO phone number that Enrollees may call to receive help in translation of the notice;

(10) A phone number at the MCO that Enrollees may call to obtain information about the DTR; and

(11) The "Your Appeal Rights" notice provided and/or approved by the STATE, which includes but is not limited to:

(a) The Enrollee's right (or Provider on behalf of Enrollee with the Enrollee's written consent) to file an Appeal with the MCO;

(b) The requirements and timelines for filing an MCO Appeal pursuant to 42 CFR § 438.402;

(c) The Enrollee's right to file a request for a State Fair Hearing without first exhausting MCO's Appeal procedures, or up to thirty (30) days after the MCO's final determination of the Appeal;

(d) The process the Enrollee must follow in order to exercise these rights;

(e) The circumstances under which expedited resolution is available and how to request it for an Appeal or State Fair Hearing;

(f) The Enrollee's right to continuation of benefits upon request within the time frame allowed, how to request that benefits be continued, and under what circumstances the Enrollee may be billed for these services if the Enrollee files an Appeal at the MCO or requests a State Fair Hearing; and

(g) The right to seek an expert medical opinion from an external organization in cases of Medical Necessity at the STATE's expense, for consideration at State Fair Hearings.

(C) Notice to Provider. The MCO must also notify the Provider of the Action. For denial of payment, notice may be in the form of an Explanation of Benefits (EOB), explanation of payments, or remittance advice. The MCO must also notify the Provider of the right to Appeal a DTR pursuant to section 8.4, and provide an explanation of the Appeal process. This notification may be through Provider contracts, Provider manuals, or through other forms of direct communication such as Provider newsletters.

(D) Notice to Enrollee of Right to Quality Improvement Organization Review for MSHO. The MCO shall ensure that the MSHO Enrollee is notified of the right to request an immediate Quality Improvement Organization (QIO) review if the MSHO Enrollee believes he or she is being prematurely discharged pursuant to 42 CFR §§ 422.620 and 422.622. This requirement is limited to hospital discharges and supersedes the otherwise required STATE DTR notice requirement specified in section 8.3.1 of this Contract.

(E) Medicare Rights. The MCO shall ensure that the MSHO Enrollees receive timely notification of termination of Medicare services provided by a skilled nursing facility, home health agency or comprehensive outpatient rehabilitation facility in accordance with 42 CFR § 422.624. The MSHO Enrollee shall also have the right to appeal such termination to an Independent Review Entity (IRE) under 42 CFR § 422.626. This provision supersedes the otherwise required STATE DTR notice under section 8.3.1 of this contract.

8.3.2 Timing of the DTR Notice.

(A) Previously Authorized Services. For previously authorized services, the MCO must mail the Notice to the Enrollee and the attending health care provider at least ten (10) days before the date of the proposed Action in accordance with 42 CFR § 438.404(c)(1). The following criteria must also be met:

(1) The ongoing medical service must have been ordered by a participating or authorized non-Participating Provider who is a treating physician, osteopath, dentist, mental health professional, nurse practitioner or chiropractor.

(2) The service must be eligible for payment according to Minnesota Statutes, § 256B.0625 and Minnesota Rules, Part 9505.0170 through 9505.0475.

(3) All procedural requirements regarding Service Authorization must have been met.

(B) Denials of Payment. For denial of payment, the MCO must mail the DTR notice to the Enrollee at the time of any Action affecting the claim.

(C) Standard Authorizations. For standard authorization decisions that deny or limit services, the MCO must provide the notice:

(1) As expeditiously as the Enrollee's health condition requires,

(2) To the attending Health Care Professional and hospital by telephone or fax within one working day after making the determination;

(3) To the Provider, Enrollee and hospital, in writing, and which must include the process to initiate an appeal, within ten (10) business days following receipt of the request for the service, unless the MCO receives an extension of the resolution period pursuant to section 8.3.2(E).

(D) Expedited Authorizations. For expedited Service Authorizations, the MCO must provide the determination as expeditiously as the Enrollee's health condition requires, not to exceed seventy-two (72) hours of receipt of the request for the service. Expedited Service Authorizations are for cases where the Provider indicates or the MCO determines that following the standard timeframe could seriously jeopardize the Enrollee's life or health, or ability to attain, maintain or regain maximum function.

(E) Extensions of Time. The MCO may extend the timeframe by an additional fourteen (14) days for resolution of a standard authorization if the Enrollee or the Provider requests the extension, or if the MCO justifies a need for additional information and how the extension is in the Enrollee's interest. The MCO must provide written notice to the Enrollee of the reason for the decision to extend the timeframe, and the Enrollee's right to file a Grievance if he or she disagrees with the MCO's decision. The MCO must issue a determination no later than the date the extension expires. The STATE may review the MCO's justification upon request.

(F) Delay in Authorizations. For Service Authorizations not reached within the timeframe specified in 42 CFR § 438.210(d)(1), the MCO must provide a notice of denial on the date the timeframe expires.

8.3.3 Continuation of Benefits Pending Decision.

(A) If an Enrollee files an Appeal with the MCO before the date of the Action proposed on a DTR and requests continuation of benefits within the time allowed, the MCO, in accordance with 42 CFR § 438.420(b), may not reduce or terminate the service until ten (10) days after a written decision is issued in response to that Appeal, unless: 1) the Enrollee withdraws the Appeal; or 2) if the Enrollee has requested a State Fair Hearing with a continuation of benefits, until the State Fair Hearing decision is reached.

(B) The continuation of benefits is not required if the Provider who orders the service is not an MCO Participating Provider or authorized non-Participating Provider.

(C) For MSHO, the MCO shall not continue the service if the service is a Medicare-only covered service per Title XVIII of the Social Security Act.

(D) The termination of Consumer Directed Community Support (CDCS) services to Elderly Waiver participants is subject to a STATE Fair Hearing and Notice requirements. However, CDCS services do not continue during the STATE Fair Hearing process. If the Enrollee is still eligible for Elderly Waiver Services, the DTR Notice to the Enrollee must include the non-CDCS waiver services that the MCO authorizes as a replacement for the terminated CDCS services.

8.4 MCO Appeals Process Requirements.

8.4.1 Filing Requirements. The Enrollee or the Provider acting on behalf of the Enrollee with the Enrollee's written consent may file an Appeal within ninety (90) days of the DTR Notice of Action, or for any other Action taken by the MCO as it is defined in 42 CFR § 438.400(b)) for both Medicare and Medicaid covered services as allowed by the MOU. In addition, attending Health Care Professionals may Appeal utilization review decisions at the MCO level without the written signed consent of the Enrollee in accordance with Minnesota Statutes, § 62M.06. An Appeal may be filed orally or in writing. The initial filing determines the timeframe for resolution. Nothing shall prevent an MSHO Enrollee from pursuing both the Medicare and Medicaid process simultaneously. If the Appeal is filed orally the MCO must assist the Enrollee, or Provider filing on behalf of the Enrollee, in completing a written signed Appeal. Once the oral Appeal is reduced to a writing by the MCO, and pending the Enrollee's signature, the MCO must:

(A) Resolve the Appeal in favor of the Enrollee, regardless of receipt of a signature, or

(B) If no signed Appeal is received within thirty (30) days, the MCO may resolve the Appeal as if a signed appeal were received.

8.4.2 Medicare Requests for Hearing for MSHO. For services covered by Medicare, the MCO must follow 42 CFR § § 422.600 through 616, which includes Enrollee access to review by an independent review entity, Administrative Law Judge, Medicare Appeals Council and Judicial Review.

8.4.3 Timeframe for Resolution of Standard Appeals. The MCO must resolve each Appeal as expeditiously as Enrollee's health requires, not to exceed thirty (30) days after receipt of the Appeal.

8.4.4 Timeframe for Resolution of Expedited Appeals.

(A) The MCO must resolve and provide written notice of resolution for both oral and written Appeals as expeditiously as the Enrollee's health condition requires, but not to exceed seventy-two (72) hours after receipt of the Appeal.

(B) If the MCO denies a request for expedited Appeal, the MCO shall transfer the denied request to the standard Appeal process, preserving the first filing date of the expedited Appeal. The MCO must notify the Enrollee of that decision orally within twenty-four (24) hours of the request and follow up with a written notice within two (2) days.

(C) When a determination not to certify a health care service is made prior to or during an ongoing service, and the attending health care professional believes that an expedited Appeal is warranted, the MCO must ensure that the Enrollee and the attending health care professional have an opportunity to Appeal the determination over the telephone. In such an Appeal, the MCO must ensure reasonable access to the MCO's consulting physician as authorized by Minnesota Statutes § 62M.06, subd.2(a).

8.4.5 Timeframe for Extension of Resolution of Appeals. An extension of the timeframes of resolution of Appeals of fourteen (14) days is available for Appeals if the Enrollee requests the extension, or the MCO justifies both the need for more information and that an extension is in the Enrollee's interest. The MCO must provide written notice to the Enrollee of the reason for the decision to extend the timeframe if the MCO determines that an extension is necessary. The MCO must issue a determination no later than the date the extension expires. The STATE may review the MCO's justification.

8.4.6 Handling of Appeals.

(A) All oral inquiries challenging or disputing a DTR Notice of Action or any Action as defined in 42 CFR § 438.400(b) shall be treated as an oral Appeal and shall follow the requirements of section 8.4.

(B) The MCO must send a written acknowledgment within ten (10) days of receiving the request for an Appeal and may combine it with the MCO's notice of resolution if a decision is made within the ten days.

(C) The MCO must give Enrollees any reasonable assistance required in completing forms and taking other procedural steps, including but not limited to providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.

(D) The MCO must ensure that the individual making the decision was not involved in any previous level of review or decision-making.

(E) If the MCO is deciding an Appeal regarding denial of a service based on lack of Medical Necessity, the MCO must ensure that the individual making the decision is a Health Care Professional with appropriate clinical expertise in treating the Enrollee's condition or disease, as provided for in Minnesota Statutes, §§ 62M.06, 62M.09 and 42 CFR § 438.406(a)(3)(ii).

(F) The MCO must provide the Enrollee with a reasonable opportunity to present evidence and allegations of fact or law, in person, or by telephone as well as in writing.

For expedited Appeal resolutions, the MCO must inform the Enrollee of the limited time available to present evidence in support of their Appeal.

(G) The MCO must provide the Enrollee, and his or her representative an opportunity, before and during the Appeals process, to examine the Enrollee's case file including medical records and any other documents and records considered during the Appeal process.

(H) The MCO must include as parties to the Appeal the Enrollee, his or her representative, or the legal representative of a deceased Enrollee's estate.

(I) The MCO must not take punitive action against a Provider who requests an expedited resolution or supports an Enrollee's Appeal.

8.4.7 Subsequent Appeals. If an Enrollee Appeals a decision from a previous Appeal on the same issue, and the MCO decides to hear it, for purposes of the timeframes for resolution this will be considered a new Appeal.

8.4.8 Notice of Resolution of Appeal.

(A) The MCO must provide a written notice of resolution for all Appeals, and must include in the text of the notice: 1) the results of the resolution process and date it was completed; and 2) the Enrollee's right to request a State Fair Hearing if the resolution was not wholly favorable to the Enrollee. The MCO must include with the notice a copy of the STATE's Notice of Rights.

(B) For Appeals of Utilization Management (UM) decisions, the written notice of resolution shall be sent to the Enrollee and the attending health care professional.

(C) The MCO must notify the Enrollee and attending health care professional by telephone of its determination on an expedited appeal as expeditiously as the enrollee's medical condition requires, but no later than seventy-two (72) hours after receiving the expedited Appeal.

(D) If an Enrollee or Attending Health Care Professional is unsuccessful in an appeal of the UM determination, the MCO must provide: 1) a complete summary of the review findings, 2) qualifications of the reviewer, 3) the relationship between the Enrollee's diagnosis and the review criteria used, including the specific rationale for the reviewer's decision, consistent with Minnesota Statutes, § 62M.06 subd. 3(e).

8.4.9 Reversed Appeal Resolutions. If a decision by an MCO is reversed by the Appeal process, the MCO must:

(A) Comply with the Appeal decision promptly and as expeditiously as Enrollee's health condition requires; and

(B) Pay for any services the Enrollee already received that are the subject of the Appeal.

8.4.10 Upheld Appeal Resolutions. If the final resolution of the appeal is adverse to the Enrollee, that is the MCO decision is upheld, the MCO may recover the cost of the services furnished to the Enrollee while the appeal was pending, to the extent that the services were the subject of the appeal, pursuant to 42 CFR § 438.420(d).

8.4.11 Additional Levels of Resolution. This Article does not prohibit an MCO from offering additional levels of internal resolution mechanisms so long as the MCO complies with the minimum requirements set forth herein.

8.5 Maintenance of Grievance and Appeal Records. The MCO must maintain and make available upon request by the STATE its records of all Grievances, DTRs, Appeals and State Fair Hearings.

8.6 Reporting of Grievances to the STATE. The MCO must submit to the STATE a quarterly electronic report of all oral and written Grievances that meets the following requirements:

(A) Is a comma-delimited text file, with data elements specified by the STATE and per STATE specifications, including identifying oral and written grievances separately in order to track both types of filed grievances;

(B) Is submitted through the Online Grievance/DTR/Appeals Reporting Web Application (ORWA), via MN-ITS;

(C) Is due on or before the 30th day of the month following the end of the quarter, for all oral and written Grievances resolved in the previous quarter. If the 30th day of the month falls on a weekend or holiday, the report is due to the STATE on the following business day.

8.7 Reporting of DTRs to the STATE. The MCO must submit to the STATE a quarterly DTR report, that meets the following requirements:

(A) Is a comma-delimited text file, with data elements specified by the STATE and per STATE specifications, including the PMI number and major program of each Enrollee.

(B) Is submitted through the ORWA, via MN-ITS;

(C) Is due on or before the 30th day of the month following the end of the quarter, for all DTRs resolved in the previous quarter. If the 30th day of the month falls on a weekend or holiday, the report is due to the STATE on the following business day.

8.8 Reporting of Appeals to the STATE. The MCO must submit to the STATE a quarterly electronic report of all oral and written Appeals that meets the following requirements:

(A) Is a comma-delimited text file, with data elements specified by the STATE and per STATE specifications, including identifying oral and written appeals separately in order to track both types of filed appeals;

(B) Is submitted through the ORWA, via MN-ITS; and

(C) Is due on or before the 30th day of the month following the end of the quarter, for all oral and written Appeals issued in the previous quarter. If the 30th day of the month falls on a weekend or holiday, the report is due to the STATE on the following business day.

8.9 Submission of Part D Grievances and Appeals. The MSHO MCO will send to the STATE a copy of its Part D Grievance and Appeals summary report for MSHO Dual Eligible persons within thirty (30) days of its availability.

8.10 State Fair Hearings.

8.10.1 Matters Heard by State Fair Hearing Human Services Judge. Pursuant to Minnesota Statutes, § 256.045, the State Fair Hearing Human Services Judge may review any Action by the MCO, as Action is defined in 42 CFR § 438.400(b) and section 2.3. Consistent with 42 CFR 438.405 (f)(2), the parties to the State Fair hearing include the MCO, the Enrollee, his or her representative, or the legal representative of a deceased Enrollee's estate.

8.10.2 Standard Hearing Decisions.

(A) The Enrollee, or the Provider acting on behalf of the Enrollee with the Enrollee's written consent, may file a request for a State Fair Hearing within thirty (30) days of the Notice of Action or Appeal decision, and within ninety (90) days, if there is good cause for the delay pursuant to Minnesota Statutes, § 256.045.

(B) The STATE must take final administrative action on any request for a State Fair Hearing within ninety (90) days of the following, whichever is earlier:

(1) The date the Enrollee filed an Appeal of the same issue with the MCO, excluding the days it subsequently took for the Enrollee to file 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: 1) an Appeal of the same issue filed at the MCO; 2) the date the Appeal was filed; and 3) 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: 1) whether an Appeal was filed with an MCO; 2) the date the Appeal was filed; 3) the resolution of the Appeal; and d) the date it was resolved; and

(3) The MCO shall notify the STATE and the State Fair Hearing Office of changes to the name or phone number of the contact within one working day of any change.

8.10.3 Costs of State Fair Hearing. The MCO shall provide reimbursement to the Enrollee for transportation, child care, photocopying, medical assessment outside the MCO's network, witness fee, and other necessary and reasonable costs incurred by the Enrollee or former Enrollee in connection with a request for State Fair Hearing. Necessary and reasonable costs shall not include the Enrollee's legal fees and costs, or other consulting fees and costs incurred by or on behalf of the Enrollee.

8.10.4 Expedited Hearing Decisions.

(A) The STATE must take final action within three (3) working days of receipt of the file from the MCO on a request for an expedited State Fair Hearing, or a request from the Enrollee which meets the criteria of 42 CFR § 438.410(a).

(B) The MCO must send the file to the State Fair Hearing Office as expeditiously as the Enrollee's health requires, not to exceed one (1) working day.

8.10.5 Continuation of Benefits Pending Resolution of State Fair Hearing.

(A) If the Enrollee files a written request for a State Fair Hearing with the STATE, and requests continuation of benefits within the time allowed, pursuant to Minnesota Statutes, § 256.045, subd. 3a, before the date of the proposed Action in either the MCO's Notice or Appeal decision, the MCO, in accordance with 42 CFR § 438.420(b), may not reduce or terminate the service until the STATE issues a written decision in the State Fair Hearing, or the Enrollee withdraws the request for a State Fair Hearing.

(B) An Enrollee whose PCA services will be reduced or terminated due to the requirements of Minnesota Statutes § 256B.0659 may request continued services pending appeal or State Fair Hearing within the time period allowed to request an appeal, or State Fair Hearing.

(C) In the case of a reduction or termination of ongoing services, services must be continued, pending outcome of all Appeal hearings if: 1) there is an existing order for services by the treating and Participating Provider; or 2) the treating and Participating Provider orders discontinuation of services and another Participating Provider orders the service, but only if that Provider is authorized by his/her contract with the MCO to order such services.

8.10.6 Compliance with State Fair Hearing Resolutions.

(A) Compliance with Decisions. The MCO must comply with the decision in the State Fair Hearing promptly and as expeditiously as Enrollee's health condition requires.

(B) MCO's Responsibility for Payment of Services. If the MCO's Action is not sustained by the State Fair Hearing decision, the MCO must promptly pay for any services the Enrollee received that are the subject of the State Fair Hearing.

(C) Upheld State Fair Hearing Resolutions. If the MCO's Action is sustained by the State Fair Hearing decision, the MCO may institute procedures to recover the cost of medical services furnished solely by reason of section 8.10.5(C).

8.10.7 Representation and Defense of MCO Determinations. The MCO agrees that it is the responsibility of the MCO to represent and defend all MCO determinations at the State Fair Hearing including compliance with the access to files and appeal summary requirements of Minnesota Statutes, §256.0451, subds. 2 and 3, and at any subsequent judicial reviews involving that determination. The MCO must receive the advice and consent of the STATE before appealing any subsequent judicial decisions adverse to the Commissioner's Order. The MCO agrees that the STATE shall provide necessary information, but that the STATE shall not assume any costs associated with such representation. The STATE shall notify the MCO in a timely manner of any State Fair Hearings that involve the MCO.

8.10.8 External Review Participation. In the course of a State Fair Hearing an Enrollee may request an expert medical opinion be arranged by the external review entity pursuant to Minnesota Statutes, § 62Q.73, subd. 2. The MCO must participate in the external review process in accordance with this section and must comply with the process as specified in Minnesota Statutes, § 62Q.73, subd. 6, (a).

8.10.9 Judicial Review. If the Enrollee disagrees with the determination of the STATE resulting from the State Fair Hearing, the Enrollee may seek judicial review in the district court of the county of service.

8.10.10 Second Opinions

(A) State Fair Hearings. At the request of the State human services judge, the MCO shall provide for a second medical opinion from the MCO and shall comply with any order of the STATE pursuant to Minnesota Statutes, § 256B.69, subd. 11, and Minnesota Rules, Part 9500.1462 C.

(B) Mental Health. The MCO shall provide for a second medical opinion for mental health conditions pursuant to Minnesota Statutes, § 62D.103.

(C) Chemical Dependency. The MCO shall provide for a second opinion for CD services as provided for in Minnesota Statutes, § 62D.103 and Minnesota Rules, Part 9530.6655. To the extent these laws are in conflict, the MCO shall apply Minnesota Rules, Part 9530.6655 to Enrollees under this Contract. The MCO shall inform the Enrollee in writing of the Enrollee's right to make a written request for a second assessment at the time the Enrollee is assessed for a program placement.

8.11 Sanctions for Enrollee Misconduct. The MCO shall place an Enrollee in the Restricted Recipient Program for the conduct described in Minnesota Rules, Part 9505.2165.

8.11.1 Notice to Affected Enrollees. The MCO must notify Enrollees in writing if the Enrollee is to be placed in the RRP. The notice must be sent at least thirty (30) days prior to placement. The notice to the Enrollee must state:

(A) Placement in the RRP 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;

(D) The right to request an Appeal with the MCO and request a State Fair Hearing, and the right to request a State Fair Hearing without first exhausting the MCO's Grievance and Appeal procedures; and

(E) A reference to the Enrollee's rights listed in the "Member Rights for Placement in the RRP" document.

8.11.2 Enrollee's Right to Appeal. An Enrollee may Appeal or request a State Fair Hearing to dispute placement in the RRP. If the Enrollee Appeals or requests a State Fair Hearing prior to the date of the proposed placement, the MCO may not impose the placement until the Appeal or State Fair Hearing is resolved in the MCO's favor. If the Enrollee does not Appeal within thirty (30) days of the date of notice, placement will occur and the designated Providers will be assigned.

8.11.3 Reporting of Restrictions.

(A) Until the MCO has access to enter data directly into MMIS, the MCO must report to the STATE, the names and PMI numbers of all Enrollees placed in the RRP, 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 during business hours on or before the day the restriction is effective.

(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 RRP, 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 during business hours on or before the day the restriction is effective.

8.11.4 Program Administration.

(A) The MCO will administer the RRP consistent with RRP criteria and process developed jointly with the MCOs and Minnesota Rules, parts 9505.2160 through 9505.2245. The RRP criteria and process are posted on the STATE's public website.

(B) The MCO must comply with the Prescription Monitoring Program (PMP) access criteria found in Minnesota Statutes, § 152.126 subd. 6, (b)(8). The MCO may have no more than two designated staff accessing the PMP. Approval for access will be through the STATE. MCOs will have in place security measures that will guard against unauthorized access to the PMP and meet the criteria for PMP access posted on the STATE's public website. The MCO shall query only Enrollees who are members of

the MCO. Queries will only be made to identify Enrollees whose use of health services may warrant placement or continuation in the RRP.

(C) When an Enrollee has changed enrollment to a new MCO within the last 12 months, and he or she is a current recipient in the RRP or is being considered for placement in the RRP, the new MCO may request data from the previous MCO such as claims and other case details, or in the case of a previous FFS coverage, the MCO may request data from the STATE. Such requests support reenrollment in the RRP or an initial placement in the RRP.

(D) The previous MCO, or in the case of FFS coverage the STATE, will share data from claims and other related case history details with the new MCO upon request. Any data or information shared will meet the minimum necessary requirement and pertain to services necessary to review for restriction purposes only, excluding services for chemical dependency. No more than one year of data from claims may be shared.

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Article. 9 Required Provisions.

9.1 Compliance with Federal, State and Local Law. The MCO and its subcontractors shall comply with all applicable federal and state statutes and regulations, as well as local ordinances and rules now in effect and hereinafter adopted, including but not limited to Minnesota Statutes, §§ 62J.695 through 62J.76 (Minnesota Patient Protection Act), Minnesota Statutes, § 62Q.47 (Alcoholism, Mental Health, And Chemical Dependency Services), Minnesota Statutes, § 62Q.53 (Mental Health Coverage; Medically Necessary Care), Minnesota Statutes, §§ 62Q.56 and 62Q.58 (Continuity of Care and Care Coordination; Access To Specialty Care) and Minnesota Statutes, § 62Q.19 (Essential Community Providers) and Minnesota Statutes § 256.969, subds. 3b and 4a, with 42 CFR 438.6 (f), (Provider-Preventable Conditions).

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

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

9.1.3 Licensing and Certification For Non-County Based Purchasing Entities. MCO warrants that it is qualified to do business in the State and is not prohibited by its articles of incorporation, bylaws or the law of the state under which it is incorporated from performing the services under this Contract. MCO further warrants that MCO has obtained any and all necessary permits, licenses, or certificates to conduct business in the State. The MCO shall be properly licensed or certified for the performance of any services pursuant to this Contract. Loss of the appropriate certificate of authority for health maintenance organization (HMO) or community integrated service network (CISN), under Minnesota Statutes, Chapters 62D and 62N respectively, shall be cause for termination of this Contract pursuant to section 5.2.3. In the event any permit, license, or certificate is canceled, revoked, suspended or expires during the term of this Contract, the MCO agrees to so inform the STATE immediately.

9.1.4 HMO and CISN Requirements For County Based Purchasing Entities. The MCO shall comply with state statutes and regulations applicable to HMOs or community integrated service networks (CISNs), including: Minnesota Statutes, § 62A.0411 (48-hour hospital stay for Maternity Care); Minnesota Statutes, §§ 62J.695 through 62J.76 (Patient Protection Act); and Minnesota Statutes, § 62D.03, 4(a) through (d), (h) through (i), (k), (m) through (n), (p), (r) through (s) and (u); 62D.041, subd. 3 and 9; 62D.06 through .08; 62D.11; 62D.123; 62M.04 through 12; 62N.28; 62N. 29; 62N.31 and 72A.201; and Minnesota Rules 4685.0300, subparts 2(A) and (B); 4685.1010; 4685.1115; 4685.1120; 4685.1900; and 4685.3300, subpart 9 (HMO and CISN requirements to the extent the Commissioner of Health has interpreted them to apply to county-based purchasers).

9.2 MCO Solvency Standards Assurance; Risk-Bearing Entity.

(A) If the MCO is a not a Federally Qualified HMO, the MCO must provide written assurance to the STATE by April 30th of the Contract Year, and any time thereafter, if there is significant change in the MCO or the Contract, that its provision against the risk of insolvency is adequate to ensure that its Enrollees will not be liable for the MCO's debts if it becomes insolvent.

(B) All MCOs must meet the solvency standards established by the State for Health Maintenance Organization (HMO) or be licensed or certified by the State as a risk-bearing entity.

9.3 Subcontractors.

9.3.1 Written Agreement; Disclosures. All subcontracts must be in writing and must include a specific description of payment arrangements. All subcontracts are subject to STATE and CMS review and approval, upon request by the STATE and/or CMS. Payment arrangements must be available for review by the STATE and/or CMS. All contracts must include:

(A) Disclosure of Ownership and Management Information (Subcontractors). In order to assure compliance with 42 CFR § 455.104, the MCO, before entering into or renewing a contract with a subcontractor, must request the following information:

(1) The name, address, date of birth, social security number (in the case of an individual), and tax identification number (in the case of a corporation) of each Person, with an Ownership or Control Interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more. The address for corporate entities must include primary business address, every business location and P.O. Box address;

(2) A statement as to whether any Person (individual or corporation) with an Ownership or Control Interest in the disclosing entity as identified in 9.3.1(A)(1) is related (if an individual) to any other Person with an Ownership or Control Interest as spouse, parent, child, or sibling;

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

(4) The name, address, date of birth, and social security number of any managing employee of the MCO.

(5) For purposes of section 9.3, subcontractor means an individual, agency, or organization to which a disclosing entity has contracted, or is a person with an employment, consulting or other arrangement with the MCO for the provision of items and services that are significant and material to the MCO's obligations under its Contract with the STATE.

(B) MCO Disclosure Assurance. The MCO must submit to the STATE, by September 1st of the Contract Year a letter of assurance stating that the disclosure of ownership information has been requested of all subcontractors, and reviewed by the MCO prior to MCO and subcontractor contract renewal.

(C) Upon request, subcontractors must report to the MCO information related to business transactions in accordance with 42 CFR §455.105(b). Subcontractors must be able to submit this information to the MCO within fifteen (15) days of the date of a written request from the STATE or CMS. The MCO must report the information to the STATE within ten (10) days of the MCO's receipt from the subcontractor.

9.3.2 Providers Without Numbers. The MCO shall submit to the STATE, in a format provided by the STATE, a form for each Provider who does not already have an NPI or STATE Provider number (UMPI), pursuant to section 3.7.1(K).

9.3.3 Proof of Subcontractor Status. The MCO must submit, upon STATE request, proof of subcontractor status.

9.3.4 Provision of MSHO Information. The MCO shall inform and educate its Primary Care Providers and/or its Care Systems about the integrated Medicare and Medicaid benefits available under MSHO and shall communicate the MCO's efforts upon request by the STATE.

9.3.5 Subcontractors Audit. The MCO shall require that all subcontractors shall provide CMS, the Comptroller General or 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.

9.3.6 Compliance with Federal Law. All contracts and subcontracts shall comply with 42 CFR § § 422.503 and 504 for MSHO, for Medicare, and for all MCOs, 42 CFR § 434.6 for Medical Assistance services, and 42 CFR § 438.6(l).

9.3.7 Health Care Services. Notwithstanding section 9.3.8, the MCO may contract with Providers of health care services to provide services to Enrollees of the MCO. Subcontracts with other Providers of health care services shall not abrogate or alter the MCO's primary responsibility for performance under this Contract.

9.3.8 Subcontractual Delegation. The MCO shall oversee 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 the Contract Year submit to the STATE an annual schedule identifying subcontractors, delegated functions and responsibilities, and when their performance will be reviewed.

(F) Take corrective action with the subcontractor if deficiencies or areas for improvement are identified, and notify the STATE in writing the reasons for and the actions taken for correction.

(G) The MCO must provide to the STATE upon request a copy of the annual subcontractor performance report. The STATE agrees to return any copies of any submitted subcontractor performance report at the close of its review. The STATE may at its discretion choose to review this on site.

9.3.9 Annual Reviews of Care System Subcontractors, County Care Coordination and Case Management Systems. The MCO shall conduct a review of each MSHO Care System, MSHO County Care Coordination Systems, and MSC+ Case Management System the MCO owns or with which the MCO has a subcontract for Enrollees covered under this Contract. Written audit reports of each Care System, County Care Coordination and County Case Management System must be submitted to the STATE by September 15th of each Contract Year in accordance with section 7.1.4(D).

(A) Annual reviews and written reports must include a description of the organizational, service delivery, and case management structures, and the risk sharing arrangement between the MCO and each Care System, County Care Coordination System or Case Management System. In addition, annual reviews must include the process used by the MCO to conduct the review, any deficiencies and/or concerns raised during the review, and any corrective actions taken by either the MCO or by the Care System, County Care Coordination System or Case Management System to address deficiencies and/or concerns raised during the review. Annual reviews and written reports must include but are not limited to Care Plan audits as specified under section 7.8.3. The review must address the Care System's County Care Coordination System or Case Management System's compliance with subcontract requirements such as those described in the STATE's "*Protocol for Annual Reviews of Care System Subcontractors*" attached as Appendix III.

(B) The MCO/SNP will work with the STATE and other MCO/SNPs on methods for coordinating County Care Coordination System and MSC+ Case Management System reviews among MCO/SNPs and across counties including development of joint review protocols and summary reporting formats. Such protocols must consider applicable components described in the STATE's "*Protocol for Annual Reviews of Care System Subcontractors*" attached as Appendix III and the Waiver Quality Assurance Plan

Survey referenced in section 7.8.4. MCO/SNPs may use a joint contractor to conduct such reviews, while meeting applicable HIPAA requirements.

(C) The MCO will work with the State and other MCOs to develop a standard audit tool for oversight of Elderly Waiver network functions delegated to counties. The workgroup will consider schedules for Care Coordination and Case Management System reviews that can vary based on performance.

9.3.10 FQHCs and RHCs Contracting Requirements. If the MCO negotiates a Provider agreement or subcontract with a federally qualified health center (FQHC) as defined in § 1905(l)(2)(B) of the Social Security Act, 42 USC § 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 that has been designated under Minnesota Statutes, § 62Q.19 as an essential community provider (ECP). The MCO is not required to pay any settle-up payments in addition to the negotiated payment rate.

9.3.11 Nonprofit Community Health Clinic, Community Mental Health Center, and Community Health Services Agencies Contracting Requirements. The MCO shall contract with nonprofit community health clinics (community health clinics), 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, § 256B.0625, subd. 30, to provide services to Enrollees who choose to receive services from the clinic or agency, if the clinic or agency agrees to payment rates that are competitive with rates paid to other MCO Providers for the same or similar services, pursuant to Minnesota Statutes, § 256B.69, subd. 22. The MCO may reasonably require a nonprofit community 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 will provide the MCO with a list of all nonprofit community health clinics, community mental health centers, and community health services agencies within the Service Area.

9.3.12 Essential Community Providers Contracting Requirements. The MCO shall offer to contract with any designated ECP, as described in a listing provided by the STATE, located within its Service Area, pursuant to Minnesota Statutes, § 62Q.19. The MCO shall offer to contract with all ECPs in their service area for medical services. The MCO may contract, but is not required to do so, for non-medical services the ECP is certified to provide.

9.3.13 Enrollees Held Harmless by Subcontractors.

(A) Except for Medical Assistance cost-sharing pursuant to section 4.4, and Waiver Obligations, the MCO shall ensure that the Enrollee is not held responsible for any fees associated with the Enrollee's medical care received from the MCO subcontractor or an

Out of Plan Provider with whom the MCO has negotiated a rate for providing the Enrollee services covered under this Contract.

(B) The MCO shall ensure, through its Provider contracts, 1) that Providers 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 Service Area or Out of Plan, the MCO shall pay the Out of Service Area or Out of Plan Provider on the condition that the Provider hold the Enrollee harmless for any financial liability.

(D) The MCO shall ensure that Enrollees receiving services at hospitals or ambulatory surgical centers are not held liable for any service provided for an authorized procedure (e.g. anesthesiologist/radiologist).

9.3.14 Exclusions of Individuals and Entities; Confirming Identity.

(A) Pursuant to 42 CFR § 455.436, the MCO must confirm the identity and determine the exclusion status of Providers and any Person with an Ownership or Control Interest or who is an agent or managing employee of the MCO or its subcontractors through routine checks of Federal databases, including the Social Security Administration's Death Master File and the National Plan and Provider Enumeration System (NPPES), and also upon contract execution or renewal, and credentialing.

(B) The MCO and its subcontractors must search monthly, and upon contract execution or renewal, and credentialing, the OIG List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS) within the HHS System for Awards Management) database (and may search the Medicare Exclusion Database), for any Providers, agents, Persons with an Ownership or Control Interest and Managing Employees to verify that these persons:

(1) Are not excluded from participation in Medicaid under § § 1128 or 1128A of the Social Security Act, and

(2) Have not been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or programs under title XX of the Social Security Act.

(C) The MCO must require subcontractors to assure to the MCO that no agreements exist with an excluded entity or individual for the provision of items or services related to the MCO's obligation under this contract.

(D) The MCO shall require all subcontractors to report to the MCO within five (5) days any information regarding individuals or entities specified in (A) above, who have been convicted of a criminal offense related to the involvement in any program established

under Medicare, Medicaid, the Title XX services program, or that have been excluded from participation in Medicaid under § § 1128 or 1128A of the Social Security Act.

(E) The MCO shall report this information to the STATE within seven (7) days of the date the MCO receives the information.

(F) The MCO must also promptly notify the STATE of any action taken on a subcontract under this section, consistent with 42 CFR § 1002.3 (b)(3).

(G) In addition to complying with the provisions of section 9.9, the MCO shall not enter into any subcontract that is prohibited, in whole or in part, under § 4707(a) of the Balanced Budget Act of 1997 or under Minnesota Statutes, § 62J.71.

9.3.15 Medical Necessity Definition. The MCO shall include in all subcontracts for the delivery of services under this Contract a requirement that the subcontractor follow the definition of Medical Necessity in section 2.86, and in subcontracts for the delivery of mental health services that the subcontractor additionally follow the Medical Necessity definition in Minnesota Statutes, § 62Q.53. Subcontracts shall include the definition in section 2.86, and the definition in Minnesota Statutes, § 62Q.53 where applicable.

9.3.16 Timely Provider Payment. The MCO agrees to pay health care Providers on a timely basis consistent with the claims payment procedure described in 42 USC § 1396a(a)(37), and 42 CFR Parts 447.45 and 447.46.

9.3.17 Care System Complaint Reporting. The MCO shall require:

(A) Participating Primary Care Providers to report quality of care complaints pursuant to Minnesota Rules, Part 4685.1110, subpart 9 (A), and

(B) Care Systems to report any complaints relating to MSHO Enrollees to the MCO on a quarterly basis.

9.3.18 Patient Safety. The MCO, in all future or renewing Provider contracts, shall encourage its Participating Providers that are hospitals to: 1) report through Leapfrog, a national patient safety initiative; and 2) develop and implement patient safety policies to systematically reduce medical errors. Such policies may include systems for reporting errors, and systems analysis to discover and implement error-reducing technologies.

9.3.19 Vulnerable Persons Reporting. The MCO will communicate to employees and subcontractors who are mandated reporters their duty to report the suspected maltreatment of a vulnerable adult or child as required under Minnesota Statutes, §§ 626.557 or 626.556. MCOs must inform employees and providers that web-based training is available at no cost to all mandated reporters: http://registrations.dhs.state.mn.us/WebManRpt/ for adults and http://www.dhs.state.mn.us/id_000152 for children.

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; or

(D) The Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

9.3.21 Nursing Facility Subcontracting.

(A) The MCO may develop contracts and negotiate rates with Nursing Facilities. The MCO must include in its payment arrangements for Nursing Facility services provisions that require the Nursing Facilities to cooperate with STATE procedures in the collection of Spenddowns.

(B) If the MCO authorizes Nursing Facility care in a NF where the MCO does not have a contracted rate, the MCO shall pay the NF the appropriate Medicaid or, for MSHO, Medicare rate. For MSHO, in non-contracting facilities, the MCO shall be responsible for determining if the NF day meets Medicare or Medicaid requirements based on current Medicare and Medicaid coverage criteria. For Medicaid leave days, fee-for-service pays qualified Nursing Facilities sixty percent (60)% of the applicable case mix payment rate. The MCO shall pay non-contracted facilities whose Nursing Facility occupancy leave rates would otherwise qualify for payment under fee-for-services at this level.

9.3.22 Elderly Waiver Provider Subcontracting. As of January 1, 2014, HCBS services including EW services will have three distinct service tiers as indicated in Appendix VI. .

(A) Tier 1 EW service Providers are listed in Appendix VI. These Providers must enroll with the STATE as MHCP providers in order to deliver reimbursable services.

(1) For Tier 1 services, the MCO shall utilize MHCP enrolled EW Providers, which may include enrolled counties and fiscal entities to provide EW services. The MCO will be notified of the MHCP enrolled Providers through the monthly PECD file. If the MCO identifies a provider who is not MCHP enrolled, they may assist the non-enrolled provider in becoming an MCHP enrolled Provider.

(a) Contracted model: MCO may develop contracts and negotiate rates with Tier I MHCP enrolled providers. The MCO must provide notice in writing to the contracted Provider who will be utilized in the MCO's network and provide written information needed for the provider to deliver and bill for EW services at the State established rate or at a negotiated rate.

(b) Open access model: MCO may use the entire network of MHCP enrolled providers and pay these providers on a non-participating basis. If paying on a non-participating basis, the MCO must pay at least the FFS rates published by the State.

(c) Mixed model: MCO may use a contracted network for some Provider types and open access for other provider types. In such a model, MCO must clearly indicate to Enrollees how to gain access to providers through a provider directory consistent with section 3.6.6(C); for provider types available through open access, MCO must indicate that there are no restrictions other than STATE enrollment.

(B) Tier 2 includes market services and Tier 3 is receipt services/goods as listed in Appendix VI, HCBS Tiers. Both Tier 2 and 3 providers must meet STATE service standards but they may deliver services or goods as enrolled or non-enrolled providers. The MCO may authorize EW service delivery by non-enrolled providers for Tier 2 and 3 services.

(1) However, if the MCO opts to use a non-enrolled Tier 2 or 3 service provider, the MCO must assure that the provider is qualified according to STATE standards to deliver services. The MCO may not impose additional service standards on non-enrolled providers.

(2) The MCO must maintain a record of non-enrolled Tier 2 and Tier 3 providers that they have determined qualified to deliver services. The STATE will provide guidance on Tier 2 and Tier 3 non-enrolled provider review and required documentation.

(3) Counties and tribal human service agencies may deliver any Tier 2 or Tier 3 service. Authorization may be for Tier 2 and Tier 3 services that are provided by the county/tribal agency or provided by a non-enrolled provider in a “pass-through” capacity. The MCO may develop a contract with a willing county or counties to submit claims to the MCO for MCO members using Tier 2 and Tier 3 providers for whom the county has agreed to act as this pass-through entity.

(4) The State expects changes to Tier 2 management of non-enrolled providers. The State will be conducting a competitive bid process to retain a contracted financial management entity to oversee the fiscal operations. The State anticipates assigning the management and oversight of Tier 2 providers to the contracted financial management agent. The STATE will provide information to the MCOs prior to issuance of an RFP for a contracted financial management entity.

(C) Waiver Obligations. The MCO must include in its payment arrangements for Elderly Waiver Providers, mechanisms that require the Provider to cooperate with the MCO’s process for Provider collection of Waiver Obligations.

(D) Group Residential Housing (GRH) and Foster Care. Where counties require that MCOs have a formal agreement with a Provider in order to access group residential

housing funding, or to license adult foster care settings, the MCO must provide evidence of a contract with the waiver provider to the county.

(E) Customized Living Subcontracting.

(1) Rates paid to Customized Living providers by the MCO for Medical Assistance covered services cannot exceed the maximum service limit rates and component rates as published by the STATE.

(2) The MCO must provide for Customized Living Services within the parameters required by the STATE. The payment agreement between the MCO and the Customized Living provider must delineate the component services included in the enrollee's Customized Living plan. The MCO must ensure there is documented need within the parameters established by the STATE for all services authorized. The payment rate must be based on the amount of component services. Component rates must not exceed payment rates for comparable EW or State Plan rates established by the STATE.

(3) Rate-Setting Tool. DHS has issued a Customized Living Planning and Rate-Setting Tool (CL Tool) that the MCO may use to meet these requirements.

(a) If the MCO chooses to use the CL Tool, The MCO will work with the STATE on a process to ensure that CL Tool worksheets are shared electronically between the MCO and the STATE so that the CL Tool and all component rates may be evaluated; or

(b) The MCO may choose to use the CL Tool and to establish its own component rates, but such component rates must not exceed those established by the STATE.

(c) The MCO will cooperate with the STATE in developing and implementing an audit process for CL component service plans and rates.

9.3.23 Relationships with Providers for MSHO. Pursuant to 42 CFR Part 422, subpart E, the MCO shall comply with all applicable Provider requirements for MSHO in that section, including, but not limited to: Provider certification requirements; anti-discrimination requirements; Provider participation and consultation requirements; the prohibition on interference with Provider advice; limits on Provider indemnification; rules governing payments to Providers; Medicare cost sharing; and limits on Physician Incentive Plans.

9.3.24 Automatic Termination of Subcontract Clause. The following provision is required to be included in all contracts and/or subcontracts entered into by the MCO related to its SNP, with the exception of contracts for the purchase of items and equipment, including leases of real property which exceed the term of this contract, unless CMS agrees to its omission.

(A) Failure of the MCO to include the clause in such a contract and/or subcontract without the written agreement of CMS to its omission, shall make the related costs incurred after the effective date of the non-renewal or termination, unallowable. The clause is as follows:

(B) "In the event the Medicare contract between CMS and the MCO is terminated or non-renewed, the contract between the STATE and _____ (name of MCO) shall be terminated unless CMS and the STATE agree to the contrary. Such termination shall be carried out in accordance with the termination requirement stated in 42 CFR § § 422.506 and 422.512."

9.3.25 Business Continuity Plans. The MCO shall ensure that its subcontractors that provide Priority Services have in place a written Business Continuity Plan (BCP) that complies with the requirements of Article. 18.

9.4 Maintenance, Inspection and Retention of Records.

9.4.1 Quality, Appropriateness and Timeliness of Services. The MCO shall provide that the STATE and CMS or their agents may evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed under this Contract.

9.4.2 Facilities Evaluation. The MCO shall provide that the STATE and CMS may evaluate, through inspection or other means, the facilities of the MCO when there is reasonable evidence of some need for that inspection.

9.4.3 Enrollment and Disenrollment Records Evaluation. The MCO must provide that the STATE and CMS may evaluate, through inspection or other means, the enrollment and disenrollment records of the MCO when there is reasonable evidence of need for such inspection.

9.4.4 Records Inspection. The MCO shall provide that the STATE, CMS or the Comptroller General, or their designees, may audit or inspect any books, documents, financial records, papers and records of the MCO and its subcontractors or transferees that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the Contract.

9.4.5 Timelines for Records Inspection. The MCO must provide that the STATE and CMS's right to inspect, evaluate and audit shall extend through ten (10) years from the date of the final settlement for any Contract Year unless: 1) the STATE or CMS determines there is a special need to retain a particular record or records for a longer period of time and the STATE or CMS notify the MCO at least thirty (30) days prior to the normal record disposition date; 2) there has been a termination, dispute, Fraud, or similar default by the MCO, in which case the record retention may be extended to ten (10) years from the date of any resulting final settlement; or 3) the STATE or CMS determined that there is a reasonable possibility of Fraud and the record may be reopened at any time.

9.4.6 Record Maintenance. The MCO agrees to maintain such records and prepare such reports and statistical data as may be deemed reasonably necessary by the STATE and CMS. It is further agreed that all records must be made available to authorized representatives of the STATE and CMS during normal business hours and at such times, places, and in such manner as authorized representatives may reasonably request for the purposes of audit, inspection, examination, and for research as specifically authorized by the STATE to the MCO in fulfillment of state or federal requirements. It is understood and agreed that the MCO shall be afforded

reasonable notice of a request by an authorized representative of the STATE or CMS to examine records maintained by the MCO or its agents, unless otherwise provided by law.

9.4.7 Record Retention by MCO. The MCO agrees to maintain and make available to the STATE and CMS all records related to Enrollees enrolled pursuant to this Contract for a period of ten (10) years after the termination date of this Contract. Records to be retained include, but are not limited to, medical, claims, Care Management, and Service Authorization records.

9.5 Settlement Upon Termination. Upon termination of the Contract, or at such time as an Enrollee terminates 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.

9.6 Trade Secret Information. The STATE agrees to protect from dissemination information submitted by the MCO to the STATE that the MCO can justify as trade secret information, pursuant to Minnesota Statutes, § 13.37, subd. 1(b). Protected information may be Marketing plans and Materials, rates paid to Providers, Medicare bid information or any other information. The MCO must identify information as trade secret prior to or at the time of its submission for the STATE to consider classifying it as non-public. If information identified by the MCO as trade secret is subject to a data practices request or otherwise subject to publication, and if the STATE determines that the MCO's trade secret identification is colorable, the STATE shall provide the MCO an opportunity to justify in writing that the information meets the requirements of Minnesota Statutes, § 13.37. Trade secret information may be shared with CMS. The STATE must notify CMS that such information is considered trade secret. Pursuant to Minnesota Rules, Part 9500.1459, rates paid to the MCO, the STATE's rate methodology, and this Contract are not trade secrets.

9.7 Requests for Time-Sensitive Data. The STATE may collect data or contract with external vendors for studies, including but not limited to, data validation, service validation, and quality improvement.

9.7.1 Notice for Time-Sensitive Data. The STATE will give the MCO at least forty-five (45) days' notice. The notice will include the time-sensitive nature of the data, and data specifications for the required data.

9.7.2 Data Specification Issues. The MCO must notify the STATE within one week of any issues concerning the data specifications.

(A) If the MCO is not able to submit all required data by the deadline, the MCO may request a delay. The STATE shall not grant a delay if such delay would result in the STATE's inability to evaluate the MCO's performance or data in the contracted study.

(B) The MCO must submit accurate and complete data within the time periods that meet the data specifications.

9.8 Ownership of Copyright. If any copyrightable material is developed in the course of or under this contract, the STATE and the U.S. Department of Health and Human Services shall have a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use, the work for government purposes.

9.9 Fraud and Abuse Requirements.

9.9.1 Integrity Program.

(A) Administrative and Management Procedures. The MCO shall have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against Fraud, Abuse and improper payments. The arrangements or procedures shall include the following:

(1) Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable federal and State standards;

(2) The designation of a compliance officer and a compliance committee that are accountable to senior management of the MCO;

(3) Effective training and education for the compliance officer and the MCO's employees;

(4) Effective lines of communication between the compliance officer and the MCO's employees;

(5) Enforcement of standards through well-publicized disciplinary guidelines;

(6) Provision for internal monitoring and auditing, including monitoring and auditing of subcontracted services to detect Fraud, Abuse and Improper Payments;

(7) Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to this Contract;

(8) Provision for profiling Provider services and Enrollee utilization that identifies aberrant behavior and/or outliers;

(9) Policies and procedures that safeguard against unnecessary or inappropriate use of services and against excess payments for services;

(10) Policies and procedures that safeguard against failure by subcontractors or Participating Providers to render Medically Necessary items or services that are required to be provided to an Enrollee covered under this Contract;

(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; and

(12) A method to verify whether services under this Contract, paid for by the MCO, were actually furnished to the Enrollees as required in 42 CFR § 455.1(a)(2). The MCO shall utilize direct methods for verifying the provision of any covered services to Enrollees. MCOs are not precluded from using a variety of direct methods to verify services, especially with provider types that have been identified by the STATE or the MCO as high risk for program integrity issues such as transportation, PCAs, medical supply, and interpreters. The MCO's direct methods and results shall be described in the Annual Integrity Program Report under section 9.9.1(D).

(a) Direct methods include:

i) Confirming clinic visits or linking authorization and payment of transportation and interpreter services to clinic visits;

ii) Expansion of HEDIS and PIP chart review contracts to require notification to the MCO of any discrepancy in charts against paid claims;

iii) Individual notices to Enrollees within forty-five (45) days of the payment of claims, in the form of an Explanation of Benefits (EOB) consistent with Minnesota Statutes, § 62J.51. EOB notices must not include any confidential services and must not be sent to the Enrollee if the only service furnished was confidential. Notices should be provided to a sample group of at least ten percent (10%) of Enrollees who received services from the provider type being verified. Notices must include a statement that the notice is not a bill. Notices must include the MCO's phone number that Enrollees can call to ask questions or obtain information about the services identified on the notice;

iv) Care manager or care coordinator follow up with Enrollees to confirm services and notification to MCO when services were not delivered,

v) Clinic authorization of a patient incentive that confirms a completed office visit;

vi) Specific service confirmation questionnaires; or

vii) Post-payment review of provider documentation of services for a sample of claims.

(b) Indirect methods such as DTRs, hotlines, billing monitoring, or customer satisfaction surveys are important program integrity practices and methods but they are not sufficient to verify services.

(B) Documentation. The MCO shall document all activities and corrective actions taken under its integrity program.

(C) Compliance Officer. The MCO shall identify to the STATE the compliance officer who is responsible for implementation of the integrity program.

(D) Annual Integrity Program Report. The MCO shall report to the STATE in writing, by August 31st of the Contract Year, detailing the MCO's integrity program, including investigative activity, corrective actions, Fraud and Abuse prevention efforts, and results according to guidelines provided by the STATE. The report must detail implementation of the requirements of section 9.9.1(A), and must specifically describe the activities it has undertaken to safeguard against Fraud and Abuse. The report must describe the activities of the previous state fiscal year. The report shall provide the following summary information about reports of provider fraud and abuse investigated by the MCO:

(1) Identify the direct methods and results for verification of services required in section 9.9.1(A)(12)(a) above,

(2) Number of reports, by Provider type;

(3) Number of opened cases, number of cases resolved, and number remaining open;

(4) Number and types of penalties or sanctions imposed;

(5) Dollar amounts recovered which had been paid on behalf of Enrollees; and

(6) Number of referrals to the Medicaid Fraud Control Unit (MFCU).

(E) Violation Report Process. The MCO shall establish and adhere to a process for reporting to the STATE, MFCU, CMS, the Office of Inspector General for the U.S. Department of Health and Human Services and the appropriate law enforcement agency credible information of violations of law by the STATE, the MCO, Participating Providers, subcontractors, or Enrollees, for a determination as to whether criminal, civil, or administrative action may be appropriate. If the MCO has reason to believe that an Enrollee has defrauded the Medicaid program, the MCO shall refer the case to an appropriate law enforcement agency as mandated in 42 CFR § 455.15(b).

(F) Quarterly Reporting of Adverse Actions. The MCO shall report quarterly to the STATE the name, specialty, address and reason for Adverse Action (in a form approved by the STATE) of Providers whose participation have been denied at enrollment, credentialing or recredentialing, and providers whose active participation status the MCO has taken action to terminate or not renew during the previous quarter. The STATE shall forward the report to the Office of the Inspector General at the federal Department of Health and Human Services consistent with 42 CFR 1002.3(b).

9.9.2 Fraud and Abuse by MCO, its Subcontractors, and/or Participating Providers.

(A) The MCO's officers understand that this Contract involves the receipt by the MCO of state and federal funds, and that they are, therefore, subject to criminal prosecution and/or civil or administrative actions for any intentional false statements or other fraudulent conduct related to their obligations under this Contract.

(B) The MCO and its subcontractors shall, upon the request of the MFCU, 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 in writing to the STATE and the MFCU any Fraud that the MCO knows or has reason to believe has been committed by a provider within twenty-four (24) hours after the MCO learns of or has reason to believe such Fraud has been committed. The MCO shall cooperate fully in any investigation of the Fraud by the STATE and MFCU and in any subsequent legal action that may result from those investigations. This may include investigation of claims paid by the MCO.

(1) The MCO shall maintain a detailed log (in a form approved by the STATE) of all reports of provider fraud and abuse investigated by the MCO or its subcontractors which shall be submitted to the STATE by fifth day of the following month for investigations opened or closed in that month.

(2) The MCO shall report in writing to the STATE any abusive billing by Providers that warrant investigation within thirty (30) days of identification of the problem. The MCO may use the log in 9.9.2(C)(1) for such a report.

(D) Except when the MCO has good cause, as described in 9.9.2(F) below, the MCO must suspend all Medicaid payments to a Provider after the following:

(1) the STATE has notified the MCO that it has suspended all Medicaid payments to the provider based on a determination there is credible allegation of Fraud against the provider for which an investigation of payments made under the Medicaid program is pending; or

(2) the MCO determines there is a credible allegation of Fraud against the provider for which an investigation is pending under the Medicaid program,

(E) The suspension of payments under this section will be temporary and will not continue after either of the following:

(1) the STATE or the MCO or the prosecuting authorities determine there is insufficient evidence of Fraud by the provider and the STATE or MCO has notified the other party of the lack of evidence; or

(2) legal proceedings related to the provider's alleged fraud are completed.

(F) An MCO may find good cause exists not to suspend payments, not to continue a payment suspension previously imposed, or to suspend payment only in part if any of the provisions of 42 CFR 455.23 (e) or (f) are applicable. For purposes of implementing a good cause exception under the provisions of 42 CFR 455.23(e) and (f), "MCO" determinations shall be substituted for "STATE" determinations. The

MCO will notify the STATE in writing of the basis for any good cause determination to not suspend payments, not to continue a payment suspension, or to suspend only in part. Whenever an MCO investigation leads to the initiation of a payment suspension by the MCO, the MCO shall notify the STATE within twenty-four (24) hours after of the imposition of the suspension. The MCO must make a written fraud referral to the MFCU not later than the next business day after the suspension is imposed.

(G) For purposes of a payment withholding under this section, "credible allegation of fraud" means an allegation, which has been verified by the STATE or the MCO from any source, and which has indicia of reliability. In determining whether there is a credible allegation of fraud, the MCO must review all allegations, facts, and evidence carefully and act judiciously on a case-by-case basis.

9.9.3 Fraud and Abuse by Recipients. The MCO shall report in writing via email to the STATE any suspected Fraud and/or patterns of Abuse by Recipients, in accordance with section 9.9.1(E).

9.9.4 Fraud and Abuse by PCA Providers.

(A) The STATE has determined that enrollment of individual PCA Providers in the FFS system will allow the STATE to safeguard against unnecessary or inappropriate use of PCA services and against excess payments. The MCO shall ensure that PCA Providers have a background study completed, pursuant to Minnesota Statutes, § 256B.0659, subd 11, prior to providing any PCA services.

(B) The MCO may work with the STATE to utilize the STATE's licensing system for these purposes, but any other process utilized by the MCO must review using the same standards as the STATE's licensing system.

(C) The MCO shall require that PCPAs submit claims to the MCO using one date of service per claim line, per PCA.

9.9.5 False Claims.

(A) If the MCO receives or makes Medicaid payments totaling five million dollars ($5,000,000) or more within a Federal fiscal year (October 1st to September 30th), the MCO must establish, implement, and disseminate written policies and procedures to all employees including management, contractors and agents that includes detailed information pertaining to the False Claims Act (federal and state) and other provisions named in § 1902(a)(68)(A) of the Social Security Act. These policies must include detailed provisions regarding the MCO's procedures for detecting and preventing fraud, waste, and abuse. The MCO shall certify to the STATE by February 1st of the Contract Year that it has complied with this requirement for the previous Contract Year, using as its certification the DHS Deficit Reduction Act (DRA) Assurance Statement posted on the STATE's Managed Care website.

(B) In addition, the MCO must include in its written policies and procedures (and in employee handbooks if any), specific discussions of the following:

(1) The False Claims Act, 31 USC §§ 3729 through 3733;

(2) Administrative remedies for false claims and false statements established under 31 USC §§ 3801, et seq.;

(3) The Minnesota False Claims Act, Minnesota Statutes, § 15C.02, and any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) The rights of employees to be protected as whistle-blowers, including the employer restrictions listed in Minnesota Statutes, § 15C.14; and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

9.10 Data Certifications. As a condition for receiving payment the MCO shall certify its data and documents that are utilized by the STATE in determining payments made to the MCO.

9.10.1 Data and Reporting Submitted to STATE. The MCO shall provide to the STATE a certification that accompanies its submission of the data indicated below. The MCO may submit a separate written Data Certification, due by the 5th day of the following month for any submissions in the previous month, which identifies each and every data submission, the date it was submitted, and certifies all data submitted. The following data must be certified:

(A) Encounter data;

(B) Data and reports associated with the reporting requirements of the managed care withhold;

(C) Data submissions as requested by the STATE for the development of rates;

(D) Health care expenditures.

(E) Financial statements under section 3.7.2(F)

(F) Dental payment report for Critical Access Dental Designated Providers, as specified in section 7.14.5;

(G) Third Party Liability reports under sections 3.7.2(O) and 10.4;

(H) Primary care and vaccine administration enhanced payment reports under section 4.2.12, and

(I) Any other data or document determined by the STATE to be necessary to comply with 42 CFR § 438.604.

9.10.2 Requirements. Each data or report 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; and

(C) Be certified by either the MCO's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual with authority to sign for and who reports to either the MCO's CEO or CFO.

(D) Certification must be submitted concurrently with the data, or pursuant to section 9.10.1.

9.10.3 Financial Filing with MDH. The MCO shall either certify to the STATE that its annual statutory financial filing with MDH represents only costs related to services covered under the STATE Plan, and Home and Community Based Services (HCBS) Waiver Services, including the MCO's administrative costs; or the MCO must certify and report the dollar value of each service that is a non-State Plan service (including but not limited to the value of cost-sharing waived by the MCO, for example the family deductible). The MCO must provide this certification no later than May 1st of the Contract Year.

9.11 Exclusions and Convicted Persons.

(A) The MCO shall not pay for any items or services furnished, ordered or prescribed by excluded individuals or entities pursuant to 42 CFR § 1001.1001.

(B) The MCO shall not include in their business entity a director, officer, partner or Person with an Ownership or Control Interest who is excluded from participation in Medicaid under §§ 1128 or 1128A of the Social Security Act. This includes entities owned or controlled by a sanctioned person pursuant to 42 CFR § 1001.1001.

(C) The MCO shall not make an employment, consulting or other agreement with an individual or entity for the provision of items or services that are significant and material to the MCO's obligations under its Contract with the STATE where the individual or entity is excluded from participation in Medicaid under §§ 1128 or 1128A of the Social Security Act. Significant and material services include, but are not limited to health care, utilization review, medical social work, or administrative services.

(D) The MCO shall not have any agents, Managing Employee, or Persons with an Ownership or Control Interests who have been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program, in accordance with 42 CFR § 455.106.

(E) The MCO shall report to the STATE, within ten (10) working days of receipt of the following:

(1) Any information regarding excluded or convicted individuals or entities, including those in paragraph (D) above; and

(2) Any occurrence of an excluded, convicted, or unlicensed entity or individual who applies to participate as a Provider.

(F) The MCO shall promptly notify the STATE of any administrative action it takes to limit participation of a Provider in the Medicaid program as mandated by 42 CFR § 1002.3(b)(3).

9.12 Conflicts of Interest. Pursuant to 42 CFR § 438.58, and Minnesota Statutes, § 256B.0914, the MCO shall have in effect conflict of interest rules at least as effective as those in 41 USC § 423.

9.13 Federal Audit Requirements and Debarment Information.

9.13.1 Single Audit Act. MCO will certify that it will comply with the Single Audit Act, OMB Circular A-128 and OMB Circular A-133, as applicable. The MCO shall obtain a financial and compliance audit made in accordance with the Single Audit Act, OMB Circular A-128 or A-133, as applicable. Failure to comply with these requirements could result in forfeiture of federal funds.

9.13.2 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, § 16C.03, subd. 2, provides the Commissioner of Administration with the authority to debar and suspend vendors who seek to contract with the STATE. Vendors may be suspended or debarred when it is determined, through a duly authorized hearing process, that they have abused the public trust in a serious manner.

BY SIGNING THIS CONTRACT, MCO CERTIFIES THAT IT AND ITS PRINCIPALS:

(A) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from transacting business by or with any federal, state or local governmental department or agency; and

(B) Have not within a three-year period preceding this Contract: 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

(C) Are not presently indicted or otherwise criminally or civilly charged by a governmental entity for: 2) 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

(D) Are not aware of any information and possess no knowledge that any subcontractor(s) that will perform work pursuant to this Contract are in violation of any of the certifications set forth above.

(E) Shall immediately give written notice to the STATE should MCO come under investigation for allegations of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing: a public (federal, state or local government) transaction; violating any federal or state antitrust statutes; or committing embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property.

9.14 Compliance with Public Health Services Act for MSHO. The MCO shall comply with:

(A) § 1318(a) and (c) of the Public Health Services Act, 42 USC § 300e-17(a)(2), that pertain to disclosure of certain financial information;

(B) § 1301(c)(1) and (c)(8) of the Public Health Services Act, that relate to fiscal, administrative and management requirements and liability arrangements to protect all members of the organization; and to notify the STATE and CMS sixty (60) days prior to any changes in its insolvency arrangements; and

(C) The reporting requirements in 42 CFR § 422.516(a) that pertain to the monitoring of an organization's continued compliance.

9.15 Receipt of Federal Funds. The MCO will receive federal payments and is therefore subject to laws which are applicable to individuals and entities receiving federal funds. The MCO shall inform all related entities, contractors and/or subcontractors that payments they receive are, in whole or in part, from federal funds.

9.16 Formal Presentations. The MCO shall provide to the STATE copies of any formal presentation by the MCO or its Administrative Services Organization, including reports, statistical or analytical materials, papers, articles, professional publications, speeches, or testimony (except testimony before the Minnesota Legislature), that is based on information obtained through the administration of this MSHO and MSC+ Contract.

Article. 10 Third Party Liability and Coordination of Benefits

10.1 Agent of the STATE. Pursuant to 42 CFR 433, subpart D and Minnesota Statutes, §§ 256B.042, subd. 2; 256B.056, subd. 6; 256.015, subd. 1, 256B.37, subd. 1, and 256B.69, subd. 35, the STATE hereby authorizes the MCO as its agent to obtain third party and Medicare reimbursement by any lawful means including asserting subrogation interest, filing liens,

asserting independent claims, and to coordinate benefits, for MCO Enrollees except in instances described in section 10.3.4(B) and section 10.7.

10.2 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, and subject to section 10.7 to ensure that primary payments from the liable third party are utilized to offset medical expenses.

(A) Known Third Parties. The STATE shall include information about known Third Party Liability resources on the electronic enrollment data given to the MCO twice a month. Any new Third Party Liability resources learned of by the STATE through its contractor(s) are added to the next available data file.

(B) Additional Resources. The MCO shall report to the STATE any additional third party resources available to an Enrollee discovered by the MCO on a form provided by the STATE, within ten (10) business days of verification of such information. The MCO shall report any known change to health insurance information in the same manner.

(C) Cost Benefit. The MCO's efforts to determine liability and use Cost Avoidance Procedures or Post Payment Recovery processes shall not require that the MCO spend more on an individual claim basis than could be recovered through those efforts.

(D) Retention of Recoveries. For recoveries listed in 10.3.4(A), the MCO is entitled to retain any amounts recovered through its efforts, provided that:

(1) Total payments received do not exceed the total amount of the MCO's financial liability for those services provided by the MCO to the Enrollee;

(2) State FFS and reinsurance benefits have not duplicated this recovery;

(3) Such recovery is not prohibited by federal or state law, and

(4) The recovery or recoveries took place within six (6) months after the date the claim was Adjudicated.

(5) The MCO is entitled to retain any amounts recovered through its efforts for recoveries listed in10.3.4(A)(2). There is no time limit for the time within which an MCO must recover these funds.

(E) Return of Payments. The MCO must require its Providers to return any third party payments to the MCO for Third Party Liability described in 10.3.4(A) except if the Provider received a third party payment more than one hundred and eighty (180) days after the date the claim was Adjudicated, then the MCO must require that the Provider return the payment to the MCO and the MCO to the STATE. Mechanisms for return of the payment from the MCO to the STATE, and return of payments from the STATE to the MCO, will be specified by the STATE..

(F) Unsuccessful Effort. If the MCO is unsuccessful in its efforts to obtain necessary cooperation from an Enrollee to identify potential third-party resources after sixty (60) days of such efforts pursuant to Minnesota Statutes, § 256B.056, subd. 8 and 42 CFR §§ 433.145 and 433.147, the MCO must inform the STATE in a format to be determined by the STATE that efforts have been unsuccessful.

10.3 Coordination of Benefits.

10.3.1 Coordination of Benefits. For Enrollees who have private health or long term care coverage, the MCO must coordinate benefits in accordance with Minnesota Rules, Part 9505.0070 and Minnesota Statutes, § 62A.046. Coordination of Benefits includes paying any applicable cost-sharing on behalf of an Enrollee, except for Medical Assistance cost-sharing pursuant to section 4.4.

10.3.2 Medicare Cost-Sharing Part of COB. For Enrollees who are also eligible for Medicare, coordination of benefits includes paying any applicable copayments, coinsurance or deductibles on behalf of an Enrollee.

10.3.3 Cost Avoidance.

(A) General: The MCO shall use a Cost Avoidance procedure for 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 has established the probable existence of Third Party Liability at the time the Provider submits the claim.

(B) Cost-effectiveness. The MCO must determine whether it is more cost-effective to provide the service or pay the cost-sharing to a Non-Participating Provider. If the MCO refers an Enrollee to a third-party insurer for a service that the MCO covers, and the third-party insurer requires payment in advance of all cost-sharing, the MCO shall make such payments in advance or at the time such payments are required.

(C) Exceptions. 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.

10.3.4 Post-Payment Recoveries.

(A) Post-Payment Recoveries to be Pursued by the MCO. The MCO shall recover funds post payment in cases where the MCO was not aware of third-party coverage at the time services were rendered or paid for, or the MCO was not able to use a Cost Avoidance procedure. The MCO shall use information from the STATE and shall identify and pursue all potential Third Party Liability payments. Potentially liable third party coverage sources include, but are not limited to,

(1) Third Party Insurance Coverage:

(a) Medicare

(b) Third party liability insurance (for example, group health plans including medical, dental, pharmacy and vision; self-insured plans; managed care organizations; pharmacy benefit managers; long-term care insurance; union and other fraternal organizations; and certain other state or federal programs);

(2) Tort/Auto/Workers Compensation:

(a) Uninsured/underinsured motorist insurance;

(b) Awards as a result of a tort action;

(c) Workers' compensation;

(d) Medical payments insurance for accidents (otherwise known as "med pay" provisions or benefits of policy); or

(e) Indemnity/accident insurance.

(B) Recoveries Not to be Pursued by the MCO.

(1) The MCO shall not pursue reimbursement under estate recovery or medical support recovery provisions. This applies to recoveries of medical expenses paid for an Enrollee because the following subsequent recovery actions are taken by a Local Agency or the STATE: 1) Medical Assistance lien or estate recovery; 2) special needs or pooled trusts; or 3) annuities.

(2) The MCO shall not pursue recoveries for Third Party insurance coverage described in 10.3.4(A)(1) above after the first one hundred and eighty (180) days after a claim has been adjudicated

(C) The MCO shall develop procedures to identify trauma diagnoses and investigate potential liability

10.4 Reporting of Recoveries.

10.4.1 Report on Encounters. The MCO shall report on the encounter claim all Third Party Liability payments as required in section 3.7.1.

10.4.2 Quarterly Report.

(A) The MCO shall, on a quarterly basis, disclose to the STATE all Cost Avoided and Post Payment Recovered amounts made from private insurance carriers and other responsible third parties, using a format provided by the STATE. in the timeframes described in3.7.2(F)(2).

(B) For MSC+, Medicare cost avoidance and recovery amounts must include FFS (Original) Medicare.

(C) For MSHO, the MCO shall also report an estimate of Medicare payment, however, the MCO may base the estimate on the methodology used for submitting bids to CMS to derive the amount.

10.5 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 an intervention, 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.

10.6 Determination of Compliance. The STATE may determine whether the MCO is in compliance with the requirements in this Article by inspecting source documents for 1) appropriateness of recovery attempt; 2) timeliness of billing; 3) accounting for third party payments; 4) settlement of claims; and 5) other monitoring deemed necessary by the STATE.

10.7 Supplemental Recovery Program The MCO shall comply with Minnesota Statutes, §256B.69, subd. 35 and work with the STATE in its efforts to collect third party liability payments for services rendered to Enrollees covered under this contract. The STATE will establish reports to the MCO on recoveries the STATE makes under section 10.3.4(A)(2); and will work with the MCO to establish mechanisms to ensure no duplication of efforts for coordination of third-party collections, and mechanisms to address concerns or issues with collections.

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Article. 11 Governing Law, Jurisdiction and Venue. This Contract, and amendments and supplements thereto, will be governed by the laws of the State of Minnesota. Venue for all legal proceedings arising out of this Contract, or breach thereof, will be in the state or federal court with competent jurisdiction in Ramsey County, Minnesota.

Article. 12 Compliance with State and Federal Laws. The MCO shall comply with all applicable state and federal laws and regulations in the performance of its obligations under this Contract. Any revisions to applicable provisions of federal or state law and implementing regulations, and policy issuances and instructions, except as otherwise specified in this Contract, apply as of their effective date. If any terms of this Contract are determined to be inconsistent with rule or law, the applicable rule or law provision shall govern.

In the performance of obligations under this Contract, the MCO agrees to comply with provisions of the following laws:

12.1 Constitutions. The Constitutions of the United States and the State of Minnesota.

12.2 Prohibitions Against Discrimination.

(A) Title VI of the Civil Rights Act of 1964 and pertinent regulations at 45 CFR § 80.

(B) Executive Order 11246 (30 FR 12319), Equal Employment Opportunity, dated September 24, 1965; "Equal Employment Opportunity," as amended by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR Part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity Department of Labor," as applicable.

(C) Section 504 of the Rehabilitation Act of 1973 and pertinent regulations at 45 CFR § 84.

(D) Section 508 of the Rehabilitation Act of 1973, as amended (29 USC 794d).

(E) Age Discrimination Act of 1975 and pertinent regulations at 45 CFR Part 91.

(F) Minnesota Statutes, §363A.36.

(G) Title IX of the Education Amendments of 1972.

(H) The MCO shall cooperate with the STATE's Medicare Revenue Enhancement Program to ensure that Skilled Nursing Facility days are covered pursuant to Medicare guidelines. Cooperation includes but is not limited to filing Requests for Redetermination for which DHS must be allowed up to one hundred and twenty (120) days from the date of denial.

(I) The Americans with Disabilities Act. 1990, 42 USC §12101, et seq., and regulations promulgated pursuant to it. The MCO also shall comply with 28 CFR §35.130(d), which requires the administration of services, programs, and activities in

the most integrated setting appropriate to the needs of qualified individuals with disabilities.

(J) Any other laws, regulations, or orders that prohibit discrimination on grounds of race, sex, color, age, religion, creed, health status, physical disability, sexual orientation, national origin, or public assistance status.

12.3 State Laws. Minnesota Statutes, § 256B.69 et seq.; Minnesota Rules, Parts 9500.1450 to 9500.1464; Minnesota Statutes, § 256D.03; Minnesota Statutes, § 256L.01 et. seq.; and Minnesota Rules, Parts 9506.0010 to 9506.0400; and:

12.3.1 Workers' Compensation. In accordance with the provisions of Minnesota Statutes, §176.182, the MCO shall provide acceptable evidence of compliance with the workers' compensation insurance coverage requirement of Minnesota Statutes, § 176.181, subd 2.

12.3.2 Affirmative Action. The MCO certifies that it has received a certificate of compliance from the Commissioner of Human Rights pursuant to Minnesota Statutes, § 363A.36. County administered MCOs are exempt from this statute.

12.3.3 Voter Registration. The MCO certifies that it will comply with Minnesota Statutes, § 201.162.

12.4 Medicaid Laws. Title XIX of the Social Security Act (42 USC § 1396 et. seq.), applicable provisions of 42 CFR § 431.200 et. seq. and 42 CFR Part 438; waivers or variances approved by CMS; the Rehabilitation Act of 1973.

12.5 Environmental Requirements. The MCO shall comply with all applicable standards, order or requirements issued under § 306 of the Clean Air Act (42 USC § 1857(h)), § 508 of the Clean Water Act (33 USC § 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Part 15).

12.5.1 Energy Efficiency Requirements. The MCO shall recognize mandatory standards and policies relating to energy efficiency which are contained in the State energy conservation plan issued in compliance with the Energy Policy and Conservation Act (PL. 94-163, 89 Stat, 871), as applicable.

12.6 Anti-Kickback Provisions. The MCO shall be in compliance with the Copeland "Anti-Kickback" Act, 18 USC § 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.

12.7 Davis-Bacon Act. The MCO shall be in compliance with the Davis-Bacon Act, as amended (40 USC §§ 276a to 276a-7), as supplemented by Department of Labor regulations (29 CFR Part 5), as applicable.

12.8 Contract Work Laws. The MCO shall be in compliance with the Contract Work Hours and Safety Standards Act (40 USC §§ 327-330), as supplemented by Department of Labor regulations (29 CFR Part 5), as applicable.

12.9 Regulations about Inventions. As applicable, the MCO will provide for the rights of the Federal Government and the recipient in any resulting invention in accordance with 37 CFR Part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any further implementing regulations issued by HHS.

12.10 Prohibition on Weapons. MCO agrees to comply with all terms of the Minnesota Department of Human Services' policy prohibiting carrying or possessing weapons wherever and whenever MCO is performing services within the scope of this Contract. Any violations of this policy by MCO or MCO's employees may be grounds for immediate suspension or termination of the contract.

Article. 13 Information Privacy and Security. The MCO will comply with the following requirements regarding Protected Information.

13.1 HIPAA Compliance. The MCO and the STATE shall be in compliance with the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), any rules promulgated thereunder, and the Health Care Administrative Simplification Act of 1994, Minnesota Statutes, § 62J.50 et. seq., including but not limited to, compliance with 45 CFR Parts 160 and 162, Health Insurance Reform: Standards for Electronic Transactions, except as provided in section 3.7.1. The MCO shall be in compliance with these requirements consistent with the applicable effective dates contained in state or federal law.

13.2 Business Associate and Trading Partner. The STATE makes available and/or transfers to the MCO certain information in connection with the provision of services provided by the MCO on behalf of the STATE and in making available and transferring certain information discloses to the MCO certain Protected Health Information (PHI) as defined in 45 CFR § 160.103.

(A) PHI. PHI is considered "private data on individuals" (as defined in Minnesota Statutes, § 13.02, subd. 12) and must be afforded special treatment and protection. PHI is subject to regulatory protection under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), implementing regulations at 45 CFR Parts 160 and 164, the Standards for Security of Protected Health Information and Privacy of Identifiable Health Information (hereinafter Privacy Regulation).

(B) Covered Entity. Both the STATE and 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.

(C) Trading Partner. The MCO exchanges electronically transmitted PHI with the STATE, and is a "Trading Partner" in accordance with the Privacy Regulation. Pursuant to the Privacy Regulation, Trading Partners must comply with the

requirements of the Privacy Regulation as it relates to conducting standard transactions. The purpose of this section is to assure and document that the parties comply with the requirements of the Privacy Regulation, including, but not limited to, the Business Associate contract requirements at 45 CFR Part 164 and the Administrative requirements for transaction standards between Trading Partners specified at 45 CFR Part 162.

(D) Definitions. Unless otherwise provided for in this Contract, capitalized terms in this Article have the same meaning as set forth in the Privacy Regulation.

13.3 Duties Relating to Protection of Information.

13.3.1 Proper Handling of Information. MCO shall be responsible for ensuring proper handling and safeguarding by its workforce members (as defined in the Privacy Regulation), subcontractors, Business Associates, and authorized agents of Protected Information collected, created, used, maintained, or disclosed on behalf of STATE. This responsibility includes ensuring that workforce members and agents comply with and are properly trained regarding, as applicable, the laws listed in section 13.1.

13.3.2 Minimum Necessary Access to Information. MCO shall comply with the "minimum necessary" access and disclosure rule set forth in the HIPAA and the MGDPA. The collection, creation, use, maintenance, and disclosure by MCO shall be limited to "that necessary for the administration and management of programs specifically authorized by the legislature or local governing body or mandated by the federal government." See, respectively, 45 CFR §§ 164.502(b) and 164.514(d), and Minnesota Statutes, § 13.05 subd. 3.

13.3.3 Part of Welfare System. MCO will be considered part of the "welfare system," as defined in Minnesota Statutes, § 13.46, subd. 1, and agrees to be bound by applicable state and federal laws governing the security and privacy of information.

13.3.4 Additional Privacy and Security Safeguards. MCO shall comply with the requirements set forth below regarding "Use of Information."

13.4 Use of Information.

(A) MCO shall:

(1) Not use or further disclose Protected Information created, collected, received, stored, used, maintained or disseminated in the course or performance of this Contract other than as permitted or required by this Contract or as required by law, either during the period of this Contract or hereafter.

(2) Use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the Protected Information by its workforce members, subcontractors and agents other than as provided for by this Contract. This includes, but is not limited to, having implemented administrative, physical, and technical safeguards that reasonably and

appropriately protect the confidentially, integrity, and availability of any Protected Information that it creates, receives, maintains, or transmits on behalf of STATE.

(3) Report to STATE's privacy official any Privacy Incident or Security Incident of which it becomes aware including breaches of unsecured protected health information as required at 45 CFR 164.410. The MCO shall comply with any corrective actions required by the STATE as a result of the Privacy Incident or Security Incident. Such corrective action may include, but is not limited to:

(a) Conducting an internal investigation of the incident;

(b) Providing the STATE a report summarizing the MCO's internal review and investigative findings of the incident;

(c) Providing notice of a breach, consistent with HIPAA regulations, to and Enrollee(s) whose Protected Information was, or is reasonably believed to have been, accessed; and

(4) Providing updates to the STATE regarding any confirmed or suspected incidents, or lack thereof, involving misuse of the unauthorized data.

(5) Consistent with this Agreement, and in accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), ensure that any agents (including contractors and subcontractors), analysts, and others to whom it provides Protected Information, agree in writing to be bound by the same restrictions and conditions that apply to it with respect to such information.

(6) Document such disclosures of PHI and information related to such disclosures as would be required for STATE to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

(7) Mitigate, to the extent practicable, any harmful effects known to it of a use, disclosure, or breach of security with respect to Protected Information by it not permitted or required by this Contract.

(8) Make available PHI in accordance with 45 CFR § 164.524 and Minnesota Statutes, § 13.04, subd. 3, within ten (10) days of the date of the request, excluding Saturdays, Sundays and legal holidays, of receipt of a written request by the STATE.

(9) Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526 within fifteen (15) days of receipt of written request by the STATE.

(10) Make its internal practices, books, records, policies, procedures, and documentation relating to the use, disclosure, and/or security of PHI available to the STATE and/or the Secretary of the United States Department of Health and Human Services (HHS) for purposes of determining compliance with the Privacy Rule and Security Standards, subject to attorney-client and other applicable legal privileges.

(11) Comply with any and all other applicable provisions of the HIPAA Privacy Rule and Security Standards, including future amendments thereto.

(12) Document such disclosures of PHI and information related to such disclosures as would be required for the MCO or the STATE to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

(13) Either: 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 fifteen (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.

(14) In accordance with HIPAA, upon obtaining knowledge of a breach or violation by a subcontractor, take appropriate steps to cure the breach or end the violation, and if such steps are unsuccessful, terminate the agreement.

(15) Not use or disclose PHI in a manner that would violate Subpart E of 45 C.F.R. Part 164 if done by DHS.

(B) The STATE shall:

(1) Only release information that it is authorized by law or regulation to share with MCO.

(2) Obtain any required consents, authorizations or other permissions that may be necessary for it to share information with MCO.

(3) Promptly notify MCO of limitation(s), restrictions, changes, or revocation of permission by an individual to use or disclose Protected Information, to the extent that such limitation(s), restrictions, changes or revocation may affect MCO's use or disclosure of Protected Information.

(4) Not request MCO to use or disclose Protected Information in any manner that would not be permitted under law if done by STATE.

13.5 Disposition of Data Upon Completion, Expiration, or Agreement Termination. Upon completion, expiration, or termination of this Contract, MCO will return or destroy all Protected Information that the MCO still maintains received from the STATE or created or received by the MCO for purposes associated with this Contract. MCO will retain no copies of such Protected Information, provided that if such return or destruction is not feasible, or if MCO is required by the applicable regulation, rule or statutory retention schedule to retain beyond the life of this Contract, MCO will extend the protections of this Contract 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.

13.6 Sanctions. In addition to acknowledging and accepting the terms set forth in this Contract 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.

13.7 MCO's Own Purposes. The STATE makes no warranty or representations that compliance by the MCO will be adequate or satisfactory for the MCO's own purposes. The MCO is solely responsible for all decisions it makes regarding the safeguarding of PHI or other Protected Information.

13.8 Privacy Act Compliance. The MCO shall comply with the requirements of the Privacy Act, as implemented by 45 CFR § 5b and 42 CFR § 401(B), as applicable. The MCO must comply with the confidentiality requirements of 42 CFR § 482.24 for medical records and for all other health and enrollment information on Enrollees that is contained in the MCO's records or obtained from CMS or the STATE. The MCO must use and disclose individually identifiable health information in accordance with the privacy requirements in 45 CFR §§ 160 and 164, subparts A and E, to the extent that the requirements are applicable.

13.9 Procedures and Controls. The MCO agrees to establish and maintain procedures and controls so that no information contained in its records or obtained from the STATE or CMS or from others in carrying out the terms of this Contract shall be used by or disclosed by it, its agents, officers, or workforce members except as provided in Minnesota Statutes Chapter 13 and in §1106 of the Social Security Act and implementing regulations.

13.10 Requests for Enrollee Data. 42 CFR § 431.301 (pursuant to 1902(a)(7) of Title XIX and 42 USC § 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 (for purposes not directly connected with the administration of the State Plan) are appropriate for any population covered under this Contract; the MCO must obtain prior approval from the STATE for such disclosures.

13.10.1 Disclosure of Enrollee Data; Exceptions. The MCO may disclose Enrollee data to other parties for studies or research that receive Institutional Review Board approval, or when using aggregated data for studies or for program evaluations, without prior approval by the STATE. Clinical trials are not included in this exception. Any report or presentation associated with studies, research or evaluations by the MCO or produced under this section must be sent to the STATE prior to release of the report or presentation.

13.10.2 MN-HIE. The STATE authorizes the MCO to enter into data sharing or subscriber agreements with the Community Health Information Collaborative for the purposes of its service HIE-Bridge (formerly Minnesota Health Information Exchange or MN-HIE.)

13.11 Authorized Representatives. The STATE's authorized representative for data privacy and security is the Minnesota Department of Human Service Privacy Official. MCO's

responsible authority for complying with data privacy and security is the MCO's Privacy and/or Security Official(s).

13.12 Indemnification. Notwithstanding section 19.4, the MCO agrees to indemnify and save and hold the STATE, its agents and employees harmless from all claims arising out of, resulting from, or in any manner attributable to any violation by the MCO of any provision of the laws listed in section 2.126 in connection with the performance of the MCO's duties and obligations under this Contract. This includes, but is not limited to, legal fees and disbursements paid or incurred to enforce the provisions of this Contract.

Article. 14 Lobbying Disclosure. The MCO certifies that, to the best of its knowledge, understanding, and belief, that:

> (A) No Federal Funds Used. No Federal appropriated funds have been paid or will be paid in what the undersigned believes to be a violation of 31 USC § 1352, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, the modification of any Federal contract, grant, loan, or cooperative agreement, or in any activity designed to influence legislation or appropriations pending before Congress.
>
> (B) Other Funds Used. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer 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.
>
> (C) Certification. The undersigned will require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and will require that all sub-recipients certify and disclose accordingly. This certification is a material representation of facts upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by 31 USC, § 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. 15 CLIA Requirements. All laboratory testing sites providing services under this contract must comply with the Clinical Laboratory Improvement Amendment (CLIA) requirements in 42 CFR § 493. The MCO shall obtain the valid CLIA 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-CLIA certified.

Article. 16 Advance Directives Compliance. Pursuant to 42 USC §1396(a)(57) and (58) and 42 CFR §422.128, and 42 CFR §489.100-104, the MCO agrees:

16.1 Enrollee Information. To provide all Enrollees at the time of enrollment a written description of applicable State law on Advance Directives and the following:

(A) Information regarding the Enrollee's right to accept or refuse medical or surgical treatment and to execute a living will, durable power of attorney for health care decisions, or other Advance Directive.

(B) Written policies of the MCO respecting the implementation of the right; and

(C) Updated or revised changes in State law as soon as possible, but no later than ninety (90) days after the effective date of the change.

(D) Information that complaints concerning noncompliance with the Advance Directive requirements may be filed with the State survey and certification agency, (i.e. Minnesota Department of Health), pursuant to 42 CFR § 422.128, as required in 42 CFR § 438.6(i).

16.2 Providers Documentation. To require MCO's Providers to ensure that it has been documented in the Enrollee's medical records whether or not an Enrollee has executed an Advance Directive.

16.3 Treatment. To not condition treatment or otherwise discriminate on the basis of whether an Enrollee has executed an Advance Directive.

16.4 Compliance with State Laws. To comply with State law, whether statutory or recognized by the courts of the State, on Advance Directives, including Minnesota Statutes, Chapters 145B and 145C.

16.5 Education. To provide, individually or with others, education for MCO staff, Providers and the community on Advance Directives.

Article. 17 Disclosure.

17.1 Disclosure Requirements. The MCO must consent to and cooperate with any financial, character, and other inquiries by the STATE.

17.1.1 General Disclosures. Upon request by the STATE, the MCO must disclose the following information as indicated in the sections below:

(A) The MCO shall notify the STATE in a timely manner of changes to the MCO's Government Programs staff and management;

(B) The type of organizational structure, a description of the management plan, the general nature of the MCO's business and general nature of the management plan's business;

(C) The MCO's full legal or corporate name and any trade names, aliases, and/or business names currently used;

(D) The jurisdiction of the MCO and date of incorporation, along with any articles of incorporation and by-laws, if applicable, along with state and federal tax returns for the past five (5) years. If the MCO is an organization other than a corporation, the copies of any agreements creating or governing the organization must be submitted;

(E) The date the MCO commenced doing business in Minnesota, and, if the MCO is incorporated outside of Minnesota, a copy of the MCO's certificate of authority to do business in Minnesota;

(F) Whether the MCO is directly or indirectly controlled to any extent or in any manner by another individual or entity. If so, the MCO must disclose the identity of the controlling entity in a description of the nature and extent of control; and

(G) Any agreements or understandings that the MCO has entered into regarding ownership or operation of the MCO.

17.1.2 Disclosure of Management/Fiscal Agents. The MCO must disclose the following, if applicable:

(A) A description of the terms and conditions of any contract or agreement between the MCO and the management or fiscal agent;

(B) All corporations, partnerships or other entities providing management or fiscal agent services;

(C) The management or fiscal agent's full legal or corporate name and any trade names currently used. The legal name, aliases, and previous names of management personnel, to the extent known;

(D) The jurisdiction of the management or fiscal agent and date of incorporation, along with any articles of incorporation and by-laws, if applicable, along with state and federal tax returns for the current period and the past five periods. Copies of any agreements creating or governing the organization must be submitted if the management or fiscal agent is an organization other than a corporation; and

(E) The date the management or fiscal agent commenced doing business in Minnesota, and if they are incorporated outside of Minnesota, a copy of their certificate of authority to do business in Minnesota.

17.2 Disclosure of, Compliance With, and Reporting of Physician Incentive Plans. The MCO may operate a Physician Incentive Plan, as defined in 42 CFR § 422.208(a), only if the requirements are met:

17.2.1 Disclosure to the STATE. The MCO must report to the STATE in writing no later than March 31st of the Contract Year, that the MCO is in compliance with the Physician Incentive Plan requirements as set forth in 42 CFR § 422.208. The MCO shall maintain in its files the following information in sufficient detail to enable the STATE or CMS to determine the MCOs compliance with 42 CFR § 422.208 and shall make that information available to the STATE or CMS upon request. The MCO must take into consideration its contractual relationship with all its subcontractors, including the relationship between its subcontractors and other Providers down to the level of the physician. These relationships include:

(A) The physician/physician group for which risk has been transferred for services not furnished by the physician/physician group, such as referral services.

(B) The type of incentive arrangement such as withhold, bonus or capitation associated with the transfer of risk for the physician/physician group.

(C) The percent of the potential payment to the physician/physician group that is at risk for referrals.

(D) The panel size, and if patients are pooled, the pooling method used to determine if significant financial risk (SFR) exists for the physician/physician group.

(E) If SFR exists, the MCO must provide an assurance that the physician or physician group at SFR has adequate stop-loss protection, including the threshold amounts for individual/professional, institutional, or combination for all services, and the type of coverage (i.e. per member per year or aggregate).

(F) If the MCO has Physician Incentive Plans that place physician/physician groups at SFR for the cost of referral services it must conduct Enrollee surveys and provide a summary of the survey results. Additionally, for MSC+, the STATE shall annually conduct the survey of Enrollees who have disenrolled, and make available the survey results to the MCO.

17.2.2 Disclosure to Enrollees. The MCO must provide the following information in accordance with 42 CFR § 438.6(h) to any Enrollee or Potential Enrollee upon request:

(A) Whether the MCO or its subcontractors use a Physician Incentive Plan that affects the use of referral services.

(B) The type of incentive arrangement(s) used.

(C) Whether stop-loss protection is provided.

(D) If the MCO was required to conduct an Enrollee survey, a summary of the survey results.

Article. 18 Emergency Performance Interruption (EPI).

18.1 Business Continuity Plan. The MCO shall have in place a written Business Continuity Plan (BCP) to be enacted in the event of an EPI. The BCP must:

(A) Identify an Emergency Preparedness Response Coordinator. Include the appointment and identification of an Emergency Preparedness Response Coordinator (EPRC). The EPRC shall serve as the contact for the STATE with regard to emergency preparedness and response issues and shall provide updates to the STATE as the EPI unfolds. The MCO shall notify the STATE immediately whenever there is a change in the MCO's EPRC and must include the contact information of its new appointed EPRC.

(B) Outline Activation Procedures. Outline the procedures used for the activation of the BCP upon the occurrence of an EPI.

(C) Ensure Priority Services. Ensure that MCO operations continue to produce and deliver Priority Services under this Contract. This includes, but is not limited to:

(1) Outlining the roles, command structure, decision making processes and emergency action procedures that will be implemented upon the occurrence of an EPI;

(2) Providing alternative operating plans for Priority Services;

(3) Providing procedures to assist the STATE to transition Enrollees to the FFS Medical Assistance program if the STATE determines such movement is necessary to properly provide service to the Enrollees; and

(4) Providing procedures to allow Enrollees to go to another clinic if their primary care clinic is not functioning.

(D) Include Reversal Process. Include procedures to reverse the process once the external environment permits the MCO to re-enter normal operations.

(E) Be Reviewed, Exercised and Updated. Be reviewed and revised as needed at least annually. The BCP shall also be exercised on a regular basis, typically annually. Exercises are not required to consist of large scale tests of multiple applications, but may instead consist of plan reviews, tabletop exercise and/or unit/component tests. When deciding on what type of exercise to use, the MCO shall balance the benefit of each type of exercise against the criticality of the service, costs (direct and indirect) associated with the exercise, and vulnerability of each service to failure.

(F) Be Available to the STATE. Upon written request, be available to the STATE during normal business hours for review and inspection at the MCO's location.

18.2 EPI Occurrence. If an EPI occurs, the MCO must:

(A) Implement its BCP within two (2) days of such EPI. In the event that the MCO's BCP cannot or is not implemented in this timeframe, the STATE shall have one or more of the following courses of action and remedies:

(1) Require joint management of contract operations between MCO and STATE staff.

(2) Move some or all of the MCO's Enrollees to another MCO.

(3) Bring some or all of the MCO's contractual duties in-house within the STATE.

(4) Immediately terminate the contract for the MCO's failure to provide the BCP services.

(5) Postpone Negotiations. If requested by the STATE, immediately postpone any active or soon to be active negotiations with the STATE for the following year's contract until such time as normal operations can be resumed. If, as a result of the EPI, a contract is not executed for the following year prior to December 15th of the Contract Year, the current Contract will be renewed in accordance with Article 5.

(B) Provide Notice to the State. Use best efforts to provide notification to the STATE of any significant closures within the MCO or its network.

(C) Affected Enrollee Access. Allow Enrollees whose Primary Care Provider(s) is significantly affected by the EPI to access other Primary Care Providers or, if found necessary by the STATE, be moved to the FFS Medical Assistance program.

(D) Continuation and Excuse from Services. Continue its duties and obligations under this Contract for as long as is practical. If the MCO believes that, despite the implementation of its BCP, it can no longer provide any or all of the Priority Services, the MCO must provide the STATE prompt written notices of such belief and request the STATE excuse it from those services. The notice and request must include specific details as to: 1) what services the MCO is requesting to be excused from providing; and 2) what circumstances prevent the MCO from providing the services.

(E) Burden for Excuse. If the MCO asserts that it can no longer provide any or all of the Priority Services as a result of the EPI, the MCO shall have the burden of proving that:

(1) Reasonable steps were taken (under the circumstances) to minimize delay or damages caused by foreseeable events;

(2) That all non-excused obligations will be substantially fulfilled; and

(3) That the STATE was timely notified of the likelihood or actual occurrence which would justify such an assertion, so that other prudent precautions could be contemplated. Failure by the MCO to prove any of these points may result in penalties for contract breach in accordance with Article 5.

(F) Relief from Breach. The MCO's liability for breach under Article 5 of this Contract will only be relieved for services excused in writing by the STATE. The STATE will not unreasonably withhold excuse from services for which the MCO has followed the procedures and met the burdens of this section.

(G) Return to Normal Operations. The MCO may suspend the performance of excused services under this Contract until any disruption resulting from the EPI has been resolved. However, the MCO shall make every effort to eliminate any obstacles resulting from the EPI so as to minimize to the greatest extent possible its adverse effects. Once the disruptions from the EPI are resolved to the point that the MCO can reasonably resume normal performance on one or more of the excused services, the MCO shall reverse the BCP process and resume normal operations for those services, and provide notice to the STATE of the same.

Article. 19 Miscellaneous

19.1 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.

19.2 Entire Agreement. The parties understand and agree that the entire agreement of the parties is contained herein and that this Contract supersedes all oral agreements and negotiations between the parties relating to this subject matter. All appendices, guidances, reference books including companion guides, technical specifications and webpages referred to in this Contract are incorporated or attached and deemed to be part of the Contract.

19.3 Assignment. The MCO shall neither assign nor transfer any rights or obligations under this Contract without the prior written consent of the STATE.

19.4 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.

19.5 Waiver. If a party fails to enforce any provision of this Contract, that failure does not waive the provision or that party's right to enforce the provision.

19.6 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.

19.7 Execution in Counterparts. Each party agrees that this Contract may be executed in two or more counterparts, all of which shall be considered one and the same agreement, and which shall become effective if and when both counterparts have been signed and dated by each of the parties. It is understood that both parties need not sign the same counterpart.

Article. 20 Survival. Notwithstanding the termination of this Contract for any reason, sections 3.7 and 9.4 (reporting and access to records), section 4.2.12 (enhanced rates for primary care and vaccine administration), section 4.6 (Managed Care Withhold), section 4.8.2 (CMS Approval), section 4.7 (Payment Error), section 5.3 through 5.6 (Deficiencies and sanctions), section 7.14

(Financial Performance Incentives.) and Article. 13 (Information Privacy and Security, including Indemnification) shall survive the termination of this Contract.

Signature page follows.

IN WITNESS WHEREOF, the parties hereto have executed this Contract. This Contract is hereby accepted and considered binding in accordance with the terms outlined in the preceding statements.

STATE OF MINNESOTA **DEPARTMENT OF HUMAN SERVICES**		**HEALTHPARTNERS, INC.**
		(Two corporate officers must execute)
By:		By:
Name:		Print Name:
Title: Commissioner		Title:
Date:		Date:
		And
		By:
		Print Name:
		Title:
		Date:
Contract # 68041 SWIFT # 0000231513		

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Appendix II: Rates

Appendix III: Protocol for Annual Review of Care System Subcontracts and Care Plans

The Minnesota Department of Human Services (DHS) requires managed care organizations (MCOs) participating in the Minnesota Senior Health Options (MSHO) program to conduct an annual review of any care system with which they have a subcontract. To assist health plans in conducting these reviews, DHS is distributing the following Guidelines. MCOs should think of these Guidelines as a tool. They can be added to or modified to meet the plans needs or to better reflect the relationship between the plan and the care system. The Guidelines are not intended as a method for regulating care systems.

As part of an annual care system review, an MCO should request the care system to provide them with the following information:

1) 2-3 case studies
2) Provider communication process or tool
3) Institutional and community-based care management models, care coordinator to member ratio, process used to determine who to case manage, and risk assessment methods or tools.
4) Utilization reports, patterns identified and interventions taken, and outcomes measured.

As part of an annual review, a health plan should consider reviewing the following information and/or policies:

5) Medical Records
6) Policy and Procedures for the following:

- Tracking and institutional status
- Completion of screening documents
- Tracking rate cell changes
- Pre-admission screening
- Authorization of enhanced services
- Care management decisions
- Providing culturally appropriate care
- Tracking 180 days of NF liability
- Spousal impoverishment referrals
- Evaluating requests for services
- Transfer to or from another care system
- Compliance with marketing procedures
- Completion and processing of referrals
- Obtaining medical records
- Coordination for MH/SA care
- Coordination for dental care
- Member complaints
- Member confidentiality
- Suspected fraud and abuse reporting
- Advance Directives
- Education and enrollment process

7) Copies and results of any member and provider satisfaction surveys conducted
8) Copies of all standard correspondence with members
9) Marketing materials, if any
10) Copies of monthly financial reports

Appendix IV. Long Term Care Elderly Waiver Risk Adjusted Payment System for Contract Year 2014.

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

(B) Development of Factors. The State developed initial 2014 risk factors using individual data on costs and characteristics of EW recipients from MCO-submitted 2011 EW service costs and demographic information available in the State's MMIS system. The Area, Age Groups, and Activities of Daily Living (ADL) Groups initial risk factors were developed by comparing the PMPM costs of each sub-population within the listed factors below (the numerator) to the total (entire) Elderly Waiver population's PMPM costs (the denominator):

Subpopulation	**2014 Initial Risk Factors**
Area	
Metro	0.902
Non-Metro	1.090
Age Group	
65 to 74	0.881
75 to 84	0.972
85 and above	1.165
ADL Group	
Low; 0 to 3 ADLs	0.669
Medium; 4 to 6 ADLs	1.411
High; 7 to 8 ADLs	1.991

(C) The Low (0 to 3 ADLs) ADL risk factor for contract year 2014 includes a 4% increase to account for the projected impact of community EW individuals that will lose their EW eligibility in 2014. The adjusted 2014 initial risk factors for ADL are as follows:

Subpopulation	**2014 Risk Factors**
ADL Group	
Low; 0 to 3 ADLs	0.696
Medium; 4 to 6 ADLs	1.411
High; 7 to 8 ADLs	1.991

(D) The initial 2014 risk factors are normalized for budget neutrality based on the 2012 distribution of members by Area, Age Group and ADL Group.

(E) The final contract year 2014 risk factors are:

Subpopulation	**2013 Final Risk Factors**
Area	
Metro	0.895
Non-Metro	1.081
Age Group	
65 to 74	0.874
75 to 84	0.963
85 and above	1.155
ADL Group	
Low; 0 to 3 ADLs	0.691
Medium; 4 to 6 ADLs	1.399
High; 7 to 8 ADLs	1.974

(F) Calculation of Annual Health Plan Elderly Waiver Risk Scores

(1) The MCO's risk score for a given contract year will be based on a member roster derived from paid managed care capitation claims for the most recent month available. The Area, Age Group, and ADL Group factors for each EW recipient will be derived from the MMIS Data Warehouse claims and LTCC Screening document tables for the most recent month available. EW enrollees without a valid and current LTCC Screening document will be excluded from the calculation

(2) Recipient-level risk scores are averaged to derive the overall MCO risk score.

Appendix V: Integrated Care System Partnerships

Seniors Appendix V: Integrated Care System Partnerships

(A) Contracting Process.

(1) If required to add additional ICSPs, by October 1, 2014 the MCO will enter into subcontracts or revise current contracts with primary, acute and/or long term care providers to implement Integrated Care System Partnerships (ICSPs) as required by (B) below. The ICSP must provide services designed to coordinate and/or integrate Medicare and Medicaid primary, acute and long term care, and/or mental health services in accordance with the Contract. New or modified ICSP contracts must become effective no later than January 1, 2015.

(2) At least one ICSP arrangement must continue to include performance-based payments with long term care providers.

(3) Notwithstanding section 5.3 of this Contract, the MCO's inability to establish ICSP arrangements before the Termination Date of this Contract shall not be construed as a breach if the MCO can demonstrate good faith attempts to do so.

(4) The STATE will continue to convene a clinical stakeholders workgroup to review and update the list of quality measures appropriate for the populations to be tied to financial performance and care outcomes with the ICSPs. The MCO, as part of an ICSP, will choose measures from this list to link performance metrics to payments based on appropriateness for the scope of services included in its ICSP contracts, the target population served and geographic utilization factors, ability to gather data to measure performance, and other factors as appropriate. The MCO may choose to implement new quality measure(s) not contained in the list of quality measures provided by the STATE. In this event, the MCO shall draft a written request which clearly conveys the new quality measure(s) as well as the need and desired outcome for the new quality measure(s). For existing ICSPs, the MCO will submit a written request for a new quality measure to the STATE thirty days prior to the MCO's targeted implementation date of the measure. For new ICSPs, the MCO shall submit the request as a part of the proposal for the new ICSP.

(5) The MCO and its existing care systems may qualify as ICSPs, provided the MCO meets these criteria or will make necessary changes to meet them within six (6) months of being provided the performance measures by the STATE.

(6) If the MCO proposed the minimum number of two proposals in 2013, the MCO must put into place one or two more for a total of four ICSPs , at least one of which must include long term care services. Providers may participate in more than one ICSP and may contract with more than one MCO. MCOs are not required to make network additions to establish an ICSP.

(7) The MCO must conduct Care Plan audits and ICSP audits in accordance with requirements in Articles 7 and 9 of the Contract.

(8) All services provided by the ICSP in coordination with the MCO, including individualized coordination of care, mental health targeted case management and other services, must be delivered in accordance with current applicable Contract requirements.

(B) Phase II ICSP Proposals. MCOs submitted Phase I proposals in contract year 2013. If the MCO submitted the minimum of two required proposals in Phase I, the MCO will submit two additional proposals on or before July 1, 2014. If the MCO submitted three proposals in Phase I, the MCO will submit one additional proposal on or before July 1, 2014. If the MCO submitted four or more proposals in Phase I, no additional proposals are required although the MCO may submit additional proposals by July 1, 2014 if they choose to do so.

(1) the MCO will submit a description of its proposed ICSPs to the STATE in a format provided by the STATE. The STATE will review each description and determine whether the ICSP criteria have been met prior to proposal acceptance. The description of the proposed ICSP(s) shall include:

(a) The service delivery and care coordination model;

(b) Target population;

(c) Current or projected enrollment numbers;

(d) Service area, which may be fewer counties than the MCO Service Area as defined in the Contract;

(e) Identification of which of the providers included in the ICSP arrangements are certified as a Health Care Home or health home (describe if some portions of the Provider entity are and other parts are not);

(f) The specified model options and payment type to be used (from the table in section (C)(4) below; MCOs may combine model options and payment types within a single ICSP, for example 1.1-A and 1.2-B , in order to meet the ICSP criteria); and

(g) The process for assigning or attributing Enrollees,

(h) Method that will be used for tracking cost of care or total costs of care as needed to implement the payment model chosen;

(i) The MCO's process for overseeing the ICSP and evaluating performance;

(j) Choice of two or more performance measures (from the list in section (A)(4) above) appropriate to the population and appropriate to the performance payment design; and

(k) The benchmarks or standards used to determine whether the Provider entity is effectively managing performance and costs of care.

(C) ICSP Payment Types.

(1) The ICSP subcontracts must establish payment arrangements tied to health outcomes and costs of care. Performance results must be reported annually to the STATE as outlined in the Contract under section 3.7.2(L)(2) The MCO will provide data necessary to verify reported results upon request as required under that section.

(2) Care Coordination, quality metrics, financial performance measures, STATE review and acceptance, and reporting requirements are required for each payment type.

(3) All models must support consumer choice of community and institutional settings and be designed to incent improved health outcomes.

(4) The following table outlines ICSP model options and payment types:

	ICSP Payment Types				
	Payment Types	Type A	Type B	Type C	Type D
Model Options		Performance rewards: performance pool or pay for performance	Primary Care Coordination of Care Payment; or partial sub-capitation for primary care and Care Coordination by Primary Care Provider or other Care Coordinator within ICSP.	Subcapitation or Virtual Capitation for Total Cost of Care across multiple defined services including primary, acute and long term care	Alternative Proposals
Model 1.1	MCO contracts with LTC providers and/or Primary Care Providers .	OPTION	NA	NA	NA

	ICSP Payment Types				
	Payment Types	Type A	Type B	Type C	Type D
Model 1.2	MCO contracts with Primary Care Providers or Care Systems to include payment for Care Coordination, as an alternative to Health Care Home care coordination fees.	NA	OPTION	NA	NA
Model 2	MCO contracts with provider Care System or a collaborative (primary care providers affiliated with long term care providers) with delegated management of care to the provider Care System or a collaborative, using risk/gain/ performance payment models across services.	NA	NA	OPTION	NA

	ICSP Payment Types				
	Payment Types	Type A	Type B	Type C	Type D
Model 3	MCO contracts with providers under payment arrangements that can provide financial and/or performance incentives for integration / coordination of Chemical and/or Mental Health services with acute / primary care services. May include certified HCH or Health Homes.	OPTION	OPTION	OPTION	NA
Model 4	Alternative defined by proposal	NA	NA	NA	OPTION

HCBS Waiver AC/Services by Service Tier – January 1, 2014

Tier 1: MHCP Enrolled Services and Licensure Requirements -- *enrollment required for Tier 1 services*

DHS HCBS License under 245D	Basic	24-hour Emergency Assistance; Companion Services (excluding services provided under Nat'l & Community Services Senior Companion Program); Homemaker (excluding providers licensed by the Department of Health under chapter 144A, and those providing cleaning services only); Night Supervision; Personal Support; Respite Care Services
	Intensive	*Intervention support services:* Behavioral Support; Specialist Services; and Crisis Respite *In-home support services:* Independent Living Skills Training; Residential-based Habilitation, (both supported living services provided in an adult's own home and in-home family support) *Residential supports & services in a licensed site:* Residential-based habilitation-supported living services; Foster care services (excluding EW/AC foster care services); ICF/DD *Day services*: Day training and habilitation; Pre-vocational; and Structured Day; Employment services: Supported Employment

Other DHS License	Adult Day Care; Family Adult Day Care EW Foster Care; Child Foster Care Settings; Family Foster Care Settings
MDH Home Care License	Customized Living; Residential Care Services; Extended Nursing & Home Health Aide; Homemakers
Professional License	Extended Home Health Care Services; Extended Nursing & Therapies
Unlicensed Services	Assistive Technology/Assessment; Caregiver Training & Education/Coaching & Counseling; Environmental Accessibility Adaptation/Home Modification Assessment; Environmental Accessibility Adaptation/ Vehicle Modification/Assessment and Installation; Extended PCA; Family Training & Counseling/Counseling; Home Delivered Meals; Housing Access Coordination; ILS Therapies; Nutritional Services; Specialized Transportation

Tier 2: Market Services *A non-enrollment option assures optimal access statewide for Tier 2 services*

Chore; Environmental Accessibility Adaptations/Home Modification/Installations; Homemaker/Cleaning; Transitional Services/EW Related Supports

Tier 3: Receipt Services *Involve strictly the purchase of items as reimbursable goods and supports*

24-hour Emergency Equipment; Assistive Technology Equipment; Caregiver Living Expenses; Caregiver Training & Education/Education; Family Training & Counseling/Training; Home & Vehicle Modification Expenses; Specialized Equipment & Supplies *(including Personal Emergency Response Systems)*; Transitional Services/Items & Expenses; Transportation-Common Carrier.

Appendix VII: CMS Memorandum of Understanding

See http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_163573#

AMENDMENT NO. 1 TO 68041

Contract Start Date:	1/1/2014	Total Contract Amount:	Per Member/Per Month
Original Contract Expiration Date:	12/31/2014	Original Contract Amount:	Per Member/Per Month
Current Contract Expiration Date:	Same	Previous Amendment(s) Total:	N/A
Requested Contract Expiration Date:	Same	Amendment Amount:	N/A

This Amendment, effective January 1, 2014, is by and between the State of Minnesota, acting through its Department of Human Services (STATE) and **HealthPartners, Inc.,** Managed Care Organization (MCO), identified as Contract No. **68041** 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;

WHEREAS, a delay in the implementation of the LTC Realignment: Nursing Facility Level of Care Criteria has resulted in a need to change certain benefit language and payment rates;

WHEREAS, a technical error in the amount of withheld funds as of January 1, 2014 required by Minnesota Statutes, § 256B.69, subd. 5a shall be corrected;

WHEREAS, other technical error corrections and policy clarifications would benefit the parties, and

WHEREAS, the STATE and MCO have agreed to amend the 2014 Minnesota Department of Human Services Contract No. 68041 to include these changes.

NOW, THEREFORE, the parties agree that the contract identified above shall be modified as follows:

CONTRACT REVISION 1:	Section 2.50 is deleted in its entirety and replaced by the following: **2.50 Essential Community Supports (ECS)** means a state-funded service to provide Home and Community Based services to eligible individuals, pursuant to Minnesota Statutes, § 256B.0922.
CONTRACT REVISION 2:	Section 3.7.2 (T) is deleted in its entirety and subsequent paragraphs renumbered accordingly.
CONTRACT REVISION 3:	Section 3.7.2 (W) is deleted in its entirety and replaced by the following: (V) Patient-centered Decision-making. During the contract year and in accordance with Minnesota Statutes, § 256B.69, subd. 9, (c), the MCO shall work with its providers to: 1) identify key conditions warranting shared decision-making based on potential to improve health outcomes and health care value; and 2) encourage use of shared decision-making by providers for the identified conditions. The STATE will survey the MCO regarding its implementation of this statute no earlier than November, 2014.
CONTRACT REVISION 4:	4.1.2 (E) (1) is deleted in its entirety and replaced by the following: (1) The Non-Performance-Based Total 37.5% (3.0 / 8.0 x 100) of the withheld funds shall be returned with no consideration of performance, no sooner than July 1st and no later than July 31st of

	the subsequent Contract Year.
CONTRACT REVISION 5:	Section 4.2.13 (A) (2)(a) is deleted in its entirety and replaced by the following: (a) The MCO's risk score for the Contract Year is based on an Enrollee roster derived from paid MCO capitation claims for the month of November of the previous Contract Year. Area, Age Group, and ADL Group factors for each EW recipient are derived from the MMIS Data Warehouse claims and LTCC Screening document tables as of the first data update in November of the year prior to the start of the Contract Year. Elderly Waiver Enrollees without a valid and current LTCC Screening document are excluded from the calculation.
CONTRACT REVISION 6:	Section 4.6 is deleted in its entirety and replaced by the following: **4.6 Medicaid Managed Care Withhold.** The STATE shall withhold eight percent (8%) from the Basic Care Rate portion of the MCS+ and MSHO rates of the MCO's payments. MSHO and MSC+ Medicaid Nursing Facility, and Home and Community Based Services, payments are excluded from the withhold provision.
CONTRACT REVISION 7:	Section 4.6.1 is deleted in its entirety and replaced by the following: **4.6.1 Return of Withhold Based on Performance.** The Performance-Based withheld funds (shown in section 4.6.4(B)(1)) shall be returned no sooner than July 1st and no later than July 31st of the year subsequent to the Contract Year only if, in the judgment of the STATE, performance targets in section 4.6.2 are achieved.
CONTRACT REVISION 8:	Section 4.6.4 is deleted in its entirety and replaced by the following: **4.6.4 Return of Withheld Funds for Contract Year 2014.** (A) For this Contract the funds available to be returned (the Withheld Total) shall be calculated as the difference between: (1) The total Contract Year 2014 Basic Care Rate portion of the MSHO Capitation Payments and the total Contract Year 2014 MSC+ Capitation payments made to the MCO, (as of May 31st of the year subsequent to the Contract Year), divided by 0.92 (92%); and (2) The total Contract Year 2014 Basic Care Rate portion of the MSHO Capitation Payments and the total Contract Year 2014 MSC+ Capitation Payments made to the MCO (as of May 31 of the year subsequent to the Contract Year). (3) This amount has been reduced to reflect MERC funding (for

	MSC+). (B) The amount of the withheld funds to be returned to the MCO shall be calculated as follows: (1) The Withheld Total shall be multiplied by 0.625 (5.0 / 8.0) or 62.5% to determine the Performance-Based Total. (2) The Performance-Based Total shall be multiplied by the Withhold Score, subject to the Loss Limit in 4.6.4(B)(3) below. (3) The difference between 4.6.4(B)(1) and 4.6.4(B)(2), the Loss Limit or amount of the unreturned funds that are kept by the STATE, shall not exceed five percent (5%) of the Performance-Based Total. (4) The Withheld Total shall be multiplied by 0.375 (3.0 / 8.0) or 37.5% to determine the Non-Performance-Based Total. (5) The resulting amount from adding the Performance-Based Total and Non-Performance-Based Total will be returned to the MCO according to section 4.1.2 (E).
CONTRACT REVISION 9:	Section 4.15 is deleted in its entirety.
CONTRACT REVISION 10:	Section 6.1.22 (A) (1) is deleted in its entirety and replaced by the following: (1) Lead Agency Role: the MCO is the Lead Agency responsible for conducting required pre-admission screenings (PAS) face-to-face assessments and reassessments and support planning services for its Enrollees to determine the need for an institutional level of care and for determination of HCBS waiver service eligibility, including institutional level of care determination as defined under Minnesota Statutes, §§ 256B.0911, subd. 4a, paragraph (d) and 144.0724, subd. 11, as directed by the STATE, and for service eligibility including State Plan home care services identified in Minnesota Statutes, § 256B.0625 subds. 6, 7, and 19, paragraphs (a) and (c). Determinations must be based on assessment and support plan development with appropriate referrals.
CONTRACT REVISION 11:	Section 6.1.22 (A) (12)(b) is deleted in its entirety and replaced by the following: (b) When requested by the STATE and with sixty (60) days' notice, the revised Care Plan will include Essential Community Supports for eligible individuals, pursuant to DHS guidance. The MCO shall submit service

	agreements for Essential Community Supports to the STATE and shall monitor enrollees' use of Essential Community Supports, in a process provided by the STATE. The MCO remains responsible to provide care coordination services for MSHO enrollees under section 6.1.4 and case management for MSC+ enrollees under section 6.1.5.
CONTRACT REVISION 12:	Section 10.1 is deleted in its entirety and replaced by the following: **10.1 Agent of the STATE.** Pursuant to 42 § CFR 433, subpart D and Minnesota Statutes, §§ 256B.042, subd. 2; 256B.056, subd. 6; 256.015, subd. 1, 256B.37, subd. 1, and 256B.69, subd. 34, the STATE hereby authorizes the MCO as its agent to obtain Third Party Liability and Medicare reimbursement by any lawful means including: asserting subrogation interest, filing interventions or liens, asserting independent claims, and to coordinate benefits, for MCO Enrollees except in instances described in section 10.3.4(B) and section 10.7.
CONTRACT REVISION 13:	Section 10.2 (E) is deleted in its entirety and replaced by the following: (E) Return of Payments. The MCO must require its Providers to return any third party payments to the MCO for Third Party Liability described in 10.3.4(A)(1) if the Provider received a third party payment more than one hundred and eighty (180) days after the date the claim was Adjudicated. The MCO will then return the payment to the STATE. Mechanisms for return of the payment from the MCO to the STATE, and return of payments from the STATE to the MCO, will be specified by the STATE.
CONTRACT REVISION 14:	Section 10.3.3 is deleted in its entirety and replaced by the following: (A) General. Except as described in paragraph (C), the MCO shall use a Cost Avoidance procedure for all claims or services that are subject to third-party payment to the extent permitted by state and federal law, and must deny payment for a service to an Enrollee if the MCO has established the probable existence of Third Party Liability at the time the Provider submits the claim. (B) Cost-effectiveness. The MCO must determine whether it is more cost-effective to provide the service or pay the cost-sharing to a Non-Participating Provider. If the MCO refers an Enrollee to a third-party insurer for a service that the MCO covers, and the third-party insurer requires payment in advance of all cost-sharing, the MCO shall make such payments in advance or at the time such payments are required. (C) Exceptions. 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.

	(1) Pursuant to H.J.Res.59 (December 26, 2013) amending section 1902(a)(25)(E) of the Social Security Act, the MCO may delay payment for prenatal and preventive pediatric care for ninety (90) days after the date the provider initially submitted a claim to the MCO, if the MCO determines doing so is cost-effective and will not adversely affect access to care. (2) Pursuant to H.J.Res.59 (December 26, 2013) amending section 1902(a)(25)(F) of the Social Security Act, the MCO may delay payment for ninety (90) days for services where child support enforcement is being carried out; however, the MCO could continue to make payment within thirty (30) days, if it found that to be cost-effective and necessary to ensure access to care.
CONTRACT REVISION 15:	Section 10.5 is deleted in its entirety and replaced by the following: **10.5 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 an intervention or (as of October 1, 2014) 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.
CONTRACT REVISION 16:	Article 20 is deleted in its entirety and replaced by the following: **Article 20 Survival.** Notwithstanding the termination of this Contract for any reason, sections 3.7 and 9.4 (reporting and access to records), section 4.1 (Payment of Capitation), section 4.2.12 (enhanced rates for primary care and vaccine administration), section 4.6 (Managed Care Withhold), section 4.7 (Payment Error), section 4.8.2 (CMS Approval), section 5.3 through 5.6 (Deficiencies and sanctions), section 7.14 (Financial Performance Incentives) and Article 13 (Information Privacy and Security, including Indemnification) shall survive the termination of this Contract.
CONTRACT REVISION 17:	Appendix II, Rates, is amended by deleting the pages captioned "MSHO & MSC+ Rates January - December 2014 " and "Minnesota Senior Health Options and Minnesota Senior Care Plus Programs January 2014 to December 2014 Contract Period Elderly Waiver Add-On Rates (PMPM)" dated in December, 2013, and replacing them with the attached pages, captioned "MSHO & MSC+ Rates January - December 2014 " and "Minnesota Senior Health Options and Minnesota Senior Care Plus Programs January 2014 to December 2014 Contract Period Elderly Waiver Add-On Rates (PMPM)" dated January 14, 2014, respectively.
CONTRACT REVISION 18:	Appendix IV, Long Term Care Elderly Waiver Risk Adjusted Payment System for Contract Year 2014, is amended by deleting all pages and replacing them with the attached pages, captioned "Appendix IV. Amendment #1 Long Term Care Elderly Waiver Risk Adjusted Payment System for Contract Year 2014."

Execution in Counterparts. Each party agrees that this Amendment may be executed in two or more counterparts, all of which shall be considered one and the same agreement, and which shall become effective if and when both counterparts have been signed and dated by each of the parties. It is understood that both parties need not sign the same counterpart.

EXCEPT AS AMENDED HEREIN, THE TERMS AND CONDITIONS OF THE ORIGINAL CONTRACT REMAIN IN FULL FORCE AND EFFECT.

Signature page follows

IN WITNESS WHEREOF, the parties hereto have executed this contract amendment. This contract amendment is hereby accepted and considered binding in accordance with the terms outlined in the preceding statements.

APPROVED:

STATE OF MINNESOTA **DEPARTMENT OF HUMAN SERVICES**		**HEALTHPARTNERS, INC.**
		(Two corporate officers must execute)
By:		By:
Name: Nathan Moracco		Print Name:
Title: Assistant Commissioner		Title:
Date:		Date:
		and
		By:
		Print Name:
		Title:
		Date:
Contract # 68041 SWIFT #0000231513		