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

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

2.112 Unique Minnesota Provider Identifier (UMPI) means the unique identifier assigned by the STATE for Atypical Providers who are not eligible for a NPI.

2.113 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.

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

3.1 Eligibility and Enrollment Duties.

3.1.1 Eligibility.

(A) **Service Area**. Only those eligible persons who are enrolled in Medical Assistance, GAMC and MinnesotaCare residing within the County(ies) of the State of Minnesota identified in Appendix I: MCO Service Areas, shall be eligible for enrollment.

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

(C) **Eligibility Determinations for Medical Assistance and GAMC.** Eligibility for Medical Assistance and GAMC and eligibility for participation in PMAP and PGAMC will be determined by the Local Agency. All persons who receive Medical Assistance or GAMC and reside in the Service Area will participate in PMAP or PGAMC, except for Recipients who are members of the following Medical Assistance and GAMC populations:

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

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

(3) Medical Assistance and GAMC Recipients who are residents of State institutions, unless the placement has been approved by the MCO. For purposes of this Contract, approval by the MCO would include a placement which is court-ordered within the terms described in section 6.1.21(C).

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

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

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

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

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

(9) Recipients, who at the time of notification of mandatory enrollment in PMAP or PGAMC, have a communicable disease whose prognosis is terminal and whose primary physician is not a Participating Provider in the MCO, and that physician certifies that disruption of the existing physician-patient relationship is likely to result in the patient becoming noncompliant with medication or other health services.

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

(11) Recipients of GAMC receiving the “GAMC Hospital Only” benefit according to Minnesota Statutes, § 256D.03, subd. 3.

(12) Medical Assistance and GAMC 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 according to Minnesota Statutes, § 256B.69, subd. 4(b)(9).

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

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

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

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

(1) Adults who are determined to have a SPMI and eligible to receive Medical Assistance covered targeted case management services pursuant to Minnesota Statutes, § 245.4711.

(2) Children diagnosed as having Severe Emotional Disturbance (SED) and eligible to receive Medical Assistance covered targeted case management services pursuant to Minnesota Statutes, § 245.4881, unless eligible for a Preferred Integrated Network (PIN) and they reside in a PIN service area.

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

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

3.1.2 Enrollment.

(A) **Nondiscrimination.** The MCO will accept all eligible Recipients who select or are assigned to the MCO without regard to physical or mental condition, health status, need for health services, marital status, age, sex, sexual orientation, national origin, race, color, religion or political beliefs, and shall not use any policy or practice that has the effect of such discrimination.

(B) **Order of Enrollment.** The MCO shall enroll Recipients in the order in which they apply or are assigned. Recipients who do not choose an MCO within the allotted time will be assigned to an MCO by the STATE. The STATE may limit the number of Enrollees in the MCO if, in the STATE's judgment, the MCO is unable to demonstrate a capacity to serve additional Enrollees.

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

(D) **Transitional MinnesotaCare.** The Local Agencies shall enroll single adults and households with no children, formerly enrolled in GAMC, in MinnesotaCare according to Minnesota Statutes, § 256D.03, subd. 3, and § 256L.07, subd. 6. The Local Agencies shall pay any required premiums for these individuals.

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

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

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

(H) **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, pages 41,006 and 41,007 of the Federal Register.

(I) **Health Care Home**. The MCO Provider network must include clinics, personal clinicians, or local trade area clinicians designated as Health Care Homes that are certified under 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.

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

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

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

as the clinic or physician is part of the MCO's statewide clinic or physician network.

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

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

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

(3) For MinnesotaCare and Transitional MinnesotaCare, when enrollment occurs and has been entered on the STATE's MMIS on or before the last working day of the month, medical coverage shall commence at midnight, Minnesota time, on the first day of the month following the month in which the enrollment was entered on the STATE MMIS.

(4) **Newborns.**

(a) **Mother Enrolled with the MCO Under This Contract.** Eligible newborns born to mothers enrolled in the MCO under a program covered by this Contract will be enrolled in the same MCO as the mother for the birth month in accordance with STATE policies and procedures, unless the newborn meets one of the exclusion reasons listed in section 3.1.1.

(b) **Mother Enrolled with the MCO Under MSHO, MnDHO or SNBC and the MCO has a Program Covered by this Contract in the Same Service Area.** If an eligible newborn is born to a mother who is enrolled with the MCO under MSHO, MnDHO, or SNBC and the MCO has a program covered by this Contract in that same Service Area, the newborn will be enrolled in the MCO under a program covered by this Contract in that service area for the birth month in accordance with STATE policies and procedures, unless the newborn meets one of the exclusion reasons listed in section 3.1.1.

(c) **Mother Enrolled with the MCO Under MSHO, MnDHO or SNBC and the MCO does not have a Program Covered by this Contract in the Same Service Area.** If an eligible newborn is born to a mother enrolled with the MCO under MSHO, MnDHO, or SNBC but the MCO does not have a program covered by this Contract in that same Service

Area, the newborn will be enrolled in accordance with STATE policies and procedures.

(d) **Enrollment within Ninety Days.** If a newborn described in paragraphs (a) or (b) above is enrolled in the MCO on MMIS within ninety (90) days of the birth, the MCO will receive a capitation payment for the birth month and the succeeding months as long as the newborn remains eligible and there is not a request to change to another MCO. If a newborn described in paragraphs (a) or (b) above is not enrolled in the MCO within ninety (90) days of the birth, the MCO will receive a capitation payment for the birth month only, and will be enrolled in the MCO for the next available month unless a change of MCOs is requested.

(5) **Hospitalization**. MCO coverage of Recipients or Enrollees who are receiving Inpatient Hospitalization services at the time coverage otherwise would become effective under (1) and (2) above of this section shall commence:

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

(b) for Medical Assistance and GAMC , on the first day of the month following the month of discharge from the hospital, except for eligible newborns who may be enrolled in the MCO effective the first day of the month of birth, even if hospitalized.

(6) **Hospitalization for Chemical Dependency**. Enrollment will be delayed until the first day of the month following discharge only for a Recipient who is receiving inpatient hospital-based CD services at the time the Recipient is scheduled to be enrolled. Enrollment will be effective on the first day of the month following discharge from the inpatient hospital-based CD services.

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

following month and subsequent months. The STATE shall pay according to Article 4 for the month of coverage in which the Enrollee was reinstated.

(O) Reenrollment. If an Enrollee is disenrolled for any reason and subsequently becomes eligible to enroll, the STATE shall reenroll the Enrollee in the same MCO, unless the Enrollee requests a change in MCOs in accordance with section 3.2.6 or 3.4.1. In no circumstance shall the MCO randomly assign an Enrollee to a Primary Care Provider upon reenrollment.

(P) Capability to Receive Electronically.

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

(2) The MCO shall provide valid enrollment data to Providers for Enrollee coverage verification by the first day of the month and within two working days of availability of enrollment data at the time of reinstatement. This shall include all subcontractors. The MCO may require its Providers to use the STATE's Electronic Verification System (EVS) or MN-ITS system to meet the requirement in this paragraph.

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

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

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

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

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

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

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

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

(G) To be furnished health care services in accordance with 42 CFR §§ 438.206 through 438.210.

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

3.2 MCO and Enrollee Communication

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

3.2.2 Americans with Disability Act Compliance.

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

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

(C) All written materials, 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 relay service)," or similar language approved by the STATE pursuant to section 3.2.4(B).

3.2.3 Requirements for Potential Enrollee/Enrollee Communication.

(A) **Written Information.**

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

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

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

(C) **Readability Test.** All written materials, including Marketing, new Enrollee information, member handbooks, Grievance, Appeal and State Fair Hearing information and other written information, which target Recipients or Enrollees under this Contract and are disseminated to Recipients or Enrollees by the MCO in the English language must be understandable to a person who reads at the seventh (7th) 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 Recipients or Enrollees must be in at least a 10-point type size, with the

exception of the ID Card, which may have non-essential items in a smaller type size.

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

(E) **American Indians.** All Enrollee and Recipient Marketing and enrollment materials that reference access to covered benefits or the MCO's network shall explain the right of American Indians to access out-of-network services at Indian Health Service (IHS) or 638 facilities.

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

3.2.4 Marketing Materials.

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

(B) **Prior Approval of Materials.** The MCO shall present to the STATE for approval all Marketing Materials that the MCO, or its subcontractors, plan to undertake during the Contract period, including but not limited to posters, brochures, Internet web sites, any materials which contain statements regarding the benefit package, and provider network-related materials, prior to the MCO's use of such Marketing Materials. Internet web sites which merely link to the DHS web site for information do not need prior approval. If the Marketing Materials target American Indian Recipients, the STATE shall consult with tribal governments within a reasonable period of time before approval. Such approval by the STATE shall not be unreasonably withheld or delayed.

(C) **Marketing Restrictions.** Except through mailings and publications as set forth below, the MCO and 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. This restriction includes, but is not limited to: telephone Marketing, face-to-face Marketing, promotion, cold-calling, and/or direct mail Marketing.

(1) **May Not be False or Misleading.** Mailings from the MCO to Recipients and Enrollees shall not contain false or materially misleading information. The MCO shall not make any written or oral assertions or statements that a

Recipient or Enrollee must enroll in the MCO in order to obtain or maintain covered benefits, or that the MCO is endorsed by CMS, the STATE, or federal government.

(2) **Mailings to Recipients.** The MCO may make no more than two mailings per calendar year to Enrollees of the MCO covered under this Contract 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 for this Contract. Any such mailing shall be at the MCO's expense, using a mailing list provided by the STATE supplied in a format as determined by the STATE. 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.

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

(a) The MCO may distribute brochures and display posters at physician offices and clinics, informing patients that the clinic or physician is part of the MCO's provider network, provided that all MCOs to which the Provider subscribes have an equal opportunity to be represented.

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

3.2.5 Enrollment Materials.

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

(1) **Certificate of Coverage (COC).** A Certificate of Coverage (COC) that has been prior-approved by the STATE and that will include the following:

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

(b) A description of 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 Service and certain tribal Providers and how such Enrollees shall obtain referral services. In prior approving this portion of the COC, the STATE shall consult with tribal governments.

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

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

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

(n) 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 sections 8.9.8, 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: i) the right to hearing; ii) the method for obtaining a hearing; and iii) 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.

(vi) The fact that, when an Appeal is requested by the Enrollee:

a Benefits will continue if the Enrollee files an Appeal or a request for State Fair Hearing within the timeframes specified for filing; and

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

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

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

(o) 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.

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

(q) A description of the Enrollee's right to request information about Physician Incentive Plans from the MCO, including whether the prepaid plan uses a Physician Incentive Plan that affects the use of referral

services, the type of incentive arrangement, whether stop-loss protection is provided, and a summary of survey results.

(r) 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.

(2) **Provider Directory.**

(a) A Provider directory which lists the contracted Providers within the MCO's network, including Primary Care Providers, specialty Providers and hospitals, and also includes their names, locations, and telephone numbers as specified in a State document entitled "Provider Directory Guidelines."

(b) 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.

(c) The information required by this section may also be listed on the MCO's web site.

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

(3) **Membership Card.** A membership card that conforms to the requirements in Minnesota Statutes, § 62J.60, subd. 3, and has been approved by the STATE prior to printing, which identifies the Recipient as an MCO Enrollee and contains an MCO telephone number to call regarding coverage, procedures, and Grievances and Appeals. The membership card shall demonstrate that the Enrollee is a Recipient of Minnesota Health Care Programs, either by printing the Enrollee's STATE PMI number on the card or by other reasonable means.

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

(B) **Advance Approval.** The STATE must approve all new enrollment materials sent to Enrollees prior to their use. The MCO must revise its COC for all substantial changes in its Grievance and Appeals procedures, and its health

care delivery systems, including changes in procedures to obtain access to or approval for health care services. All revisions to the COC must be approved in writing by the STATE in accordance with this section and issued to Enrollees prior to implementation of the change. Approvals by the STATE for these materials shall not be unreasonably withheld. The MCO must submit its documents in a final version prior to receiving an approval from the STATE. The STATE agrees to inform the MCO of its approval or denial of these documents within thirty (30) days of receipt of these documents from the MCO.

(C) Primary Care Network List (PCNL).

(1) **Specifications.** The MCO must supply all Local Agencies within its Service Area, and the STATE for MinnesotaCare, with copies of a standardized document (known as a "Primary Care Network List" or "PCNL") that provides information about the MCO's Provider network and that includes a description of the essential components of the MCO, to be used by the Local Agencies to educate consumers. This document must follow the STATE specification as indicated in the STATE document "PCNL Guidelines," and be prior approved by the STATE in accordance with section 3.2.4(B). The document must be printed on a grade of paper that is equivalent to bond paper which is not less than nineteen (19) pound bond but not greater than twenty (20) pound bond. If the PCNL has a cover, the grade of paper must be on uncoated offset paper or on glossy paper. The paper must be 8 ½" x 11" or 17" x 11", and the 17" x 11" document must fold to 8½" x 11". The document must contain the following information:

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

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

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

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

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

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

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

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

> "Enrolling in this health plan does not guarantee you can see a particular Provider on this list. If you want to make sure, you should call that Provider to ask whether he or she is still part of this health plan. You should also ask if they are accepting new patients. This health plan may not cover all your heath care costs. Read your contract, or 'Certificate of Coverage,' carefully to find out what is covered."

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

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

(3) When the MCO is new to a Service Area, the MCO must supply the STATE, or in certain cases, the Local Agency, with a supply of the final, printed and approved PCNL pursuant to the STATE's specifications, in quantities sufficient to meet the STATE need. If the MCO's Service Area expands for MinnesotaCare, additional PCNLs must be supplied to the STATE sixty (60) days prior to the effective date of the expanded Service Area. 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 3.2.4(B). 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.

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

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

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

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

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

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

(E) **Recipient Education.**

(1) The STATE or the Local Agency will inform Recipients who reside in the Service Area of the options available in health care coverage. The STATE or Local Agency shall describe through presentations and/or written materials the various MCOs available to Recipients in a particular geographic area and complete enrollment of Recipients by obtaining the

signature of Recipients or their lawful representatives on the enrollment form. For Recipients who are assigned to an MCO, a signature will not be obtained. Tribal governments may assist the STATE or Local Agency in presenting or developing materials describing the various MCO options for their members. If the tribal government revises any MCO materials, the MCO may review them prior to distribution. If the MCO deems the revisions to be substantial, the MCO shall have thirty (30) days to respond to the tribal government and no MCO materials will be distributed until there is mutual agreement on the revisions.

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

(F) **Enrollee Education.** The MCO, or its subcontractors, is not prohibited from providing information to Enrollees for the purpose of educating Enrollees about Provider choices available through the MCO, subject to the limitations in this Contract.

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

(A) **Material Modification of Provider Network.**

(1) **Notice to STATE**. The MCO must notify the STATE of a possible Material Modification in its Provider Network within ten (10) working days from the date the MCO has been notified that a Material Modification is likely to occur. A Material Modification shall be reported in writing to the STATE no less than 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 sub-contract without one hundred and twenty (120) days notice in those situations where the termination is for cause. For the purposes of this section, termination of a Provider for cause does not include the inability to reach agreement on contract terms.

(2) **Notice to Enrollees.** The MCO shall provide prior written notification to Enrollees who will be affected by a Material Modification. Such prior written notice shall be approved by the STATE. The notice must inform each affected Enrollee that:

(a) One of the Primary Care Providers they have used in the past is no longer available and that they must choose a new Primary Care Provider

from the MCO's remaining choices; or that the Enrollee has been reassigned from a terminated sole source Provider; and

(b) In either case, the Enrollee has the opportunity to disenroll and change MCOs up to 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 or her Primary Care Provider and his or her physician specialists. Examples of methods of Provider access include, but are not limited to: 1) Enrollee has open access to all Primary Care Providers; 2) Enrollee may self-refer to a physician specialist; 3) Enrollee must choose one Primary Care Provider; and 4) Enrollee must receive a referral to a physician specialist from his or her Primary Care Provider. For purposes of this section, a substantive change in the method of Provider access shall not include the addition or deletion of Service Authorization requirements for services.

(C) **Network Stability.** The MCO shall provide the same network of Providers for all Enrollees covered under this Contract.

(D) **County-Based Purchasing Notice**. For County-Based MCOs, the STATE must review for approval any proposed change involving the movement of counties or eligibles within a county under this Contract, or from this Contract to another country-based purchasing project. The MCO shall submit any such proposed changes to the STATE at least one hundred and eighty (180) days prior to the proposed implementation date.

3.2.7 Enrollee Notification of Terminated Primary Care Provider. The MCO, or if applicable its subcontractor, shall make a good faith effort to provide written notice of the termination of a 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 Participating 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.

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

3.4 Termination of Enrollee Coverage; Change of MCOs.

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

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

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

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

(D) The Enrollee changes MCOs without cause pursuant to 42 CFR § 438.56(c) within ninety (90) days following the Enrollee's initial enrollment with the MCO. For counties where the MCO is the only choice, the Enrollee cannot disenroll, but may change Primary Care Providers pursuant to section 3.1.2(J).

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

(F) 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 no longer participates in PMAP, PGAMC or MinnesotaCare.

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

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

(I) The Enrollee elects to change MCOs within one hundred twenty (120) days following notice of a Material Modification of the MCO's Provider Network as outlined under section 3.2.6(A)(2).

(J) A GAMC Enrollee who becomes eligible for the Medical Assistance program will be disenrolled from GAMC and enrolled in Medical Assistance. The MCO, to the best of its ability as soon as it becomes aware, shall notify the

Local Agency regarding potential changes in an Enrollee's eligibility status because of such factors as pregnancy or disability.

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

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

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

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

(C) When termination takes place due to ineligibility for Medical Assistance, GAMC or MinnesotaCare, or for participation in the PMAP or PGAMC 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 eligibility for Medical Assistance, GAMC, MinnesotaCare, PMAP or PGAMC 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 the month of discharge from the hospital.

3.5 Reporting Requirements.

3.5.1 Encounter Data.

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

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

(1) Individual Enrollee-specific, claim-level encounter data for services provided by the MCO to Enrollees detailing all medical and dental diagnostic and treatment encounters, all pharmaceuticals, supplies and medical equipment dispensed to Enrollees, and all nursing facility services which the MCO provides as a Substitute Health Service. Encounter data shall include all paid lines associated with a claim, and those denied claims or lines, for which Medicare or a third party has paid in full. Third party paid claims include immunizations which are paid for by the Minnesota Vaccines for Children Program (MNVFC).

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

(3) All encounter claims must be submitted electronically and must comply with STATE and federal requirements, including the requirements to submit charge data and to use the standard formats and procedures, using HIPAA standard transaction formats. Charge data shall be the lesser of the usual and customary charge (or appropriate amount from a Relative Value Scale for missing or unavailable charges) or submitted charge. Claims submitted must include, as applicable, the units of service and/or valid procedure codes, bill type, place of service, dates of services and accurate Provider numbers (See the “837 Encounter Data Companion Guides” which are incorporated by reference and made a part of this Contract, as applicable, on the STATE’s public website for Managed Care.)

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

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

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

(7) The MCO shall submit encounter data on all personal care assistance (PCA) services using the X12 837 P 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 units of service by date, and the treating PCA Provider. The STATE will monitor PCAs as treating Providers.

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

(C) The MCO shall submit encounter claims with all of the required data elements to the STATE no later than ninety (90) days after the date the MCO adjudicated the claim. The MCO shall make submissions at least monthly. If the MCO is unable to make a submission during a certain month, the MCO shall contact the STATE to notify it of the reason for the delay and the estimated date when the STATE can expect the submission.

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

(E) Unless otherwise specified in the contract, the MCO may submit replacement claims for encounter claims previously submitted, at any time.

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

(G) The STATE will provide 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. (See the Encounter Data Companion Guides, which are referenced on the DHS managed care website, incorporated by reference and made a part of this Contract, as applicable for remittance advice requirements).

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

pay-to Provider. Group practice Provider categories that bill on the 837P format or 837D format and will require a treating Provider are:

(1) Community Mental Health Clinics;

(2) Physician Clinics;

(3) Dental Clinics;

(4) County Contracted Mental Health Providers;

(5) Indian Health Service;

(6) Federally Qualified Health Centers;

(7) Rural Health Clinics;

(8) Chiropractic Clinics;

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

No treating Provider is required for any other claim type.

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

(J) 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.

(K) **Coding Requirements.**

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

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

(b) Procedure codes obtained from Physician's Current Procedural Terminology (CPT) and from CMS' 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.

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

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

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

(L) **National Provider Identifier (NPI)/Atypical Provider Types (UMPI).** The MCO shall use the NPI for all Providers for whom CMS issues NPIs. For Providers of Atypical Services, the MCO shall use the UMPI.

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

(N) Encounter Data Due Dates:

Capitation Payment Dates	Final Encounter Data Due Dates	Assessment Periods
April 2010 - June 2010	February 1, 2010	July 1, 2008 - June 30, 2009
July 2010 - September 2010	May 1, 2010	October 1, 2008 - September 30, 2009
October 2010 - December 2010	August 1, 2010	January 1, 2009 - December 31, 2009
January 2011 - March 2011	November 1, 2010	April 1, 2009 - March 31, 2010

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

(A) **Birth of Child to an Enrollee.** The MCO may report to the STATE or the Local Agency the birth of any Child to an Enrollee on a form approved by the STATE, as soon as reasonably possible after the MCO knows of the birth.

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

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

(D) **Provider Information.**

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

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

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

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

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

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

(I) **EPSDT/C&TC Information.** The MCO shall report EPSDT/C&TC information as specified in this Contract.

(J) **Health Care Home**. As a condition of contracting with the Health Care Home, the MCO shall require that the Health Care Home report data to the STATE, and to the Minnesota Department of Health as required in Minnesota Statutes, § 256B.0751.

(K) **Third Party Resources.** Pursuant to section 11.2.2, the MCO shall report to the STATE any additional third party resources in a format provided by the STATE.

(L) **Third Party Payments.** Pursuant to section 11.4, the MCO shall report all recovery/Cost Avoided amounts on the encounter claim as third party payments.

(M) **Cost Avoided and Recovered.** Pursuant to section 11.4, the MCO shall, on a quarterly basis, disclose to the STATE all Cost Avoided and recovered amounts.

(N) **Quality Assurance Workplan.** The MCO shall submit its Quality Assurance Workplan, pursuant to Article 7.

(O) **Disclosure of Ownership Information**. On September 1st of Contract Year, the MCO shall report to the STATE full disclosure information as required to assure compliance with 42 CFR § 438.610. The required information includes:

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

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

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

(P) **FQHCs and RHCs.** The MCO shall provide to the STATE a quarterly report for the first quarter of Contract Year 2010, due no later than thirty (30) days following the end of the quarter. The report must identify MCO payments made to FQHCs and RHCs for all programs covered under this Contract. As of April 1st of Contract Year, reports shall be submitted monthly, with the first monthly report due no later than May 31st, 2010.

(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.

(Q) **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 of two years preceding the Contract Year through June 30th of the year preceding the Contract Year, combining expenditures under all Minnesota Health Care Programs (MHCP) contracts. The report must be submitted to the STATE in a format specified by the STATE and include health care expenditures within the following groups and for each of the service categories:

(1) Major Program Groups – (Medical Assistance, GAMC and MinnesotaCare).

(2) Age Groups – (Children under eighteen (18) years, and adults eighteen (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).

(R) **Inpatient and Outpatient Services.** Pursuant to Minnesota Statutes, § 256.969, subd. 9(f), the MCO shall submit a report to the STATE of charges and payments made under Medical Assistance, GAMC and MinnesotaCare for each claim of inpatient and outpatient hospital service. This report shall also include any other information specified by the STATE as needed by the STATE for the purpose of obtaining federal matching funds. This report shall include all such charges, payments and other specified information for services occurring on or after July 1, 2004. This data is only to be used by the STATE for this purpose and not for any other, except with the express written consent of the MCO. This data shall be submitted by the MCO to the STATE in accordance with specifications designated by the STATE and provided to the MCO. The first report in this format shall be submitted by the MCO to the STATE within sixty (60) days after the MCO receives the report specifications from the STATE, and annually thereafter.

(S) **CD 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 9.16.

(T) **Reporting Provider Payment Rates**.

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

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

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

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

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

(2) The MCO agrees to participate in a workgroup with the STATE to provide input on the data collection format and parameters for the reporting requirements under 3.5.2.T(1). The scope of the data collection will include detailed provider reimbursement data, aggregate expenditure data based on service groupings, and narrative information. The MCO will submit the first phase of the provider payment data reporting beginning no later than July 1, 2010, and will include information on aggregate provider payment data, information on legislatively-mandated provider rate changes, and information and data on provider reimbursement rates and rate methodologies.

(U) **Dental CHIP RA Data Files Submission**. In accordance with section 501(e) of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP RA) to promote and improve access to dental services for children, the MCO shall submit quarterly data files to the STATE that include information about dental providers in the MCO's network. The data files shall comply with the specifications and submission guide outlined in the document entitled, "Insure Kids Now (IKN) Provider Data Submission Technical Information" modified by the STATE and posted on the DHS managed care website.

3.5.3 Electronic Reporting Data Capability.

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

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

(1) Accept and transmit eligibility transactions;

(2) Accept claims transactions; and

(3) Transmit payment and remittance advice.

3.5.4 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.

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

Article. 4 Payments to MCO.

4.1 Payment of Capitation. Except as noted below in section 4.1.1, on the STATE's first warrant date or the 14th day of each month, whichever is earlier, the STATE agrees to pay the MCO the following rates as specified in Appendices II-A, II-B, and II-C, per month, per Recipient enrolled with the MCO, as full compensation for 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.

4.1.1 Exceptions. Section 4.1 does not apply to:

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

(B) 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.