2009 MnDHO Contract

UCare Minnesota

MINNESOTA DEPARTMENT OF HUMAN SERVICES CONTRACT
FOR MINNESOTA DISABILITY HEALTH OPTIONS PROJECT SERVICES

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MINNESOTA DEPARTMENT OF HUMAN SERVICES CONTRACT FOR MINNESOTA DISABILITY HEALTH OPTIONS PROJECT SERVICES

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

Through this renewal contract, **B22528,** the STATE and the MCO have agreed to renew the 2008 Contract, numbered B06797, for the period of January 1, 2009 through December 31, 2009.

The STATE, pursuant to Minnesota Statutes, § 256B.69, subd. 23(b), § 252.46, subd. 21: and § 256B.5016, subd. 1; may implement the demonstration project Minnesota Disability Health Options (hereinafter MnDHO) to create an alternative delivery system for acute and long-term care services including home-and community-based waiver services that integrates Medicare and Medicaid funding for Persons with a Physical Disability who are between the ages of 18 through 64.

The MnDHO service delivery system is designed to: 1) support Enrollees to live independently in the community with necessary medical services and social supports; 2) facilitate a maximum level of Enrollee choice; 3) maximize, to the extent of an Enrollee's ability, the Enrollee's involvement in his or her own care as defined in Minnesota Rules, Part 9505.0335 subpart 1, item A; and 4) focus on the person being served in the context of his or her living situation and disability diagnosis.

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

The STATE has authority to enter into contracts for the provision of prepaid medical and remedial services under Medicaid, pursuant to: 1) Title XIX of the Social Security Act, 42 U.S.C. 1396 et. seq.; 2) 42 CFR § Parts 434 and 438; 3) Minnesota Statutes, § 256B.69 (hereinafter the Prepaid Medical Assistance Program, or PMAP); 4) a Medicaid waiver under § 1915(a) of the Social Security Act; and 5) a Medicare waiver under 1395b-1 of the Social Security Act.

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), the 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 Part D services.

The STATE and the MCO agree to continue to coordinate and share Medicare and Medicaid information about MnDHO Enrollees.

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

Article. 1 Overview. This Contract implements the MnDHO program. MnDHO creates an alternative health care and support services delivery system for people with physical (MnDHO) disabilities age 18 through age 64 who are eligible for Medicaid or Dually Eligible for Medicaid and Medicare.

All references to "days" in the Contract mean calendar days unless otherwise specified in the Contract (e.g. "business days").

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

(1) **638 Facility** means a facility operated by an American Indian tribe or tribal organization rather than by the Indian Health Service pursuant to either a compact or contract between the tribe and the federal government under Public Law 93-638.

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

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

(4) **Adjudicate** means the point at which a claim has reached its final disposition of paid or denied.

(5) **Adult Guardianship** means:

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

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

(6) **Advance Directive** means advance directives as defined in 42 CFR § 489.100.

(7) **American Indian** means those persons for whom services may be provided pursuant to 25 CFR § 900.6.

(8) **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.

(9) **Assessment** means determining the: 1) functioning; 2) health status, including high risk health conditions; 3) living environment; 4) social supports; 5) mental and/or chemical dependency problems; 6) Mental Retardation/Related Condition; and 7) language or comprehension barriers of an Enrollee. This includes, but is not limited to, identifying appropriate services and evaluating effectiveness of services.

(10) **Assistive Technology Device** means any item, piece of equipment or product system, whether acquired commercially, modified or customized, that is used to increase, maintain or improve the functional capabilities of a disabled individual. Assistive Technology Devices may include, but are not limited to, durable medical equipment, and devices designed and/or intended for repeated use that assist and/or support an individual so that they may meet their functional needs.

(11) **Assistive Technology Service** means any service that directly assists an individual with a disability in the selection, acquisition or use of an Assistive Technology Device. Assistive Technology Services include, but are not limited to: 1) assessments; 2) plan development; and 3) device trials, training and evaluation.

(12) **Atypical Services** or **Atypical Provider** means those non-health care 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.

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

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

(15) **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).

(16) **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.

(17) **Care Coordination Services** means coordination of the provision of all Medicare and Medicaid health and long-term care services for each MnDHO Enrollee and coordination of services to an 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.

(18) **Care Coordinator** means the person who provides Care Coordination Services as defined in section 2.16. A Coordinator may be called a "care coordinator," "service coordinator," "resource coordinator" or "health coordinator" provided that the individual performs Care Coordination Services.

(19) **Care Coordination** means the overall method of providing on-going health care in which the MCO manages the provision of primary health care services with additional appropriate services provided to an Enrollee. See section 6.1.3 of the Contract.

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

(21) **Child with a Severe Emotional Disturbance** (SED) means a child with a severe emotional disturbance as defined in Minnesota Statutes, § 245.4871, subd. 6.

(22) **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.

(23) **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.

(24) **CMS** means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

(25) **Commissioner** means the Commissioner of the Minnesota Department of Human Services, or the Commissioner's designee.

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

(27) **Community Alternatives for Disabled Individuals** (CADI) Waiver means the Home and Community-Based Services waiver program, authorized by a

federal waiver under § 1915(c) of the Social Security Act, 42 U.S.C. § 1396n(c), and pursuant to Minnesota Statutes, § 256B.49, for people with disabilities who are at risk of the level of care provided in a Nursing Facility.

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

(29) **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, dentist, or a certified public health nurse operating under the direct authority of an enrolled unit of government

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

(31) **Community Support Plan** means a service plan designed for each Enrollee who is screened and determined to require HCBS waiver services or State plan Home Care Services. The Community Support Plan includes, at a minimum:

(a) The type of services (informal and formal), goods or supports to be furnished to the Enrollee;

(b) The amount, frequency, duration and cost of each good or service;

(c) The type of provider furnishing each service (including non-paid care-givers and other informal community supports or community resources);

(d) Documentation on the services an Enrollee will use to meet his or her needs in order to remain in or return to the community;

(e) A list of safeguards that will reasonably address the Enrollee's health and welfare;

(f) Backup services, contingency plans and emergency services that address potential situations that may arise;

(g) The Enrollee's desired outcomes or result to be achieved as a result of the plan;

(h) Contact information;

(i) All of the elements from DHS Form 4166.

(32) **Comprehensive Care Plan** means a care plan developed based on available information including, but not limited to, issues or needs identified by risk and comprehensive assessments, medical records and/or prior utilization to the extent they are available, and Enrollee and/or family input. The Comprehensive Care Plan shall be based on the results of a health assessment and the LTCC Screening Assessment and will include the Community Support Plan for people receiving Home and Community-Based Services, pursuant to section 6.1.12(E), and a risk management plan. In addition, for Nursing Facility Enrollees, information located at the Nursing Facility should be considered. The Comprehensive Care Plan should incorporate an interdisciplinary/ holistic and preventive focus and include Advance Directive planning and Enrollee participation.

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

(34) **Conversion** means an Enrollee who: 1) has been Institutionalized for at least 180 consecutive days and then moved into a community setting; 2) has received a Preadmission Screening according to procedures in section 6.1.11(A); 3) has been identified in need of Nursing Facility level of care as defined by the Level of Care Criteria; and 4) has been enrolled in MnDHO in the Institutionalized Rate Cell Category for at least one month.

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

(36) **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.49 and 256B.092, and that was provided in accordance with the MCO's Service Delivery Plan and the MCO Certificate of Coverage, as approved by the STATE.

(37) **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 chapter 144D.

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

(39) **Developmental Disabilities (DD) Waiver** means the Home and Community-Based Services waiver program, authorized by a federal waiver under § 1915(c) of the Social Security Act, 42 U.S.C. 1396n(c), and pursuant to Minnesota Statutes, § 256B.092 subd. 4, for people with disabilities who are at risk of the level of care provided in an Intermediate Care Facility for a Person with Mental Retardation or Related Conditions (ICF/MR).

(40) **Developmental Disability** means a condition which meets the definition of Mental Retardation as defined in Minnesota Rules, Part 9525.0016, subpart 2, item B, or

a Related Condition as defined in Minnesota Statute 252.27 Subd. 1a. and Minnesota Rules part 9525.0016 subpart 2, item A.

(41) **Disability Payment System** means the diagnosis classification system used to adjust the acute care portion of the MCO's capitation based on the chronic condition profile of Enrollees.

(42) **Disclosing Entity** means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent as stated in 42 CFR § 455.101.

(43) **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. In addition, this program: 1) supports the physician/patient relationship and place of care; 2) emphasizes prevention of exacerbation and complications utilizing cost-effective evidence-based practice guidelines and patient empowerment strategies such as self-management; and 3) continuously evaluates clinical, humanistic, and economic outcomes with the goal of improving overall health.

(44) **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.

(45) **Emergency Care** means the provision of Covered Services that are required to treat an immediate Medical Emergency as defined at section 2.77.

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

(47) **Enrollee** means a MnDHO eligible person whose enrollment in the MCO has been entered on MMIS. Where this contract confers certain rights or obligations that the individual (or a court of law acting on the individual's behalf) has conferred to a guardian, conservator, legal representative or authorized representative, the use of the terms "Recipient" or "Enrollee" does not preclude the legal or authorized representative from meeting those obligations or exercising those rights, to the extent of the legal or authorized representative's authority.

(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.

(49) **Excluded Time** means Excluded Time as defined in Minnesota Statutes 256G.02 Subd. 6.

(50) **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.

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

(52) **Fraud** means the definition set out in Minnesota Rules, Part 9505.2165, Subpart 4.

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

(54) **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.

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

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

(57) **Home and Community-Based Waiver Services** (HCBS) means services provided under a federal waiver under § 1915(c) of the Social Security Act, 42 U.S.C. 1396n(c), 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 or neurobehavioral rehabilitative hospitalizations.

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

specified in Minnesota Statutes, §256B.0625, subd. 6(a). These services include the following:

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

(b) Skilled nursing visits including telehomecare visits, provided by a certified Home Health Care Agency as authorized by Minnesota Statutes, §256B.0625, subd.6(a) and §256B.0653, subd. 1(a)(4)(b);

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

(d) Durable medical equipment, and associated supplies when accompanied by a home care service as described in Minnesota Statutes §144A.43 subd.4 (10); and

(e) Personal Care Assistance (PCA) services as authorized by Minnesota Statutes, §256B.0655, subd. 2.

(59) **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 § §418.00 et. seq.

(60) **Hospice** means a set of services, as determined by the Medicare program, for individuals with terminal illnesses, authorized under § 1861(dd) of the Social Security Act and defined in 42 CFR § 418.100 et seq.

(61) **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, any payment to: 1) 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.

(62) **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.

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

(64) **Informed Choice** means a voluntary decision made by the Enrollee 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 primary mode of communication.

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

(66) **Institutional Spenddown** means a type of Spenddown for Enrollees who are long term care facility residents. A Spenddown is used for people who have income in excess of the Medical Assistance standard. Please refer to the definition of a Spenddown in section 2.156.

(67) **Institutionalized** means Recipients who are coded in MMIS as being in a Nursing Facility for MnDHO, at the time of enrollment in MnDHO. For changes in MnDHO Rate Cell categories after initial enrollment, Institutionalized Recipients are those MnDHO Enrollees who have been in a Nursing Facility for MnDHO, at capitation.

(68) **Intermediate Care Facility for Persons with Mental Retardation** (ICF/MR) means a program licensed to provide services to Persons with Developmental Disability under Minnesota Statutes, § 252.28 and Chapter 245A, and a physical plant licensed as a supervised living facility under Chapter 144, which together are certified by the Minnesota Department of Health as meeting the standards in 42 CFR § 440.150, for an intermediate care facility which provides services for Persons with Developmental Disability or persons with Related Conditions who require 24-hour supervision and active treatment for medical, behavioral, or habilitation needs.

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

(70) **Legal Representative** means the parent or parents of a person who is under 18 years of age, or a guardian or conservator, or guardian ad litem who is authorized by the court to make decisions about services for a person. Parents or private guardians or conservators who are unable to make decisions about services due to temporary unavailability may delegate their powers according to Minnesota Statutes, § 524.5-426.

(71) **Level of Care Criteria** means classifications and questions developed by the Minnesota Departments of Health and/or Human Services used to determine an Enrollee’s Nursing Facility care needs or the criteria used by the Department of Human Services to determine neurobehavioral hospital level of care for MnDHO.

(72) **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 program.

Local Agency also means a federally recognized American Indian tribe's agency that is responsible for DD, CADI or TBI waiver services.

(73) **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 or for admission to or transitioning out of Nursing Facilities and to offer cost-effective alternatives appropriate for the Enrollee's needs, and to assure appropriate admissions to a Nursing Facility. LTCC assessments shall be completed by a social worker, public health nurse, registered nurse, physician assistant, nurse practitioner or physician.

(74) **Long Term Care Hospital** means a Minnesota hospital or a metropolitan statistical area hospital located outside Minnesota in a county contiguous to Minnesota that meets the requirements under 42 CFR § 412.23(e).

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

(76) **Managing Employee** means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency as defined in 42 CFR § 455.101.

(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 re-enroll in the MCO's product(s) under this Contract.

(79) **Marketing Materials** means materials that: (1) are produced in any medium, by or on behalf of an MCO; and (2) can reasonably be interpreted as intended to influence individuals to enroll or reenroll in the MCO's product(s) under this Contract..

(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; 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); or 3) a change which involves a termination of a sole source Provider where the termination is for cause. Such changes include both Medicare and Medicaid Providers and pharmacy benefit managers (PBM). For purposes of this section,

termination of a Provider for cause does not include the inability to reach agreement on contract terms.

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

(82) **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.

(83) **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 preventative health service is not a Medical Emergency.

(84) **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.

(85) **Medically Necessary** or **Medical Necessity** means, with the exception of CADI and TBI 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) is rendered:

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

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

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

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

(e) A preventive health service defined under Minnesota Rules, Part 9505.0355.

(86) **Medical Spenddown** means a type of spenddown for Enrollees who live in the community and are eligible for Medical Assistance with a medical spenddown. A spenddown is used for people who have income in excess of the medical assistance standard.

(87) **Medicare** means the federal insurance program for aged and disabled people as defined under 42 U.S.C. 1395 et. seq.

(88) **Medicare Advantage (MA) Organization** 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.

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

(90) **Medicare Advantage Special Needs Plan** (MA SNP) means a Medicare Advantage coordinated care plan that: 1) exclusively enrolls, or enrolls a disproportionate percentage of special needs individuals as set forth in 42 CFR § 422.4(a)(1)(iv); 2) provides Part D benefits under 42 CFR § 423 to all Enrollees; and 3) 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.

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

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

(93) **Minnesota Extended Treatment Options** (METO) means the specialized service model created pursuant to Minnesota Statutes, § 252.025, to serve Minnesotans who have a Developmental Disability and exhibit severe behaviors that present a risk to public safety. METO combines extensive outreach and support services with the availability of specialized residential beds so that individuals can be served in the least restrictive setting necessary.

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

(95) **MMIS** means the Medicaid Management Information System.

(96) **Minnesota Disability Health Options** (MnDHO) means the Minnesota prepaid managed care program, pursuant to Minnesota Statutes, § 256B.69, subd. 23, that is an alternative delivery system for acute and long-term care services, including home- and community-based waiver services, that provides Medicaid services and/or integrated Medicare and Medicaid services for persons with a physical or developmental disability who are ages eighteen (18) through sixty-four (64).

(97) **Minnesota Senior Care** (MSC) is the mandatory PMAP program for Enrollees age sixty-five (65) and over. MSC uses §1915(b) waiver authority for state plan services, and, as applicable, §1915(c) waiver authority for Home and Community-Based Services.

(98) **Minnesota Senior Care Plus** (MSC+) 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.

(99) **Minnesota Senior Health Options** (MSHO) means the Minnesota prepaid managed care program, pursuant to Minnesota Statutes, § 256B.69, subd. 23, that provides Medicaid services and/or 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.

(100) **MnDHO Rate Cell Categories** means the Rate Cell Categories (RCCs) that are based on the Enrollee living arrangement and Nursing Home Certifiable (NHC) status included in the MnDHO rate setting model. Every MnDHO Enrollee will be assigned to one of these twenty-one (21) categories, upon which payments to the MCO will be based:

Living Arrangement	Rate Cell Category
Community Non-NHC	A
Community NHC	B, E, I, J
Community NHC – Conversions	K, N, R, S
Nursing Facility	U

(101) **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.

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

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

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

(105) **Nursing Facility Resident** (NFR) means a Recipient who is coded as being in a Nursing Facility living arrangement in MMIS at the time of requested enrollment in MnDHO. For MnDHO, changes in MnDHO Rate Cell Categories after initial enrollment, NFR Recipients are those MnDHO Enrollees who have been residing in the Nursing Facility for thirty (30) consecutive days.

(106) **Nursing Home Certifiable** (NHC) means a designation indicating that an Enrollee is in need of Nursing Facility level of care as defined by the Minnesota Departments of Health (MDH) and Human Services 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 6.1.12(G).

(107) **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.

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

(109) **Ownership Interest** means the possession of equity in the capital, the stock, or the profits of the Disclosing Entity.

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

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

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

Disclosing Entity (if it is organized as a corporation) or is a partner in the MCO or the Disclosing Entity (if it is organized as a partnership).**Person with Developmental Disability** means a person who has been determined by the Local Agency to have a Developmental Disability and has a condition which meets the definition of Developmental Disability or Related Condition as defined in Minnesota Rules Part 9525.0016 subpart 2, item B, or a Related Condition as defined in Minnesota Statutes, § 252.27 subd. 1a, or in Minnesota Rule Part 9525.0016 subpart 2, item A.

(116) **Person with Physical Disability** means a person who: 1) has been certified disabled by the Social Security Administration (SSA) or the State Medical Review Team (SMRT); and 2) has a physical disability resulting in a chronic condition requiring ongoing treatment; and 3) does not have autism, Prader-Willi Syndrome, or other conditions as defined in Minnesota Rules, 9525.0016, subpart 2, items B, C and D.

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

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

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

(120) **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 a MnDHO MCO.

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

(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 pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

(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.

(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).

(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), including, but not limited to, improper and/or unauthorized use or disclosure of Protected Information, and incidents in which the confidentiality of the information maintained by it has been breached.

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

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

(b) Medical records (as governed by the Minnesota Health Records Act [Minnesota Statutes, §144.335]);

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

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

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

(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.

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

(129) **Qualified Professional** means a licensed social worker, registered nurse, physician assistant, nurse practitioner, public health nurse or physician.

(130) **Rate Cell** means the category attributed to an Enrollee to determine the monthly prepaid Capitation Payment that will be paid by the STATE and CMS to the MCO for health coverage of that Enrollee. A Rate Cell is determined based on Rate Cell determinants, which may consist of all or a part of the following, consistent with MMIS requirements: 1) county of residence; 2) living arrangement; and 3) Medicare status. For MnDHO, it may also include Nursing Home Certifiability or CADI and TBI waiver status.

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

(133) **Related Condition** means a condition defined by Minnesota Statutes, § 252.27, subd. 1a and Minnesota Rules part 9525.0016 subpart 2, item A.

(134) **Related Condition Checklist** means the DHS-developed Form # 3848.

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

(a) Requiring that for a period of twenty-four (24) or thirty-six (36) months of eligibility the Enrollee must obtain health services from:

(i) a designated Primary Care Provider located in the Enrollee's or Recipient's local trade area, a hospital used by the primary care

provider, a pharmacy, or any other designated health service Provider, including a Minnesota Health Care Program (MHCP) enrolled Personal Care Provider Organization (PCPO) or Medicare certified Provider; or

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

(c) Consumer Directed Community Support Services are not available to an individual or their representative who has at any time been restricted by the Restricted Recipient Program for fraud or abuse of public funds.

(136) **Rural Area** means any area other than an urban area, as an urban area is defined in 42 CFR § 412.62(f)(1)(ii).

(137) **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.

(138) **Serious and Persistent Mental Illness** means a condition which meets the criteria defined in Minnesota Statutes, § 245.462 Subd. 20(c).

(139) **Service Area** means the Counties of Minnesota in which the MCO agrees to offer coverage under this Contract. See **Exhibit** I- MCO Service Areas.

(140) **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.

(141) **Significant Business Transaction** means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and five percent (5%) of the Disclosing Entity's operating expenses.

(142) **Skilled Nursing Facility** (SNF) means a facility that is 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.

(143) **Special Needs BasicCare** (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).

(144) 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.

(145) **STATE** means the Minnesota Department of Human Services or its agents and the Commissioner.

(146) **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: 1) the delivery of health services by or participation in the MCO; 2) denial (full or partial) of a claim or service by the MCO; 3) failure by the MCO to make an initial determination in thirty (30) days; or 4) any other Action.

(147) **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.

(148) **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.

(149) **Traumatic Brain Injury (TBI) Waiver** means the Home and Community-Based Services waiver program, authorized by a federal waiver under § 1915(c) of the Social Security Act, 42 U.S.C. 1396n, and pursuant to Minnesota Statutes, §§ 256B.0915, 256B.093 and 256B.49, for people with acquired or traumatic brain injury who are at risk of the level of care provided in specialized nursing facilities or neurobehavioral hospitals.

(150) **Unique Minnesota Provider Identifier** (UMPI) means the unique identifier assigned by the STATE for atypical Providers that are not eligible for a NPI. See also definition (101) above.

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

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

3.1 Eligibility and Enrollment Duties .

3.1.1 Eligibility .

(A) **Service Area**. Only those eligible persons residing within the Counties of the State of Minnesota identified in Exhibit I – MCO Service Areas shall be eligible for enrollment in MnDHO.

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

(C) **Eligibility Determination**. Eligibility for Medical Assistance will be determined by the Local Agency. Eligibility for Medicare will be determined by CMS.

(D) **Enrollment Exclusions**. The following populations are excluded from enrollment in the MCO for MnDHO:

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

(2) Residents of State Regional Treatment Centers, unless the MCO approves placement. For purposes of this Contract, approval by the MCO would include a placement that is court-ordered within the terms described in section 6.1.22(C). For purposes of this section the Woodhaven Senior Community is not considered a state institution.

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

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

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

(6) Persons up to eighteen years of age, or over age sixty-five (65) and not already enrolled in MnDHO.

(7) Undocumented and non-immigrant non-citizen Medical Assistance Recipients who are eligible only for emergency Medical Assistance under Minnesota Statutes, § 256B.06, subd. 4.

(8) Non-citizens eligible for Medical Assistance according to Minnesota Statutes, § 256B.06, subd. 4(e), under program "N".

(9) Any person committed to a regional treatment center with a diagnosis of sexual psychopathic personality as defined by Minnesota Statutes, § 253B.02, subd. 18b, or a diagnosis of sexually dangerous person as defined by Minnesota Statutes, § 253B.02, subd. 18c.

(10) Persons living in a long-term care hospital or rehabilitation hospital. These individuals may be eligible to enroll upon discharge, if they meet the other eligibility criteria.

(11) Persons with a diagnosis of End Stage Renal Disease (ESRD) prior to enrollment in the MCO.

(12) Enrollees who become Medicare eligible after enrollment in the MCO and who refuse to receive their Medicare benefits through the MCO.

(13) Persons who are eligible for Medicare Part A only, or Medicare Part B only.

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

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

(16) Any person with a certified disability, who has autism, Prader-Willi Syndrome, or other conditions as defined in Minnesota Rules, part 9525.0016, subpart 2, items B, C and D.

(17) Any person certified as SPMI, unless the person also has a Physical Disability as defined in section 2.112.

(18) Any person with a Developmental Disability or a Related Condition as determined by the local agency.

(19) Any person receiving services under the Developmental Disability Waiver.

(20) Any person living in an Intermediate Care Facility (ICF).

(21) Any person receiving services under the Elderly Waiver program.

(22) Any person receiving services under the Community Alternative Care (CAC) waiver program.

(E) **MnDHO Eligibility Determinations**. In order to be eligible to enroll in the MCO for MnDHO, the individual must:

(1) Be age eighteen (18) through age sixty-four (64), or over 64 if already enrolled prior to reaching 65th birthday; and

(2) Be eligible for Medical Assistance; and

(3) Be residing within the MnDHO Service Area for the appropriate program; and

(4) Have a certified disability through the Social Security Administration (SSA) or the State Medical Review Team (SMRT); and

(5) Be a Person with a Physical Disability as determined by an initial assessment and/or utilization experience as reflected in the STATE's MMIS, and has been OBRA I screened.

(F) **Additional Eligibility Parameters**.

(1) **Nursing Facility and Community Residents**. For MnDHO, community and Nursing Facility Residents, persons receiving Inpatient Hospital Services and persons living in the community are eligible to enroll in the MCO.

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

(3) **End Stage Renal Disease (ESRD)**. Enrollees who are identified by CMS as having ESRD after enrollment in MnDHO are not required to disenroll from the MCO's MnDHO product.

(4) **Spenddown**. Medical Assistance Recipients who otherwise meet all the enrollment requirements for MnDHO are eligible to enroll in the MCO if they agree to pay their Spenddown as required on a monthly basis. Payment of the Spenddown obligation for the first month after enrollment is waived for the new Enrollee. The value of the first month Spenddown obligation is deducted from the Capitation Payment.

(5) **MnDHO Enrollees Over Age 65**. MnDHO Enrollees who enrolled in the MCO's MnDHO product before reaching age 65 may remain enrolled in the MCO's MnDHO product after reaching age 65 if they do not lose Medicaid eligibility. If they do not have a Spenddown, these Enrollees may also choose to enroll in the MCO's MSHO or MSC+ products. Enrollees with a Spenddown may choose to return to FFS.

(6) **Persons in Excluded Time**. Persons with a disability who establish Medicaid eligibility in one county and then move to another county may be considered to be in Excluded Time, if they are receiving designated

Excluded Time services or reside in a designated Excluded Time facility. Persons in Excluded Time as defined in this section may enroll in MnDHO.

(7) **County of Residence**. Eligibility is based on county of residence. Persons in Excluded Time status will be eligible to enroll in the product as long as they continue to reside in the MCO Service Area and meet eligibility criteria. The capitation rate for an Enrollee in Excluded Time will be based on the Enrollee's current county of residence.

(8) **Waiver Status**. Persons with a Physical Disability who are currently receiving services under the Traumatic Brain Injury (TBI) waiver or the Community Alternatives for Disabled Individuals (CADI) waiver are eligible to enroll in MnDHO. Persons who are receiving services under the Elderly or DD Waivers are not eligible to enroll in MnDHO.

(9) **Medicare Status**. Only Medicare eligibles who are eligible for both Medicare Parts A and B, or Recipients who are eligible for Medical Assistance without Medicare, may enroll.

3.1.2 Enrollment.

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

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

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

(D) **MCO Enrollment Responsibilities**. The MCO shall:

(1) Maintain records of all persons who inquire about MnDHO, and who reasonably appear to be eligible for the program, including but not limited to the individual's enrollment outcome, and shall at the request of the STATE make this information available.

(2) Assure that prospective Enrollees are eligible for Medical Assistance by checking the Medicaid eligibility verification system (EVS) before having the Recipient complete an enrollment form. Persons who are found to be ineligible for Medical Assistance are ineligible for enrollment in MnDHO.

(3) Prior to submitting or entering an enrollment form to the STATE, the MCO must verify 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.

(4) The MCO must ensure that appropriate MCO staff has access to the MN-ITS and appropriate Medicare eligibility and managed Care Systems as directed by the STATE and CMS including MARx.

(5) Have Recipients sign an enrollment form which incorporates a “Statement of Informed Enrollment and Enrollee Rights” prior to conducting

(a) Long Term Care Consultation (LTCC) and OBRA Level 1 screening or development of the Comprehensive Care Plan. This Statement of Informed Enrollment shall include, but is not limited to the following:

(b) An explanation that the Enrollee is assigning their Medicaid benefits, and for Dual Eligibles also their Medicare benefits, to the MCO.

(c) The Enrollee’s right to disenroll on a monthly basis and that upon disenrollment from MnDHO, they will return to the fee-for-service program, unless they are otherwise required to enroll in PMAP.

(d) Unless requested by the Enrollee, the MCO may not disenroll any Enrollee who is part of the eligible population, as long as the Enrollee meets enrollment criteria.

(6) For Enrollees who become eligible for Medicare coverage after enrollment in the MCO, the MCO must obtain a signature on the STATE’s supplemental enrollment application. This application must be received by the STATE within sixty (60) days of the initial payment of a Medicare capitation payment to the MCO by CMS.

(7) The MCO agrees to retain Medicare eligible Enrollees for three months after they lose Medicaid eligibility in the MCO, as part of the MCO’s Medicare Special Needs Plan enrollment.

(E) **Enrollment Limitation**.

(1) The STATE may limit the number of Enrollees in the MCO if in the STATE or CMS’s judgment, or by MCO request, 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 MnDHO products.

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

(F) **Voluntary Enrollment**. Recipient enrollment in the MCO for the MnDHO program shall be voluntary.

(G) **Enrollee Change of MCO**. If multiple MCOs are available, Enrollees may change to a different MCO at any time. Enrollment in the MCO will be effective as set forth under this section in (L).

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

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

(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 administrative sanctions pursuant to section 8.8.

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

(L) **Effective Date of Coverage for Mn DHO**. MCO coverage of Enrollees shall commence as follows:

(1) 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. Enrollment received after capitation must be submitted directly to the STATE.

(2) If a MnDHO Enrollee is hospitalized in a long term care hospital on the first of the month in which MnDHO enrollment is effective, the effective date of coverage will be postponed until the first day of the month following discharge from the hospital.

(3) If a MnDHO Enrollee is hospitalized in Bethesda Neurobehavioral Unit on the first of the month in which MnDHO enrollment is effective, the effective date of coverage will be the first day of the month. The daily per diem charge for the hospital stay will not be the responsibility of the MCO, if the Enrollee belonged to a different MCO or obtained his or her care in

the Fee-For-Service system prior to enrollment. The MCO will be responsible for payment of all ancillary services beginning on the effective date of coverage.

(4) MnDHO enrollees receiving Inpatient Hospitalization services will be enrolled in accordance with 3.1.2(L)(1). All charges related to Inpatient Hospitalization for any MnDHO Enrollee who is receiving Inpatient Hospitalization services on the effective date of coverage will not be the responsibility of the MCO.

(5) If an Enrollee disenrolls from MnDHO and is required to enroll in PMAP, but is hospitalized on the first of the month when PMAP enrollment is effective, the effective date of coverage will be postponed until the first day of the month following the month of discharge from the hospital.

(6) **Inpatient Hospitalization for Chemical Dependency Services and Enrollment**.

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

(7) For MnDHO Duals receiving inpatient hospital based CD services, or are in a Residential Treatment Facility (Rule 31), at the time of enrollment in the MCO, enrollment will not be delayed. Financial responsibility of the MCO is as follows:

(i) For the Contract Year, the MCO will be financially responsible for inpatient hospital based CD services unless these services are covered by Medicare.

(ii) 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.

(M) **Enrollment Forms**. Original enrollment forms and any Medicare assignment supplemental forms shall be maintained by the MCO.

(N) **Supplemental Enrollment Application**. For Enrollees who become eligible for Medicare coverage after enrollment in the MCO, the MCO must obtain a signature on the MCO’s supplemental enrollment application that will be mailed by the MCO, as determined by the TPA contract and procedures.

(O) **Screening Document Entry**. The MCO will be responsible to enter all Screening Documents into MMIS for all MCO performed screenings, for the

purpose of determining Rate Cell and payment. The MCO may enter the Screening Documents, or may contract with subcontractors who will be responsible for entering Screening Documents into MMIS. Approved Screening Documents must be entered into MMIS prior to Cut-Off Dates.

(1) 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.

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

(3) 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. "Blue Zone" is an internet-based application.

(4) The MCO shall be responsible for entering initial LTCC Documents, and reassessments for all Enrollees, and telephone screenings for nursing home placements.

(P) STATE and CMS MnDHO Enrollment; TPA Functions

(1) Enrollment in MnDHO for Medicaid in MMIS will be performed by the STATE. Assignment of Rate Cell Categories will be done by the STATE. The STATE will continue to be available to provide enrollment TPA services to the MnDHO MCOs. The charge and scope of duties for this TPA service will be negotiated in a separate agreement between the MCO and the STATE. These duties will include, but not be limited to the submission of Medicare SNP enrollment to CMS on a monthly basis.

(2) To facilitate coordination of SNP Medicare enrollment with MnDHO Medicaid enrollment, the MCO must perform the following functions when a TPA agreement exists between the MCO and the STATE:

(a) Appoint a security liaison and staff for enrollment keying.

(b) Continue to grant STATE MARx User Representative Access.

(c) Give STATE access to Gentran Mailbox (a server which provides Electronic Data Interchange (EDI) capabilities to CMS and supports the transfer of files to and from CMS with CMS business partners).

(Q) **Reinstatement in MnDHO**. 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/her Medical Assistance eligibility and such eligibility is entered into MMIS by the last business day of the month.

(S) **Reenrollment in MnDHO**. A MnDHO Enrollee who loses Medical Assistance eligibility for not more than three months, or any break of time within a three month period, may be re-enrolled for the month following disenrollment and subsequent months in the same MCO without completing a new enrollment form. Upon re-enrollment, the STATE may update the Enrollee's Rate Cell category using information from the MCO, Care System, or MMIS/MAXIS. For MnDHO, 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.

(U) **Call Prior to Renewal**. The MCO shall place a follow-up renewal call to each Enrollee at least sixty (60) days prior to the Enrollee's eligibility renewal date as authorized by Minnesota Statutes, § 256.962, subd. 7(b), utilizing eligibility renewal data provided by the STATE.

(W) **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 3.2.12(B) 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 this requirement. Additional enrollment parameters for MCOs who contract with the STATE for TPA services are subject to the terms and conditions of the separate TPA contracts.

(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) Be free from any form of aversion or deprivation procedures as described in Minnesota Rules, parts 9525.2700 through 9525.2810.

(G) 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.

(H) Be provided with health care services and, as applicable, Home and Community-Based Services, in accordance with 42 CFR § 438.206 through 438.210.

(I) 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.

(J) Assistance in identifying services needed to maintain the Enrollee in the least restrictive setting, pursuant to Minnesota Statutes, § 256B.0911, Subd. 1a(a)(4).

(K) Be offered a choice of institutional or Home and Community Based Waivered Services and choice among Providers, whenever possible.

(L) Be offered choice in types of Home and Community Based Waivered Services and choices among Providers, whenever possible.

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

3.2.1 Compliance with Title VI of the Civil Rights Act . Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et. seq. and 45 CFR § Part 80 provide that no person shall be subjected to discrimination on the basis of race, color or national origin under any program or activity that receives Federal financial assistance and that in order to avoid discrimination against persons with limited English proficiency (LEP) and for LEP persons to have meaningful access to programs and services, the MCO must take

adequate steps to ensure that such persons receive the language assistance necessary, free of charge. The MCO shall comply with the recommendations of the revised Policy Guidelines published on August 8, 2003 by the Office for Civil Rights of the Department of Health and Human Services, titled "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (hereinafter "Guidance" and "LEP") and take reasonable steps to ensure meaningful access to the MCO's programs and services by LEP persons, 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. (P.L. 101-336. Americans with Disabilities Act of 1990, 42 U.S.C., § 1210, et. seq.)

(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 visual impairment or 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 711, or through the Minnesota Relay Service at 1-877-627-3848 (speech to speech relay service)," or similar language approved by the STATE pursuant to section 3.2.5.

3.2.3 Requirements for Written Information.

(A) **Written Information**. The MCO will make available written material, including Marketing and enrollment materials, and member handbooks. Written material for MnDHO will include both Medicare and Medicaid information. 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 a 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 targets 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 Services (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 General Marketing. The MCO shall participate with the STATE in the development of general Marketing Materials, member materials and enrollment materials.

3.2.5 CMS and STATE Review Process for MnDHO. The MCO shall present to the STATE for approval all Marketing Materials for MnDHO that the MCO or its subcontractors plan to undertake solely related to MnDHO during the contract period prior to the MCO's use of such Marketing Materials. All Enrollee education and Marketing Materials for MnDHO, including but not limited to Marketing scripts for such activities as presentations or radio advertisements, posters, brochures, Internet web sites, any materials which contain statements regarding the benefit package, and Provider network-related materials, must be prior approved by the STATE and CMS. Internet web

sites that merely link to the DHS web site for information do not need prior approval. If the Marketing Materials target American Indian Recipients, the STATE shall consult with tribal governments within a reasonable period of time before approval. Such approval by the STATE shall not be unreasonably withheld or delayed. The MCO must submit all materials, including Medicare and Part D materials, for review in a final version to the STATE. 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. Upon receiving STATE approval of MnDHO materials, the MCO is responsible for submitting materials 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 STATE shall review Medicaid only materials.

3.2.6 If Care Coordination is delegated to an organization with disability expertise, Marketing and enrollment Materials for this product must include specific information on how to contact the Care Coordination organization, and be reviewed by the Care Coordination organization.

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

3.2.8 Direct Marketing

(A) The MCO may do direct Marketing of its MnDHO product to MnDHO-eligible individuals. Direct Marketing includes, but is not limited to, mailings, promotions, individual and group meetings, activities supervised by licensed sales staff and actual enrollment conducted by licensed sales staff, consistent with Medicare regulations. If the MCO directly markets to MnDHO-eligible individuals within a given service area, it must market to both institutional and community MnDHO-eligible individuals.

(B) All Marketing activities and Materials must be Prior Approved in writing by the STATE and CMS before use or implementation. The MCO may not use subcontractors to market MnDHO to MnDHO-eligible individuals not currently enrolled in the MCO.

3.2.9 Notices to Recipients . For MnDHO, the STATE may send notices to all MnDHO-eligible Recipients who reside in the Service Area, at MCO expense. The MCO's notices must not contain false or materially misleading information.

3.2.10 Marketing Standards and Restrictions.

(A) 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 a MnDHO 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 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 MnDHO 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 Enrollees.

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

(B) **Enrollment Requirements**. In its Marketing, the MCO must establish and maintain a system for confirming that enrolled Recipients have in fact enrolled in the MCO and understand the rules applicable under the plan.

3.2.11 Other Publications.

(A) The MCO, acting indirectly through the publications and other material distributed by the Local Agency or the STATE, or through mass media advertising (including the Internet), may inform Recipients who reside in the Service Area as defined in Exhibit I**Error! Reference source not found.** of this Contract of the availability of medical coverage through the MCO, the location and hours of service and other plan characteristics. The MCO may also distribute brochures and display posters at physician offices and clinics, informing patients that the clinic or physician is part of the MCO's Provider network. All posters, brochures and Provider network-related materials must be Prior Approved by the STATE and CMS in accordance with section 3.2.5.

(B) 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.

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

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

3.2.12 Enrollee and Potential Enrollee Information.

(A) **Prior Approval Required**. The MCO agrees that the integrated Medicare (including Part D) and Medicaid Certificate of Coverage (COC)/Evidence of Coverage (EOC) sent to each MCO Enrollee and all Marketing Materials, plans, procedures, mailings, enrollment forms and their revisions, which are designed for Recipients shall be used only after receiving approval in accordance with section 3.2.5. The MCO must revise its COC for all substantial changes in its Complaint and Appeals procedures, and its health care delivery systems, including changes in procedures to obtain access to or approval for health care services. All revisions to the Certificate of Coverage must be approved in writing by the STATE and CMS in accordance with section 3.2.5 and must be issued to Enrollees prior to implementation of the change.

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

(1) **Certificate of Coverage (COC)**. A Certificate of Coverage (COC) that has been Prior Approved by the STATE and that includes the following:

(a) A statement that Enrollees are accountable to make efforts to maintain their health and inform their coordinator and health care Providers of changes in their health.

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

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

(d) Cost sharing, if applicable.

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

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

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

(h) 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.

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

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

(k) The COC must also include a notice that MnDHO Enrollees who are eligible for CADI or TBI waiver programs may retain their eligibility for these programs should they disenroll from MnDHO, if the county has a waiver slot available and if the Enrollee meets county or State eligibility criteria.

(l) A description of how transportation is provided.

(2) **Provider Directory**. An integrated Medicare and Medicaid Provider directory which lists the contracted Providers within the MCO's network, including Care Systems, specialty and sub-specialty Providers, hospitals, nursing homes, and emergency settings. Names, locations, and telephone numbers must be included. For Provider directories developed in Contract year 2009, the MCO must include a statement on how an Enrollee can request a listing of home care agencies and Personal Care Provider Organizations (PCPOs). The MCO must describe the network of Home and

Community-Based Services Providers and Care Systems (e.g., use of any county-approved Provider), and how to access them, including a toll-free phone number that Enrollees can call for more information. The directory shall also indicate those current Participating Providers who speak a non-English language. For hospitals, MCOs should list only the languages spoken by on-site interpreter staff. The MCO must identify any Participating Provider that is not accepting new patients. The Provider directory shall be updated annually and shall include a phone number where an Enrollee may call to verify or receive current information. The information required by this section may also be listed on the MCO's website.

(3) If not included in the directory referenced in (2), then the MCO must provide a list of Waiver service providers who are available to eligible Enrollees based on the Enrollee's place of residence. This Waiver service provider list shall be updated annually and shall include a phone number where an Enrollee may call to verify or receive current information.

(4) **Pharmacy Directory**. An integrated Medicare and Medicaid pharmacy directory.

(5) **Membership Card**. An integrated Medicare and Medicaid membership card that conforms to the requirements in Minnesota Statues, § 62J.60 subd. 3 and has been approved by the STATE prior to printing, that 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. The card may include data elements required by CMS for Medicare eligible Enrollees.

(6) **Access to Service**. A description of how the Enrollee may obtain services, including: 1) hours of service; 2) appointment procedures; 3) Service Authorization requirements and procedures; 4) what constitutes Medical Emergency and Post Stabilization care; 5) the process and procedures for obtaining both Medical Emergency and Post Stabilization care, including a 24-hour telephone number for Medical Emergency Services; and 6) procedures for Urgent Care, and Out of Plan care and how Enrollees may access Home and Community-Based Services. The MCO must indicate that Service Authorization is not required for Medical Emergencies and that the Enrollee has a right to use any hospital or other setting for Emergency Care. If the MCO does not allow direct access to specialty care, the MCO must inform Enrollees the circumstances under which a referral may be made to such Providers.

(7) **Toll-Free Numbers**. 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.

(8) **Coordinator Information**. The name and telephone number of the coordinator assigned to the Enrollee.

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

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

(b) The right to file Grievances and Appeals.

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

(d) The availability of assistance in the filing process.

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

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

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

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

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

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

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

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

(13) 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.

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

(C) **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.

(D) **Primary Care Network List (PCNL)**.

(1) **Specifications**. The MCO will provide a Primary Care Network List (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 to educate consumers. The MCO's Primary Care Network List must also include information on how to access Home Care, CADI, and TBI services, as applicable, and must be Prior Approved by the STATE and CMS in accordance with section 3.3.5. The document must be printed on a grade of paper that is equivalent to bond

paper that is not less than nineteen (19) pound bond but not greater than twenty (20) pound bond. If the PCNL has a cover, the grade of paper may be on un-coated offset paper or on glossy paper. The paper must be 8 ½" x 11" or 17" x 11". A 17" x 11" document must fold to 8 ½" x 11". The document must contain the following information:

(a) A list of Participating Providers with addresses and phone numbers including clinics, Primary Care physicians, specialists, hospitals, nursing homes, and Care Systems Providers. 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 may list other affiliated Providers and their addresses or provide a phone number where a Potential Enrollee may call to obtain the information. The information required by this section may also be listed on the MCO's web site. All Primary Care Providers and dental Providers, when the Enrollee must select a primary dental Provider, must be numbered using a numeric code of up to seven digits.

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

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

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

(e) A description of the MCO's MnDHO Care Systems, Care Coordination systems and any other distinguishing information that will assist the Enrollee in making a decision to enroll in the MCO's MnDHO product.

(f) 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.

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

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

(i) 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.

(j) 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:

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

(ii) If 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 provide a PCNL. The MCO must update the PCNL as necessary to maintain accuracy, particularly with regard to the list of Participating Providers but not less than twice per year. The PCNL and all revisions to it must be submitted to the STATE along with a cover letter detailing all changes in the PCNL. The PCNL must be approved in writing by the STATE and CMS before being distributed by the MCO. Such approval by the STATE shall not be reasonably withheld.

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

(F) **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.

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

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

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

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

3.2.13 Recipient Education .

(A) The STATE or the Local Agency will inform Medical Assistance Recipients who reside in the Service Area of the options available in health care coverage. The STATE or Local Agency shall describe through presentations and/or written materials the various MCOs available to Recipients in a particular geographic area. The STATE, Local Agency and/or MCO shall complete enrollment of Recipients by obtaining the signature of Recipients or their Authorized Representatives on the enrollment form. Tribal governments may assist the STATE or Local Agency in presenting or developing materials describing the various MCO options for their members. If the tribal government revises any MCO materials, the MCO may review them prior to distribution. If the MCO deems the revisions to be substantial, the MCO shall have thirty (30) days to respond to the tribal government and no MCO materials will be distributed until there is mutual agreement on the revisions.

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

(C) Enrollment Education. The MCO, or its subcontractors, is not prohibited from providing information to Recipients eligible for MnDHO for the purposes of educating Recipients about Provider choices available through the MCO, subject to the Marketing Standards and Restrictions in section 3.2.10.

(D) MCO staff shall make available to Recipients the information about Providers as specified in section 3.2.12(B)(2)

(E) If a Recipient currently receives Community Alternative Care Waiver (CAC) services, the MCO shall inform the Recipients in writing that, by leaving CAC

to enroll in MnDHO, the Recipient may not be able to later re-enroll back into CAC.

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

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

(1) **Notice to STATE**. The MCO must notify the STATE of a possible Material Modification in its Provider network within ten (10) working days from the date the MCO has been notified of the possibility that a Material Modification is likely to occur. A Material Modification shall be reported in writing to the STATE no less than one hundred and twenty (120) days prior to the effective date or within two (2) working days of becoming aware of it, whichever occurs first. 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 that 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 the Enrollee must choose a new Primary Care Provider from the MCOs remaining choices or

(b) that the Enrollee has been reassigned from a terminated sole source Provider; and

(c) In either case, the Enrollee has the opportunity to disenroll at any time. 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 clinic 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 Provider clinic Providers; 2) Enrollee may self-refer to a physician specialist; 3) Enrollee must choose one Primary Care Provider clinic Provider; and 4) Enrollee must receive a referral to a physician specialist from his or her

Primary Care Provider clinic Provider. For the purposes of this section, a substantive change in the method of Provider access shall not include the addition or deletion of Service Authorization requirements for services.

(C) **Network Stability**. The MCO shall provide the same network of Providers for all MnDHO Enrollees covered under this contract. The MCO shall assure that Primary Care Provider clinics are educated and understand the product covered by this contract prior to listing the clinic in the PCNL.

(D) **Contract with CMS for Special Needs Plan**. The MCO shall notify the STATE 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. The MCO shall inform the STATE regarding significant changes in its Medicare Program or the administration of Medicare Programs, in order to facilitate operating MnDHO in as fully integrated a manner as possible.

(E) **Changes in Medicare Special Needs Plan**. The MCO will notify the STATE of changes, including terminations of SNP plans, changes in type of SNP approved or applied for, denial of a SNP application or failure to meet the CMS Low Income Subsidy (LIS) requirements, a CMS decision to conduct a Federal investigative audit that may lead to the termination of the SNP, or within thirty (30) days of such actions for any SNP that may enroll Dual Eligibles. The MCO also agrees to inform the STATE of any requests to CMS for service area changes in its SNP(s) service area 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 and within fifteen (15) days of receipt of notice from CMS, whichever is applicable.

(F) **Additional Benefits and Premiums**. The MCO/SNP will notify the STATE of proposed changes with the understanding that the STATE will not share this information unless required to do so by law. The process of notification is as follows:

(1) Prior to the submission of annual Medicare Advantage bids to CMS, the MCO/SNP will consult with the STATE about any changes in proposed Plan Benefit Packages (PBPs), including 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.

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

3.2.15 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 provide the following information to the STATE:

(A) Date the Participating Provider is no longer be available to Enrollees;

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

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

(D) Remedy offered by MCO to alleviate the situation.

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

3.3 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 .

3.4.1 Voluntary Disenrollment from MnDHO. The Enrollee may disenroll from the MCO's MnDHO 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 3.5.4. Additional conditions for disenrollment include:

(A) If the Enrollee disenrolls from the MCO's MnDHO product, the Enrollee shall return to the Medical Assistance fee-for-service system.

(B) If the Enrollee is sixty-five (65) or older and does not have a Medical Spenddown, the Enrollee must enroll in MSC+ or MSHO.

(C) If the Enrollee is sixty-five (65) or older and has a Medical Spenddown, the Enrollee must return to Medical Assistance fee-for-service or enroll in MSHO.

(D) If the Enrollee is under age sixty-five (65) and has a Medical Spenddown, the Enrollee must return to Medical Assistance fee-for-service upon disenrollment.

3.4.2 Voluntary Disenrollment. The Enrollee may voluntarily disenroll and thereby terminate from the MCO's MnDHO product at the end of a thirty (30) day period of

consecutive enrollment. Except as provided in this section 3, the MCO may not orally or in writing or by any action or inaction encourage a MnDHO 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.

3.4.3 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.

(B) The Enrollee becomes ineligible for Medicare Part A or Part B. If the Enrollee loses eligibility for both Parts A and B but remains eligible for Medical Assistance, the Enrollee remains eligible for MnDHO.

(C) 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.

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

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

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

(G) The Enrollee elects to change MCOs as described in 42 CFR § 422.62.

(H) This Contract is terminated for any reason by the federal government.

(I) The Enrollee engages in disruptive behavior as described in 42 CFR § 422.74 and the process described has been followed.

(J) The Enrollee does not pay the Medical Spenddown for three consecutive months directly to the State.

(K) MnDHO Enrollees rejected by CMS will be re-enrolled into Fee For Service Medical Assistance (FFS) unless the Enrollee is sixty-five (65) years or older and has no Spenddown, in which case the Enrollee will be enrolled in MSC+. The capitation will be reprocessed in these instances.

3.4.4 Termination by MCO. The MCO may not request disenrollment of an Enrollee for any reason, except as described in section 3.4.3.

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

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

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

(C) When termination takes place while the Enrollee is receiving Inpatient Hospitalization services, inpatient costs shall be the responsibility of the MCO.

(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, coverage of hospital only costs shall cease at midnight, Minnesota time, on the first day of the month following discharge from the hospital.

3.4.6 Notice to STATE of Enrollee Moving. The MCO shall provide the STATE notice when the MCO knows that an Enrollee is moving out of the Service Area. The MCO shall provide this notice in the same calendar month that the MCO discovers the Enrollee is moving.

3.5 Reporting Requirements. In all cases where reporting requirements for MnDHO are met by meeting the requirements for MSHO, the MCO's MSHO reports shall include MnDHO Enrollees, if appropriate, and consideration of MnDHO as a unique product.

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 § 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 MnDHO Enrollees detailing all Medicare and Medicaid medical and dental diagnostic and treatment encounters, all pharmaceuticals including Medicare Part D covered items, supplies and medical equipment dispensed to Enrollees, Nursing Facility services, Home Care Services, and Home and Community-Based services for which the MCO is financially responsible. Encounter data shall include all paid lines associated with a claim, and include in the encounter submission 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 and specified HCBS Waiver Services, inpatient and outpatient hospital services, Nursing Facility 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 or federal requirements, including the requirements to submit charge data and to use the standard 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 procedures codes, bill type, place of service, dates of services and accurate Provider numbers (See the "837 Data Companion Guides" 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 Medicaid 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, affiliation 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) All encounter data for Nursing Facility and Skilled Nursing Facility services must be submitted according to procedures as prescribed by the STATE in the EDI specifications document titled "Minnesota Health Programs Encounter UB92/LTC Electronic Billing Instructions," dated September 1998. Also see the Long Term Care (LTC) Facilities Provider Update #161, dated August 21, 2003.

(8) 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.

(9) 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.

(10) The MCO agrees to participate in a workgroup with the STATE to ensure that all Home Care and Home and Community-Based Services units of service are reported by or map to the STATE's units of service.

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

(12) The MCO shall submit encounter data on Mental Health Targeted Case Management services as specified by the STATE, after consultation with the MCOs, for services provided on or after July 1, 2009.

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

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

(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 X12 835 standard transaction format. Claims submitted must include the units of service and/or procedures performed, bill type, place of service, dates of services and applicable provider numbers. (See the Encounter Data Companion Guides, which are referenced on the STATE'S 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), when the provider is part of a group practice that bills on the CMS 837P format or 837D format. The treating Provider is not required when there is an individual practice office (i.e., a sole treating provider), because in those cases it will be identical to the Pay-to Provider. Group practice Provider categories that bill on the CMS 837P format or 837D format and will require a treating Provider are:

(1) Community Mental Health Clinics;

(2) Physician Clinics;

(3) Dental Clinics;

(4) Local Agency Contracted Mental Health Providers;

(5) Indian Health Service;

(6) Federally Qualified Health Centers;

(7) Rural Health Clinics;

(8) Chiropractic Clinics; and

(9) Personal Care Provider Organizations (PCPOs).

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 (ADA) 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 HCBS codes must be HIPAA compliant according to the most current published Minnesota Department of Human Services instructional bulletin.

(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) and Atypical Provider Types. The MCO shall use the NPI for all Providers for whom CMS issues NPIs. For Providers of Atypical Services, 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 Due Dates.

Capitation Payment Dates	**Final Encounter Data Due Dates**	Assessment Periods
January 2009 – March 2009	N/A	June 1, 2007 – May 31, 2008
April 2009 – June 2009	February 1, 2009	September 1, 2007 – August 31, 2008
July 2009 – September 2009	May 1, 2009	December 1, 2007 – November 30, 2008
October 2009 – December 2009	August 1, 2009	March 1, 2008 – February 29, 2009
January 2009 – March 2010	November 1, 2009	June 1, 2008 – May 31, 2009

3.5.2 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 shall be provided to the STATE as outlined in this Article.

(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 Systems**. By April 1st of the Contract Year, the MCO must provide an updated description of the Care Coordination Systems for MnDHO. This description shall include, but will not be limited to, the Medicare Special Needs Plan (SNP) Model of Care submitted to CMS, lists and descriptions of Care Coordination contractors including each county or clinic Care System contracted, duties of contractors, contracting and delegation arrangements, care coordination assessment tools, time lines and process and a description of the MCO's oversight and training of contractors and coordinators, qualifications and case loads/ratios. Changes and updated descriptions must be included in Care System audit reports provided annually by September 15th as provided in sections 7.1.5(D) and 9.3.10.

(D) **Provider Information**.

(1) The MCO must submit annually by April 15th of the Contract Year a complete list of Participating Providers for both Medicare and Medicaid services, 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 Participating Providers, in the same format, by the 15th day of October of the Contact Year. (Note: this excludes pharmacists, transportation providers, and interpreters.)

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

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

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

(F) **Proposed Plan Benefit Packages (PBPs) and Bids**. The MCO/SNP will provide a copy of its CMS approved bid to the STATE's actuarial firm within thirty (30) days of final CMS approval for the purpose of assuring that the STATE does not duplicate payments on any provided services. The STATE will not directly review this information. The MCO must identify information as "Trade Secret" prior to or at the time of its submission for the STATE to consider classifying it as non-public, as described in Article. 9.

(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. 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 Article. 9.

(H) **Health Outcomes Survey-Modified**. By October 15 of the Contract Year , or within thirty (30) days of availability, the MCO will provide the HOS-M survey results related to MnDHO enrollees to the STATE.

(I) **Quality Assurance Materials**. Information shall be provided to the STATE as specified in Article. 7 on Quality Assurance and Improvement.

(J) **Grievance System Summaries**. Information regarding Grievances, Appeals and Denial, Termination, or Reduction (DTR) Notices shall be provided to the STATE as required under Article. 8.

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

(L) **.Documentation of Comprehensive Care Coordination and Comprehensive Care Plan**. The MCO shall maintain documentation necessary to support its Care Coordination responsibilities set forth in section 6.1.3 and for Waiver services set forth in section 6.1.15. Upon request of the STATE, the MCO shall provide the STATE or its designee access to a random sampling of Comprehensive Care Plans of MCO Enrollees.

(M) **Third Party Resources**. Pursuant to section Article. 11, the MCO shall report to the STATE any additional third party resources, including Long Term Care Insurance, except for Medicare.

(N) **Third Party Payments**. Pursuant to section 11.4, the MCO shall report all recovery/Cost Avoided amounts on the encounter claim as third party payments. The MCO shall also report an estimate of Medicare payment, and may base the estimate on the methodology used for submitting bids to CMS to derive the amount.

(O) **Costs Avoided and Recovered**. Pursuant to section 11.4, the MCO shall, on a quarterly basis, disclose to the STATE all Cost Avoided and recovered amounts, including Medicare. The MCO shall also report an estimate of Medicare payment, and may base the estimate on the methodology used for submitting bids to CMS to derive the amount.

(P) **Quality Assurance Workplan**. The MCO shall submit its Quality Assurance Workplan, pursuant to Article. 7. If the MCO has submitted this report under either its PMAP or MSHO contract, and that report addresses MnDHO, this report is waived.

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

(1) The ownership of any subcontractor with whom the MCO has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of the request;

(2) Any Significant Business Transactions between the MCO and any wholly owned supplier, or between the MCO and any subcontractor, as defined in 42 CFR § 455.101, during the five (5) year period ending on the date of the request.

(3) For purposes of paragraphs (R)(1) and (2), subcontractor means 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. See 42 CFR § 455.101.

(R) **Disclosure of Ownership Information**. : On September 1st of Contract Year, the MCO shall report to the STATE full disclosure information as required in 42 CFR § 455.104. 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 Ownership or Control Interest identified in 3.5.2(R)(1) above is related to any other Person with Ownership or Controlling Interest such as spouse, parent, child, or sibling; and

(3) The name of any other 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, consistent with 42 CFR § 455.104 (A)(3).

(S) **FQHCs and RHCs**. Pursuant to the STATE's specifications found in the annual update to the document entitled, "FQHC/RHC Payment Data Report," the MCO shall provide to the STATE quarterly reports that identify MCO payments made to FQHCS and RHCS for all programs covered under this contract, no later than thirty (30) days following the end of the quarter.

(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, exclusive of Medicare, 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 of the MCO's 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).

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

3.5.3 Electronic Reporting Data Capability.

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

(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 by the stated date.

(1) Accept and transmit eligibility transactions by January 15, 2009;

(2) Accept claims transactions by July 15, 2009; and

(3) Transmit payment and remittance advice by December 1, 2009.

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 SNP Participation Requirements for MnDHO.

(A) The MCO agrees to participate in Medicare Advantage as a Dual Eligible SNP and to meet CMS requirements as a low income benchmark plan for Part D benefits.

(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 or required to be returned to CMS for the benefit of Dually Eligible Enrollees of the SNP and agrees to consult with the STATE about any such benefits offered.

3.7 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 42 U.S.C. 423.

3.8 Continued Integration of Medicare and Medicaid Benefits under MnDHO. The MCO will cooperate with the STATE to promote the continued integration of Medicare and Medicaid benefits for MnDHO Enrollees. The MCO shall respond to reasonable requests from the STATE for Special Needs Plan 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 affect the continued integration of Medicare and Medicaid benefits under this contract. The STATE shall notify the MCO of Medicaid changes that are likely to impact its CMS SNP contract.

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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 Exhibit II of this Contract, per month, per Enrollee as full compensation for Medical Assistance medical goods and services provided hereunder in that month, except for the Capitation Payment for those Enrollees who have been reinstated, which the STATE agrees to pay the MCO on the next available warrant.

4.1.1 Exceptions. Section 4.1 does not apply to:

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

(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.

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

4.1.2 Medicaid Capitation Payment. The STATE will pay to the MCO a Medicaid Capitation Payment for each MnDHO Enrollee in accordance with Article 4 for the month in which coverage becomes effective and thereafter until termination of Enrollee coverage becomes effective according to section 3.5 of this Contract. For MnDHO Enrollees with only Part A or Part B, the STATE will pay the Medicaid capitation until the Enrollee is disenrolled from MnDHO. During periods when an Enrollee with only one part of Medicare is enrolled in MnDHO, the MCO or its subcontractors may bill Medicare fee-for-service for services covered by Medicare. If the Enrollee has permanently lost both Medicare Parts A and B, the Enrollee will remain enrolled in MnDHO as a Medicaid Enrollee.

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

4.2 Review and Reconciliation of Medicare Payment Reports. On a monthly basis, the MCO must download, review and reconcile the Group Health Plan (GHP) Medicare payments reports available from the CMS Data Center as required by the STATE and CMS, and shall submit adjustment requests for Medicare payments to the STATE.

4.3 Acute Care Disability Risk Adjusted Payment System.

4.3.1 Risk Adjustment Methodology. In order to account for variation in risk or health status across Enrollees, the STATE will calculate an MCO specific risk score for the Medicaid portion of the acute care rates on a quarterly basis using a capitation risk adjustment method based on disease categories assigned by the Chronic Illness and Disability Payment System (CDPS).

4.3.2 Disability Risk Adjustment Method. The risk adjustment method utilizes two sets of weights, one for Medical Assistance only (non-Dual) enrollees, and one for Dual Eligible enrollees. These two models are identical in structure, but distinct with respect to specific values of the risk factor weights. The weights were developed from the statewide fee-for-service population of recipients with disabilities, using 1) demographic information; 2) diagnoses from health care claims and costs for services provided to individuals during calendar year 2005; and 3) Institutional status (MMIS indication of living arrangement of NF upon enrollment) and home and community based waiver status (MMIS indication of one of the following waivers upon enrollment; CAC, CADI, and TBI). The risk adjustment weights in Exhibit III and the development methodology used in the risk adjustment calculations are described in Exhibit IV (A) "Acute Care Capitation Risk Adjustment for Minnesota Special Needs Plans Serving People with Disabilities (SNBC/MnDHO): USERS GUIDE."

4.3.3 Individual Risk Score. For all MCO enrollees with one or more months of Medical Assistance eligibility in the assessment period, the STATE will use all diagnoses from fee-for-service and encounter claims to apply the CDPS grouper software to these diagnoses, and include age, gender institutional and waiver values to determine an individual risk score..

4.3.4 MCO Aggregate Risk Score. Individual scores will be aggregated into MCO specific average risk adjustment scores, which will be applied to the rates for the subsequent quarter. Specifically, for each MCO, individual risk scores are multiplied by individual enrollee member months in the assessment period and the totals are summed and divided by the total number of enrollee months in the assessment period. Average scores for each MCO will be updated on a rolling quarterly basis.

4.3.5 Acute Care Base Rates. Based on FFS data for MnDHO eligible enrollees, the STATE will calculate four base rates based on the following factors: Dual and non Dual status, institutional (NF), and community status.

4.3.6 Rebasing. The STATE agrees not to rebase the base rates for risk adjustment during the term of this contract. Base rates are provided in Exhibit II.

4.3.7 New Enrollees. Risk scores will be calculated by the STATE based on FFS data and/or encounter data diagnoses during the assessment period pursuant to section 3.5.1(N) of this contract. If an enrollee has no Medical Assistance eligibility during the assessment period the enrollee will be assigned the MCO risk score plan average.

4.4 Acute Care Risk Adjustment Payment. For the Contract Year:

4.4.1 Payment Rates. For MnDHO, monthly acute care rates paid to the MCO shall be paid by the STATE according to the payment rates specified in Exhibit II, Appendix 1. The MCO shall receive for each Enrollee:

(A) The acute base rate for risk adjustment (Column D) which is the product of the sum of the Acute Base Rate (Column A) plus the Rx Base Rate (Column B) plus the Spenddown Adjustment (Column C).

(B) The Acute Base Rate for Risk Adjustment is then multiplied by the MCO STATE calculated aggregated risk score (Dual or Non-dual) in Column E which produces the Base Rate After Risk Adjustment (Column F)

4.4.2 Risk Score The MCO's aggregate risk score will be based on the MCO Enrollees' experience during the assessment period as listed in section 3.5.1(N) of this contract. The STATE shall base the risk factor for each subsequent quarter of payment on the MCO specific Enrollees' risk factor for an annual period that is advanced by one quarter of experience and used to calculate the risk adjusted payments to the MCO.

4.5 Long Term Care Risk Adjusted Payment System

4.5.1 Risk Adjustment Methodology. In order to account for variation in risk or health status among Enrollees, the STATE will calculate an MCO-specific risk score for the Medicaid portion of the long term care rates for CADI, TBI-NF and Home Care enrollees on a quarterly basis.

4.5.2 Disability Risk Adjustment Method. The long term care risk adjustment weights were developed from the seven county Metro area fee-for-service population of recipients with disabilities enrolled in the CADI waiver during calendar year 2007. The risk adjustment development methodology and weights used in the risk adjustment calculations are described in Exhibit IV (B) "Long Term Care Capitation Risk Adjustment for Minnesota Disabilities Health Options."

4.5.3 Individual Risk Score. The STATE determines individual risk scores by utilizing information contained in the MnDHO LTCC approved screening document, demographics, Group Residential Housing (GRH) information in MAXIS and conversion status. If an enrollee does not have an approved LTCC screening document in MMIS the enrollee will not be assigned an individual risk score and will not be included in the aggregate risk score calculation.

4.5.4 MCO Aggregate Risk Score. Individual scores will be aggregated into MCO program (CADI, TBI, and Home Care) specific average risk adjustment scores. The scores will be applied to the rates for the subsequent quarter. Average scores for the MCO will be updated on a rolling quarterly basis.

4.5.5 LTC Base Rates. Based on FFS data for CADI, TBI, and Home Care MnDHO eligible enrollees, the STATE calculates base rates specific to each program, provided in Exhibit II.

4.5.6 Rebasing: The STATE agrees not to rebase the base rates for long term care risk adjustment during the term of this contract. Long term care base rates are provided in Exhibit II.

4.6 Capitation Payment Rates. Monthly long term care rates paid to the MCO shall be paid by the STATE according to the methodology specified in Exhibit II of this Contract.

4.7 Description of MnDHO Rate Cell Category Components. See sections 3.1.2 for Cut-Off Date and Enrollment specifications. The following column references are to columns A through Q in Exhibit II, Appendix 1.

4.7.1 Nursing Facility Rate Cell Category (U). The Institutionalized Rate Cell Category includes the following component, which is adjusted for Medicare eligibility:

(1) Acute Care Base Rate (Column A).

(2) Rx Base Rate (Column B)

(3) Spenddown Adjustment (Column C)

(4) Base Rate for Risk Adjustment (Column D) This number is the result of the addition of Column A, Column B, and Column C)

(5) MCO specific quarterly acute risk score (Column E)

(6) Base Rate after Risk Adjustment (Column F) This number is the result of the multiplication of Column D and Column E.

(7) Total Rate for January 1, 2009 through June 30, 2009 is in Column N This number is the result of the addition of Column F, Column K and Column L.

(8) Total Rate paid for January 1, 2009 through June 30, 20009, including Premium Tax, is in Column O.

(9) Total Rate for July 1 through December 31, 2009 is in Column P. This number is the result of the addition of Mental Health Targeted Case Management in Column (M) plus Column N.

(10) Total Rate paid for July 1 through December 31, 2009 is in Column Q. This number is the result of the addition of premium tax to Column P.

4.7.2 Community CADI and TBI-NF Waiver Rate Cell (B and J). The Community Waiver Rate Cell Category includes the following components:

(1) Acute Care base Rate (Column A), which is adjusted for Medicare eligibility.

(2) Rx Base Rate (Column B)

(3) Spenddown Adjustment (Column C)

(4) Base Rate for Risk Adjustment (Column D). This number is the result of the addition of Column A, Column B, and Column C.

(5) MCO specific quarterly acute risk score (Column E)

(6) Community Medicaid Acute Care Base Rate After Risk Adjustment (Column F). This number is the result of the multiplication of Column D and Column E.

(7) Total LTC Base rate Column I. This column is the result of the addition of Column G (PCA/PDN) and Column H (Waiver Services)

(8) MCO specific quarterly LTC risk score (Column J)

(9) Community Medicaid LTC Base Rate after Risk Adjustment (Column K) This number is the result of the multiplication of Column I times J.

(10) Medicaid NF Add-on for 180 Day Benefit Base Rate (Column 10)

(11) Total Rate (Column N). This number is the result of the addition of Column F, Column K and Column L.

(12) Total Rate paid for January 1 through June 30, 2009, including Premium Tax, is in Column O.

(13) Total Rate for July 1 through December 31, 2009 is in Column P. This number is the result of the addition of Mental Health Targeted Case Management (Column M) to Column N.

(14) Total Rate paid for July 1 through December 31, 2009 is in Column Q. This number is the result of the addition of premium tax to Column P.

4.7.3 Conversion CADI, TBI-NF Community Waiver Rate Cell (K, R and S).

(A) The Conversion Community Waiver Rate Cell Category includes the following components:

(1) Acute Care Base Rate. (Column A), which is adjusted for Medicare eligibility.

(2) Rx Base Rate (Column B)

(3) Spenddown Adjustment (Column C)

(4) Base Rate for Risk Adjustment (Column D). This number is the result of the addition of Column A, Column B, and Column C.

(5) MCO specific quarterly acute risk score (Column E)

(6) Community Medicaid Acute Care Base Rate After Risk Adjustment (Column F). This number is the result of the multiplication of Column D and Column E.

(7) Total LTC Base rate Column I. This column is the result of the addition of Column G (PCA/PDN) and Column H (Waiver Services)

(8) MCO specific quarterly LTC risk score (Column J)

(9) Community Medicaid LTC Base Rate after Risk Adjustment (Column K) This number is the result of the multiplication of Column I times J.

(10) Total Rate (Column N) for January 1 through June 30, 2009. This number is the result of the addition of Column F, Column K and Column L

(11) Total Rate paid for January 1 through June 30, 2009, including Premium Tax, is in Column O.

(12) Total Rate for July 1 through December 31, 2009 is in Column P. This number is the result of the addition of Mental Health Targeted Case Management in Column (M) plus Column N.

(13) Total Rate paid for July 1 through December 31, 2009 is in Column Q. This number is the result of the addition of premium tax to Column P

(B) The MCO may receive the Conversion Rate Cell for a maximum of twelve (12) months for any individual Enrollee.

4.7.4 Nursing Home Certifiable (NHC) Home Care Community Rate Cell Category (E). The Community Home Care Rate Cell Category includes the following components:

(1) Acute Care Base Rate (Column A), which is adjusted for Medicare eligibility.

(2) Rx Base Rate (Column B)

(3) Spenddown Adjustment (Column C)

(4) Base Rate for Risk Adjustment (Column D). This number is the result of the addition of Column A, Column B, and Column C.

(5) MCO specific quarterly acute risk score (Column E)

(6) Community Medicaid Acute Care Base Rate After Risk Adjustment (Column F) . This number is the result of the multiplication of Column D and Column E.

(7) Total LTC Base rate Column I. This column is the result of the addition of Column G (PCA/PDN) and Column H (Waiver Services)

(8) MCO specific quarterly LTC risk score (Column J)

(9) Community Medicaid LTC Base Rate after Risk Adjustment (Column K) This number is the result of the multiplication of Column I times J.

(10) Medicaid NF Add-on for 180 Day Benefit Base Rate (Column L)

(11) Total Rate (Column N) for January 1 through June 30, 2009. This number is the result of the addition of Column F plus Column K and Column L.

(12) Total Rate paid for January 1 through June 30, 2009, including Premium Tax, is in Column O.

(13) Total Rate paid for July 1 through December 31, 2009 is in Column P. This number is the result of the addition of Mental Health Targeted Case Management (Column M) plus Column N.

(14) Total Rate paid for July 1 through December 31, 2009 is in Column Q. This number is the result of the addition of Premium Tax to Column P.

4.7.5 Community Non-Nursing Home Certifiable (Non-NHC) Rate Cell Category

(A). The Community Non-NHC Rate Cell Category includes the following components:

(1) Acute Care Base Rate (Column A), which is adjusted for Medicare eligibility.

(2) Rx Base Rate (Column B)

(3) Spenddown Adjustment (Column C)

(4) Base Rate for Risk Adjustment (Column D). This number is the result of the addition of Column A, Column B, and Column C.

(5) MCO specific quarterly acute risk score (Column E)

(6) Medicaid NF Add-on for 180 Day Benefit Base Rate (Column L)

(7) Total Rate (Column N) for January 1 through June 30, 2009. This number is the result of the addition of Column F plus Column K and Column L.

(8) Total Rate paid for January 1 through June 30, 2009, including Premium Tax, is in Column O.

(9) Total Rate for July 1 through December 31, 2009 is in Column P. This number is the result of the addition of Mental Health Targeted Case Management in Column (M) plus Column N.

(10) Total Rate paid for July 1 through December 31, 2009 is in Column Q. This number is the result of the addition of Premium Tax to Column P.

4.7.6 Community TBI-NB Waiver Rate Cell Category (I) The Community TBI-NB Waiver Rate Cell Category includes the following components:

(1) Acute Care base Rate (Column A), which is adjusted for Medicare eligibility.

(2) Rx Base Rate (Column B).

(3) Spenddown Adjustment (Column C).

(4) Base Rate for Risk Adjustment (Column D). This number is the result of the addition of Column A, Column B, and Column C.

(5) MCO specific quarterly acute risk score (Column E).

(6) Community Medicaid Acute Care Base Rate After Risk Adjustment (Column F) This number is the result of the multiplication of Column D and Column E.

(7) Total LTC Base rate Column I. This column is the result of the addition of Column G (PCA/PDN) and Column H (Waiver Services).

(8) Medicaid NF Add-on for 180 Day Benefit Base Rate (Column L).

(9) Total Rate (Column N) for January 1 through June 30, 2009. This number is the result of the addition of Column F plus Column K and Column L.

(10) Total Rate paid for January 1 through June 30, 2009, including Premium Tax, is in Column O.

(11) Total Rate for July 1 through December 31, 2009 is in Column P. This number is the result of the addition of Mental Health Targeted Case Management in Column (M) plus Column N.

(12) Total Rate paid for July 1 through December 31, 2009 is in Column Q. This number is the result of the addition of premium tax to Column P.

4.7.7 Community TBI-NB Conversion Waiver Rate Cell Category (R).

(A) The Community TBI-NB Conversion Waiver Rate Cell Category includes the following components:

(1) Acute Care base Rate (Column A), which is adjusted for Medicare eligibility.

(2) Rx Base Rate (Column B)

(3) Spenddown Adjustment (Column C)

(4) Base Rate for Risk Adjustment (Column D). This number is the result of the addition of Column A, Column B, and Column C.

(5) MCO specific quarterly acute risk score (Column E)

(6) Community Medicaid Acute Care Base Rate After Risk Adjustment (Column F) This number is the result of the multiplication of Column D and Column E.

(7) Total LTC Base rate Column I. This column is the result of the addition of Column G (PCA/PDN) and Column H (Waiver Services)

(8) Total Rate (Column N) for January 1 through June 30, 2009. This number is the result of the addition of Column F plus Column K and Column L.

(9) Total Rate paid for January 1 through June 30, 2009, including Premium Tax, is in Column O.

(10) Total Rate for July 1 through December 31, 2009 is in Column P. This number is the result of the addition of Mental Health Targeted Case Management in Column (M) plus Column N.

(11) Total Rate paid for July 1 through December 31, 2009 is in Column Q. This number is the result of the addition of Premium Tax to Column P.

(B) The MCO may receive the Conversion Rate Cell for a maximum of twelve (12) months for any individual Enrollee.

4.8 Basis of Assignment of Rate Cells. Assignment of Rate Cells for MnDHO shall be made according to the criteria in Exhibit II, Appendix 4, and based on:

(A) Information on the STATE MMIS,

(B) Information provided by the MCO to STATE for MnDHO including Long Term Care Consultation (LTCC), health assessment information and any additional information, as required for TBI-NB (Traumatic Brain Injury-Neurobehavioral, Rate Cells I and R).

(C) Information entered into MMIS by the MCO,

(D) Information contained on the MCO Enrollment Form,

(E) Availability of Waiver slots,

(F) The Capitation Payment rates specified in Exhibit II, and

(G) As specified by the STATE and CMS.

4.9 Requirements for Assignment of MnDHO Rate Cell Categories.

(A) MnDHO Rate Cells shall be assigned by the STATE upon receipt of the required information from the MCO as specified in this section and in section 3.1.2(P). Rate Cells shall be assigned prospectively for the next available month.

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

(C) When a Rate Cell category change has been entered in the STATE MMIS after the enrollment Cut-Off Date, the MCO will be paid at the rate corresponding to the new Rate Cell category at the time of the MCO's next Capitation Payment, unless the requirements provided for in section 4.9.11 are met.

4.9.2 Community Non-NHC. (Rate Cell Category A):

(A) The Community Non-NHC 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 enrolled in the CADI or TBI waiver program for the first day of the following month.

(B) For changes in MnDHO Rate Cell Categories after initial enrollment, the Community Non-NHC Rate Cell category will be assigned after the MCO notifies the STATE that an Enrollee is living in a community setting and is not Nursing Home Certifiable as defined in Definition (106).

4.9.4 Waiver Community Nursing Home Certifiable. (Rate Cell Categories B, I and J):

(A) The Waiver Community NHC Rate Cell category will be assigned to those Recipients who, at the time of enrollment in the MCO, are:

(1) Enrolled in the TBI or CADI Waiver program at the time of enrollment into the MCO, as indicated in MMIS with an open waiver span for the first day of the following month; and

(2) Coded in a community living arrangement in MMIS; and

(3) Receiving Medicaid paid waiver services (not including case management services), the cost of which is reimbursed under the approved Medicaid waiver plan.

(B) Waiver services must be delivered to those meeting HCBS level of care criteria based on demonstration of need. MCOs are responsible for delivery of HCBS services even if the waiver rate cell component was not paid in a given month.

(C) For changes in MnDHO Waiver Community Nursing Home Certifiable Waiver Rate Cell Categories after initial enrollment, the Community Waiver NHC Rate Cell category will be assigned after the MCO:

(1) Notifies the STATE that an Enrollee is living in a community setting; and

(2) Has indicated that an Enrollee has received a Long Term Care Consultation and has been identified to be in need of Home and Community-Based Services; and

(3) Notifies the STATE the Enrollee has been determined to be eligible for LTC services by approval of a form DHS 3543; and

(4) Requests a CADI/TBI waiver slot and the STATE determines there is a CADI or TBI waiver slot available within the MnDHO program.

(5) Enters in MMIS the Screening Document (DHS-3427) completed for that Enrollee. If a TBI-NB or NF Rate Cell is being requested, then additional documentation according to the STATE's specifications shall be provided to the STATE. The additional documentation will include, but not be limited to:

(a) Demonstration that the Enrollee's needs cannot be met under the CADI Waiver or Home Care program.

(b) Demonstration of documented recent significant cognitive and behavioral impairments related to the brain injury.

(c) The potential to benefit from rehabilitative services as determined by a score of Level IV or above on the Rancho Los Amigo Scale of Cognitive Functioning.

(d) The Enrollee has a formal behavioral program developed by professional(s) necessitating that the Enrollee access the behavioral services within the TBI waiver.

(e) The Enrollee is receiving Medicaid paid waiver services (not including case management services), the cost of which is reimbursed under the approved Medicaid waiver plan.

(D) The STATE shall verify the Enrollee has an open waiver span for the next available month, has been determined to be eligible for LTC services by approval of a DHS form 3543 and there is a waiver slot available within the MnDHO program.

4.9.5 Waiting List for HCBS Waiver Rate Cell Assignments

(A) The STATE shall allocate a total of two hundred (200) new waiver slots to the MCO for Contract Year 2009. A portion of these slots must be reserved for priority allocations in 4.9.5(C)(1), 4.9.5(C)(2), or 4.9.5(C)(3), outlined below, as agreed by the STATE and MCO.

(B) If an Enrollee is eligible for waiver services, the MCO and STATE must determine whether there is a waiver slot available to immediately begin waiver services. If there is no waiver slot available the Enrollee will:

(1) Be placed on a waiting list for MnDHO Home and Community-Based Waiver services;

(2) Be enrolled for basic care services only (i.e. assigned to community Rate Cell A); and

(3) Receive PCA and PDN or waiver services through the fee-for-service Medicaid program, provided the STATE has implemented MMIS system changes to accommodate this method.

(C) The MCO shall develop and obtain STATE approval of "Resources Management Policy" and supporting Procedures including policy and procedures for establishing and maintaining a waiting list of Enrollees who are eligible for and would choose waiver services, but are unable to access the services. The policy must include a prioritization for allocation of all available waiver slots including the reserved slots in (A) above. Waiver slot assignments must be prioritized according to the following criteria:

(1) Enrollees or prospective enrollees who have lived 180 consecutive days in a nursing home, hospital or long term care hospital;

(2) Enrollees or prospective enrollees who are being discharged from an acute care hospital and who are at imminent risk (within 30 days) of admission to nursing facilities, long term care hospitals or other institutions;

(3) Enrollees or prospective enrollees at imminent risk (within 30 days) of admission to nursing facilities, long term care hospitals and other institutions;

(4) Other Enrollees or prospective enrollees meeting level of care criteria for waivers and who require waiver services.

(D) The MCO Waiver Resources Management Policy and Procedure must also assure that:

(1) The needs, choices and options for those enrollees on the waiting list for waiver services are periodically re-evaluated and documented

(2) All enrollees including those on the waiting lists are made aware of available Medicaid State Plan services which could meet their needs

(3) The MCO establishes and follows a standard process for tracking the number of people exiting the waivers, and that care coordinators complete an exit screening document whenever an Enrollee leaves the CADI or TBI waiver to assure that entry and exits of CADI and TBI enrollees can be accurately tracked.

(4) Any waiver slots made available through 4.9.5(D)(3) above are reassigned to enrollees who meet criteria for these services according to the priorities established in this section.

(5) The MCO holds the waiver slot for an enrollee who exits the waiver but is expected to reenter the waiver within 60 days.

(E) Additional policies and procedures will be developed as needed through consultation between the STATE and the MCO.

(F) The STATE may require the MCO to modify the MCO Waiver Resources Management Policy at any time based on CMS requirements to the STATE.

4.9.6 Community Home Care Nursing Home Certifiable (Rate Cell Category E):

(A) The Community Home Care NHC Rate Cell category will be assigned to those Recipients who, at the time of enrollment in the MCO, are:

(1) In need of NHC level home care; and

(2) Coded in a community living arrangement in MMIS; and

(3) Indicated in MMIS to have an open home care services agreement and receiving Medicaid home care services the cost of which are reimbursed under the approved Medicaid State plan.

(B) The Home Care Rate Cell (E) is assigned when a person has been assessed as meeting a nursing home level of care and when personal care or private duty nursing services are delivered at least monthly based on a demonstrated need. Home health aide, skilled nurse visits and home care therapies are included under the risk adjusted acute care base rate and must not be counted toward under the long term care home care rate cell. Medicare home care services are also paid separately and are not counted under this rate cell.

(C) For changes in MnDHO Community Home Care Nursing Home Certifiable Rate Cell Categories after initial enrollment, the Community NHC Home Care Rate Cell category will be assigned after the MCO:

(1) Notifies the STATE that an Enrollee is living in a community setting;

(2) Notifies the STATE that an Enrollee has received a Long Term Care Consultation and has been identified to be in need of Home and Community-Based Services;

(3) Provides the STATE with a copy of or enters in MMIS the Screening Document (DHS-3427) completed for that Enrollee.

(4) Provides information documenting that the person has been assessed as meeting a nursing home level of care and that personal care or private duty nursing services are required at least monthly based on a demonstrated need. Home health aide, skilled RN visits and home care therapies are included under the risk adjusted acute care base rate and must not be counted toward under the long term care home care rate cell. Medicare home care services are also paid separately and are not counted under this rate cell.

4.9.8 Waiver Community Conversion. (Rate Cell Categories K, R and S):

(A) The Conversion Rate Cell category will be assigned after the MCO:

(1) Notifies the STATE that an Enrollee has been Institutionalized for one hundred and eighty (180) consecutive days and then has moved into a community setting; and

(2) Notifies the STATE that an Enrollee has received a Long Term Care Consultation Screening and has been identified to be in need of Home and Community-Based Services; and

(3) Provides the STATE with a copy of or enters into MMIS the Screening Document (DHS-3427) completed for that Enrollee. If a Q or TBI-NB or NF Rate Cell is being requested, then additional documentation according to the STATE'S specifications shall be provided to the STATE. The additional documentation will include, but not be limited to:

(a) Demonstration that the Enrollee's needs cannot be met under the CADI Waiver or Home Care program.

(b) Demonstration of documented recent significant cognitive and behavioral impairments related to the brain injury.

(c) The potential to benefit from rehabilitative services as determined by a score of Level IV or above on the Rancho Los Amigos Scale of Cognitive Functioning.

(d) The Enrollee has a formal behavioral program developed by professional(s) necessitating the Enrollee access the behavior service within the TBI waiver.

(4) STATE verifies that the Enrollee has been enrolled in the MnDHO Nursing Facility Resident Rate Cell category (RCC "U") for at least one month prior to becoming a Conversion.

(D) The STATE shall verify the Enrollee has an open waiver span for the next available month, has been determined to be eligible for LTC services by approval of a DHS 3543 and that there is a waiver slot available within the MnDHO program.

4.9.10 Nursing Facility Resident. (NFR) (Rate Cell Category "U"):

(A) The "U" Rate Cell category will be assigned to those Recipients who, at the time of enrollment in the MCO, are coded in a Nursing Facility institutionalized living arrangement in MMIS.

(B) For changes in MnDHO Rate Cell Categories after initial enrollment, the NFR Rate Cell categories will be assigned after the MCO notifies the STATE that an Enrollee has been Institutionalized in a Nursing Facility and has been determined to be eligible for the LTC services by STATE approval of a DHS Form 3543, when required..

(C) The MCO will be required to close waiver spans promptly following placement in a nursing facility.

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

4.9.11 Rate Cell Notification Payment Adjustment. The MCO shall promptly request a Rate Cell change from the STATE when warranted by a change in the Enrollee's condition or living situation. If the Rate Cell change would have resulted in a lower payment to the MCO and the MCO did not notify the STATE within a maximum of sixty (60) days, the STATE shall adjust the MCO's payment. In August of the Contract Year, the STATE shall deduct from an MCO warrant an amount equal to all Rate Cell overpayments from January through December of the year preceding the Contract Year. The STATE shall calculate the overpayment amount and notify the MCO prior to the adjustment to the August warrant.

4.9.12 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 MnDHO enrollment, and was assigned an RCC other than "U", the STATE will:

(A) Retroactively close the current 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.

(B) Prospectively change the Rate Cell Category to "U". This change will be effective according to existing capitation Cut-Off guidelines. See section 3.1.2.

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

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

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

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

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

4.12 STATE Request for Data. In accordance with Minnesota Rules, Part 9500.1460, subpart 16, the MCO shall comply with the requests for data from the STATE or its actuarial agent for rebasing risk adjustment or for any other data required by the STATE for rate-setting purposes. The MCO shall make the data available: (A) within thirty (30) days from the date of the request, and (B) in accordance with the STATE's specifications.

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

4.14 Renegotiation of Prepaid Capitation Rates. The prepaid capitation rates for Recipients enrolled in the MCO shall be subject to renegotiation not more than once per contract term unless required by State or federal law, regulation or directive, or necessary due to changes in eligibility and/or benefits. Renegotiated rates will require prior CMS approval according to section 4.16. The rates for this contract period are based upon a specific group of Enrollees' costs. If the MCO and its subcontractor gain Enrollees during the Contract year who are significantly more or less costly than the historical cost of the current base of Enrollees for the six months prior to enrollment, the STATE or MCO may request renegotiation under this section.

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

4.16 Assumption of Risk. The MCO shall assume the risk for the cost of comprehensive services covered under this Contract and shall incur the loss if the cost of those services exceed the payments made under this Contract, except as otherwise provided in sections 4.9.11 and 4.9.12 of this Contract.

4.17 Prior Approval of Contract. Prior approval of the Contract by CMS is a condition for Federal Financial Participation (FFP). Payment of rates are conditional upon CMS approval and if not approved would reopen negotiations pursuant to section 4.14. If CMS approval is not received payment continues at rates established in the most recent contract, pending federal approval of renegotiated rates and will be adjusted to the new rates as of the federally approved effective date.

4.18 Medical Assistance Copayments.

4.18.1 Medical Assistance Enrollees must make copayments for the following services, except those listed in (A) below:

(A) Exemptions: The following individuals or services are exempt from these copays:

(1) Children under age 21;

(2) Pregnant women;

(3) Recipients expected to reside for thirty (30) days in an institution;

(4) Recipients receiving Hospice care;

(5) Services provided by an Indian Health Service or 638 facility that are one hundred percent (100%) federally funded;

(6) Emergency Services;

(7) Family Planning;

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

(9) Copayments that exceed one per day per provider for non-emergency visits to a hospital-based emergency room and

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

(B) **Medical Assistance**: Prescription drugs ($3 per prescription for brand name drugs, $1 per prescription for generic drugs, with a maximum of $7.00 per month; except that no copay is required for anti-psychotic drugs).

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

(D) The MCO must ensure that no provider deny Covered Services to an Enrollee because of the Enrollee's inability to pay the copayment pursuant to 42 CFR § 447.53. The MCO must also ensure that Enrollees retain the ability to seek services from other Providers.

(E) **Co-pay and Family Income**. For individuals identified by the commissioner with income at or below one hundred percent (100%) of the federal poverty guidelines, total monthly co-payments must not exceed five percent (5%) of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on co-payments as authorized by Minnesota Statutes 2007 Supplement, § 256B.0631, subd. 1(b)(3). MCO will work with the STATE to develop this process.

(F) Upon notification to the MCO that a Medical Assistance Enrollee has been a resident of a Nursing Facility for 30 days or more, the MCO shall ensure that its Providers do not require the Enrollee to pay any copayments, and shall reimburse its Providers any copayment amount paid. The MCO may submit an invoice and a data certification to the STATE for all copayments the MCO has reimbursed to its providers in the previous quarter not 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.

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

(A) Emergency room visits.

(B) Medicaid Prescription drugs (those prescription drugs still covered by Medicaid for dually eligible Medicare Enrollees, and prescription drugs for those eligible for Medicaid only).

4.18.3 Notification of Enrollees. The MCO shall explain the copay policy in the MCO's Certificate of Coverage and other materials for Enrollees. Unless CMS has approved waiver of payment of copays by the MCO as an additional benefit in the

MCO's Medicare bid process, the MCO shall not offer waiver of copay as an inducement to enroll nor described it in any of the MCO's Marketing Material.

4.19 Medical Assistance 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 in excess of $500,000, due to reasons not including rate-setting methodology, or Fraud or Abuse by the MCO or the Enrollee, the STATE or the MCO may make a claim under this section.

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

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

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

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

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

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

4.19.3 Two Year Limit to Assert Claim.

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

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

4.19.4 Payment Offset. When possible, a recovery for an overpayment or reimbursement due to an underpayment shall be offset against or added to future payment made according to section 4.1 of this Contract.

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

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

4.20.1 One Year Limit to Assert Claim.

(A) The STATE shall in no event assert any claim for, seek the reimbursement of or make any adjustment for any alleged overpayment made by the STATE to the MCO under this Article 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 4.19.2, does not apply to duplicate payments made because of multiple identification numbers for the same Enrollee, payments for full months for a Medical Assistance Enrollee who is incarcerated in a facility, and payments for full months after the death of the Enrollee.

(B) The MCO shall in no event assert any claim for, 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.

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

4.21 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 the change.

4.22 Skilled Nursing Facility/Nursing Facility Benefit. The MCO shall provide:

4.22.1 180-Day SNF/NF Benefit Period for MnDHO.

(A) For any Recipient who enrolls in the MCO's MnDHO product while in a community setting (MnDHO Rate Cell categories A, B, E, I and J), the MCO shall have financial responsibility for Nursing Facility services for one hundred and eighty (180) days. The one hundred and eighty (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 one hundred and eighty (180) day benefit period, except that the MCO shall not pay for nursing home 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 one hundred and eighty (180) days shall be counted cumulatively. After the one hundred and eighty (180) day benefit period is expended, the STATE shall assume responsibility for Medical Assistance Nursing Facility Days. The one hundred and eighty (180) day benefit period may be applied to an individual more than once if the requirements of the one hundred and eighty (180) day Separation Period are met as specified in section 4.22.4.

(B) On a monthly basis, the STATE shall identify Community MnDHO Enrollees with Rate Cell Categories A, B, E, I and J for whom the one hundred and eighty (180) day NF benefit is not in effect. Of these, if the Enrollee is not within a one hundred and eighty (180) day MnDHO separation period, the STATE shall begin a new one hundred and eighty (180) day NF benefit period on the first day of the next available month.

(C) **Countable Days**: The MCO may accrue the following types of days toward the cumulative one hundred and eighty (180) day benefit period:

(1) **Medicare SNF Days**. Medicare SNF days incurred during the 180 day period may count towards the 180 day Benefit Period. 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. Medicare SNF days for the Enrollee incurred prior to the begin date of the one hundred and eighty (180) day NF benefit do not count toward the one hundred and eighty (180) day benefit.

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

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

(D) **Non-Countable Days**: The MCO may not accrue the following types of days toward the cumulative one hundred eighty (180) day Benefit Period for MnDHO:

(1) DOPNA (Denial of Payments for New Admissions): Days during a DOPNA period do not count towards the Medicaid or Medicare benefit period.

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

(3) Hospice. Institutional SNF or NF days that accrue during a Hospice election period do not count toward the one hundred and eighty (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) .The MCO agrees to waive the Medicare requirement of a three-day hospital stay prior to SNF admission for MnDHO Enrollees.

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

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

4.22.2 Responsibility for Payment of Medicare SNF. After the one hundred and eighty (180) day benefit period is expended, the MCO shall retain responsibility for Medicare SNF days according to Medicare SNF benefit policy and the STATE shall assume responsibility for Medical Assistance Nursing Facility days.

4.22.3 Responsibility for Tracking 180-Day Benefit. The MCO shall be responsible for tracking accrual of days toward the one hundred and eighty (180) day SNF/NF benefit period for MnDHO 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 one hundred and eighty (180) days of SNF/NF services and the STATE will verify the information documented by the plans.

(1) Acceptable notification shall include but is not limited to the following:

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

(b) Internal patient account summaries;

(c) Service Authorizations if used by the MCO;

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

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

4.22.4 180-Day Separation Period for MnDHO.

(A) The one hundred and eighty (180) Day Separation Period is defined as one hundred and eighty (180) consecutive days that an Enrollee resides in the community after the MCO has already paid for one hundred and eighty (180) days of SNF/NF services as required under the one hundred and eighty (180) day SNF/NF benefit policy. After this separation period has expired, the MCO shall be liable for a new, distinct one hundred and eighty (180) day SNF/NF benefit period for any Enrollee who is still community-based (i.e., an Enrollee is in MnDHO Rate Cell Category "U" on the last day of the separation period).

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

(C) The STATE shall have the responsibility for tracking the one hundred and eighty (180) day Separation Period. The MCO shall cooperate with the STATE in verifying the one hundred and eighty (180) day Separation Period.

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

4.22.5 Exclusion of Enrollees in the Conversion Enrollment Category. The one hundred and eighty (180) day SNF/NF benefit does not apply to a MnDHO Enrollee while that Enrollee is assigned to the Conversion Rate Cell Categories. The MCO is responsible for paying for Medicare SNF days while the Enrollee is in a Conversion Rate status.

4.23 End Stage Renal Disease (ESRD) Payments. For MnDHO Enrollees identified by CMS as having ESRD, the MCO will continue to receive the Medicaid capitation rate as appropriate for these Enrollees.

4.24 Long Term Care Ineligibility Periods. The STATE will notify the MCO when a Recipient has an ineligibility period. As long as the Recipient remains enrolled in MnDHO, the MCO shall be required to reassume financial responsibility for all services covered under MnDHO after the ineligibility period has passed. During the ineligibility period payment for Nursing Facility, ICF-MR and DD, CADI and TBI Waiver services will be the responsibility of the Enrollee.

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

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Article. 5 Term, Termination and Partial Breach.

5.1 Term and Renewal The term of this Contract shall be the Contract Year from January 1, 2009 (Effective Date), and shall remain in effect through December 31, 2009 (Termination Date). Coverage will begin at 12:00 a.m. on January 1st and end at 11:59:59 p.m. on December 31st (Central Standard Time) unless this Contract is: (1) terminated earlier pursuant to 5.2; (2) extended through: (a) an amendment pursuant to Article. 20, 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 5.2.1.

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 offer to enter into negotiations for a renewal of this Contract on an annual basis (Renewal Contract), upon a one hundred and twenty (120) day written notice to the MCO. The MCO has the right to decline the option to renew this Contract. If the MCO declines this offer, this Contract will automatically renew in accordance with section 5.1.1 unless the MCO or the STATE provides notice of termination or non-renewal in accordance with section 5.2. If the Parties negotiate and execute a Renewal Contract with the intent that it takes effect upon the termination of this Contract on its original or modified Termination Date, this Contract will so terminate and the Renewal Contract will replace it upon the Renewal Contract's effective date.

5.1.3 Notice of County-Based Purchasing. 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.

5.2 Contract Non-Renewal and Termination.

5.2.1 MCO Notice of Non-Renewal. 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.

5.2.2 Termination Without Cause. This Contract may be terminated by the STATE or CMS at any time, without cause, upon a one hundred and fifty (150) calendar day written notice to the MCO.

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 5.3.3 prior to termination.

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

(a) Fraudulent action by the MCO;

(b) Criminal action by the MCO;

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

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

(e) Loss of Medicare contractual agreement with CMS.

(C) **Legislative Appropriation**. Continuation of this Contract is contingent upon continued legislative appropriation of funds for the purpose of this Contract. If

these funds are not appropriated, the STATE will immediately notify the MCO in writing and the Contract will terminate on June 30th of the Contract Year.

5.2.4 Contract Termination Procedures. If the Contract is terminated:

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

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

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

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

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

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

5.3 Deficiencies.

5.3.1 Quality of Services. If the STATE or CMS finds that the quality of care or services offered by the MCO is materially deficient, the STATE has the right to terminate this Contract pursuant to section 5.2.2, or to enforce remedies pursuant to section 5.4.

5.3.2 Failure to Provide Services. The MCO shall be subject to one of the remedies listed in section 5.4.3or 5.4.4 if the MCO fails substantially to provide Medically Necessary items and services that are required to be provided to an Enrollee covered under this Contract, and if the failure has adversely affected or has a substantial likelihood of adversely affecting the Enrollee.

5.4 Partial Breach. The STATE and the MCO agree that if the MCO fails to perform any of the duties in this Contract, the STATE may, in lieu of terminating this Contract, enforce one of the remedies listed in section 5.4.3 or 5.4.4, at the STATE's option. Enforcing one of the remedies shall not be construed to bar other legal or equitable remedies that may be available to the STATE, including, but not limited to criminal prosecution. Concurrent breaches of the same administrative functions may be construed as more than a single breach.

5.4.1 Determination of Remedy. In determining the remedy, the STATE shall consider the following factors:

(A) The number of Enrollees or Recipients affected by the breach;

(B) The effect of the breach on Enrollees' or Recipients' health and access to health services;

(C) If only one Enrollee or Recipient is affected, the effect of the breach on that Enrollee's or Recipient's health;

(D) Whether the breach is an isolated incident or part of a pattern of breaches; and

(E) The economic benefits derived by the MCO by virtue of the breach.

5.4.2 Opportunity to Cure. The STATE shall give the MCO reasonable written notice of a breach by the MCO prior to imposing a remedy under this section. The MCO shall have a period of time not to exceed sixty (60) days from the date it receives the notice of breach, unless a longer period to cure the breach is mutually agreed upon, to cure the breach if the breach can be cured. In urgent situations, as determined by the STATE, the STATE may establish a shorter time period to cure the breach.

5.4.3 Remedies for Partial Breach. If the STATE determines that the MCO failed to cure the breach within the time period specified in section 5.4.2, the STATE may enforce one or more of the following remedies, which shall be consistent with the factors specified at section 5.4.1:

(A) Withhold Medical Assistance capitation premiums or a portion thereof until such time as the partial breach is corrected to the satisfaction of the STATE.

(B) Monetary payments from the MCO to the STATE in the amount of up to one thousand dollars ($1,000) per day, offset against payments due the MCO by the STATE, until such time as the problem is corrected to the satisfaction of the STATE.

(C) Monetary payments from the MCO to the STATE in the amount of up to one thousand dollars ($1,000) per day, offset against Capitation Payments, from the time the notification by the MCO should have occurred or the time the correction should have been made until the time when notification by the MCO is actually made or the correction is made. This paragraph allows the STATE to enforce a remedy against the MCO for actions that have been corrected prior to coming to the attention of the STATE.

(D) Not offer the MCO as an enrollment choice for Recipients in the affected county until thirty (30) days after the STATE receives the required Marketing and enrollment Materials.

(E) If the MCO does not comply with the Marketing requirements specified in section 3.2 of this Contract, the STATE may require the MCO to cease all MnDHO Marketing activities until such time as the MCO has complied with section 3.2 of this contract as defined by the STATE.

(F) Provide to the STATE and CMS or designated CMS evaluator, data abstracted from medical records comparable to the data that would have been available from encounter reporting required in this Contract, if encounter data is not submitted pursuant to section 3.5.1 of this Contract.

(G) Payments provided for under the Contract will be denied for new Enrollees when, and for so long as, payment for those Enrollees is denied by CMS in accordance with the requirements in 42 CFR § 438.730.

5.4.4 Temporary Management. In addition to the remedies listed in section 5.4, 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.

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

5.4.5 Notice: If the STATE enforces a remedy under this section, the STATE shall provide the MCO written notice of the remedy to be imposed.

5.5 Mediation Panel. The MCO may request the recommendation of a three-person mediation panel within three working days of receiving notice of a remedy, a one hundred and fifty (150) day notice of termination, or notice of non-renewal from the STATE. The panel shall be composed of one designee of the Minnesota Council of Health Plans, one designee of the Commissioner of Human Services, and one designee of the Commissioner of Health. The mediation panel shall meet, accept both written and oral argument as requested, and make its recommendation within fifteen (15) days of receiving the request for recommendation unless the parties mutually agree to a longer time period. The Commissioner shall resolve all disputes after taking into account the recommendations of the mediation panel and within three days after receiving the recommendation of the mediation panel.

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Article. 6 Benefit Design and Administration. Medicare services provided by the MCO shall comply with the requirements of this Article.

6.1 MnDHO Covered Services. The MCO shall provide, or arrange to have provided, to all MnDHO Enrollees comprehensive preventive, diagnostic, therapeutic and rehabilitative and long term care health care services as defined in: 1) Minnesota Statutes, § 256B.0625 and corresponding Minnesota Rules, Parts 9505.0170 to 9505.0475; 2) Home Care Services as defined in Minnesota Statutes, §§ 256B.0651, and 256B.0653 through 256B.0656; 3) CADI services pursuant to Minnesota Statutes, § 256B.49 and the federally approved CADI waiver plan; and 4) TBI waiver services as defined in Minnesota Statutes, §§ 256B.49 and 256B.093 and the federally approved TBI waiver plan. Except for sections 6.1.29 and 6.1.37 or as otherwise specified in the Contract, these services shall be provided to the extent that the above law and rules were in effect on the effective day of this Contract. Sections 6.1.29, and 6.1.37 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 Enrollees, Medicare benefits as provided pursuant to 42 U.S.C. 1395, and specialized Medicare Advantage (MA) plans for Special Needs Enrollees, known as Special Needs Plans (SNPs), established by the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, pursuant to the MCOs MA/SNP contract with CMS and the MOU between CMS and the STATE. Pursuant to section 6.6.1, 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 Article. 2(85). For purposes of this section, mandated services do not include the benefits described in Minnesota Statutes, Chapter 256B.

The MCO shall provide services that shall include but are not limited to the following**:**

6.1.1 Advanced Practice Nurse Services. Certified Advanced Practice Nurse Services are services provided by nurse practitioners, nurse anesthetists, nurse midwives and clinical nurse specialists.

6.1.2 Cancer Clinical Trials. Routine care that is provided through the administration or performance of items or services that are: 1) required as part of the Protocol Treatment in a high-quality Clinical Trial; 2) usual, customary and appropriate to the Enrollee's condition; and 3) would be typically provided to that Enrollee when cared for outside of a Clinical Trial, including those items or services needed for the prevention, diagnosis or treatment of adverse effects and complications of the Protocol Treatment.

6.1.3 MnDHO Care Coordination Services. The MCO must provide Care Coordination services to all MnDHO Enrollees. These services are designed to ensure access to and to integrate the delivery of all Medicare and Medicaid preventive, primary, acute, post acute, rehabilitative, and long term care services, including state plan Home Care under 6.1.15, CADI, and TBI Home and Community-Based Waiver services to MnDHO 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 and its subcontractors

shall develop and maintain written descriptions as provided in 3.5.2(C) policies and procedures for operation of its Care Coordination system(s), in accordance with this section, and the written descriptions shall be made available as part of an EQRO review and for CMS Home and Community Based Waiver reviews.

6.1.4 MnDHO Care Coordination Components The Care Coordination system must be designed to ensure communication and coordination of an Enrollee's care across Medicare and Medicaid network provider types and settings and to ensure smooth transitions for Enrollees who move among various settings in which care may be provided over time, and strive to facilitate and maximize the level of the Enrollee's self-determination and choice of services, Providers and living arrangements. The Care Coordination system shall provide each Enrollee with an assigned coordinator who will assist the Enrollee in simplifying access to services and information. The system must be designed to promote and ensure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, culturally appropriate care and fiscal and professional accountability. At a minimum, Care Coordination must incorporate the following elements:

(A) **Partnership with Enrollee**. The MCO shall ensure that the coordinator performs as a facilitator for the Enrollee and works in partnership with the Enrollee and/or authorized family members or guardians, and Primary Care physicians in consultation with any specialists caring for the Enrollee, to develop, coordinate and, in some instances, provide supports and services identified in the Enrollee's Comprehensive Care Plan and to assure consent to the medical treatment or service. The level of involvement of the coordinator will depend on the needs and desires of the Enrollee and/or authorized family members or guardian, and as appropriate to implement and monitor the Comprehensive Care Plan.

(B) **Integrated Care Coordination Process**. The MCO shall ensure an integrated Care Coordination system with the capacity to coordinate the provision of all Medicare and Medicaid acute and long term care services and supports, including services and supports which the MCO subcontracts to a Care System.

(C) **Comprehensive Assessment**. The MCO shall conduct an initial face to face comprehensive assessment of each Enrollee's health and support service needs within 30 calendar days of enrollment. The comprehensive assessment should also address medical, social, environmental, and mental health factors. All comprehensive assessments shall be kept in the individual Enrollee health record at the MCO or Care System. 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.

(1) **MnDHO Long Term Care Consultation (LTCC) Screening**.

(a) At a minimum, the comprehensive assessment shall include conducting a complete Long Term Care Consultation (LTCC), OBRA Level I and health assessment for all new Enrollees using the Minnesota Long Term Care Consultation Assessment Form (DHS -3428) and the state screening document (DHS-3427). The LTCC shall be face-to-face with the Enrollee and completed by a Qualified Professional as defined in Article. 2(129) using the Minnesota Long Term Care Consultation Assessment Form (DHS -3428) and shall be used to:

(i) Provide information for determination of MnDHO eligibility.

(ii) Determine if the Enrollee is at risk of Nursing Facility level of care (i.e., is Nursing Home Certifiable) or TBI-NB level of care (i.e. Neurobehavioral Hospital)).

(iii) Support the MCO's Rate Cell request and assign the Enrollee into the appropriate Rate Cell.

(iv) The MCO shall retain the completed Long Term Care Consultation Form in the Enrollee's record for a minimum of three years. The MCO or its care system must enter the screening document into MMIS within thirty (30) calendar days of enrollment.

(b) At a minimum, comprehensive re-evaluation assessments shall include conducting a complete health assessment and LTCC using the Minnesota LTCC Assessment Form (DHS -3428) at least every twelve (12) months and as needed if the Enrollee's functioning, health condition or living status changes. The re-evaluation shall be face-to-face with the Enrollee and completed by a Qualified Professional as defined in Article. 2(129) and shall be used to:

(i) Modify the Enrollee's Comprehensive Care Plan as appropriate.

(ii) Determine if the Enrollee is or continues to be at risk of placement in a Nursing Facility (i.e., is Nursing Home Certifiable).

(iii) Support the MCO's Rate Cell request if a Rate Cell change is requested.

(iv) When a comprehensive reassessment is conducted, the MCO must enter the information into MMIS within thirty (30) days of the comprehensive reassessment.

(v) The results of the LTCC and OBRA Level I are reported to the STATE using the Long Term Care Screening Document (DHS 3427). Additional documentation is required and shall be submitted to the

STATE if the MCO requests a TBI-NB Rate Cell. All comprehensive assessment documentation shall be maintained by the MCO in the Enrollee's medical record for a minimum of three years. If the MCO is requesting a Rate Cell other than Rate Cell A "Other Community," the Enrollees must meet the criteria to be Nursing Home Certifiable for the CADI waiver, or specialized Nursing Facility for the TBI-NF waiver, or neurobehavioral rehabilitative hospital for the TBI-NB waiver, or meet MCO Medical Necessity criteria for accessing home care.

(D) **Comprehensive Care Plan Development**. An Enrollee Comprehensive Care Plan shall be developed within sixty (60) calendar days of enrollment. For each Enrollee, the MCO shall develop a Comprehensive Care Plan 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 and as determined during team care planning conferences with the Enrollee. For all MnDHO Enrollees, the person centered Comprehensive Care Plan should incorporate an interdisciplinary and holistic and preventive focus and include advance directive planning.

(1) **MnDHO Comprehensive Care Plan Basis**. MnDHO Comprehensive Care Plan shall be based on the results of a health assessment and the LTCC Screening Assessment and will include:

(a) the Community Support Plan for people receiving Home and Community-based Services or State Plan home care services pursuant to Section 6.1.15, and

(b) a risk management plan that identifies any risks to health and safety and

(c) plans for addressing the risks,

(d) Informed Choices made by Enrollee to manage their own risk,

(e) a back up emergency plan and

(f) a crisis intervention plan for any Enrollee at risk

(2) **Interdisciplinary/Holistic Focus**. The Comprehensive Care Plan shall employ an interdisciplinary and holistic approach by incorporating the unique primary, acute, long term care, mental health and social service needs of each Enrollee with appropriate coordination and communication across all Providers. For nursing home Enrollees, this includes review of the nursing home chart, gathering input from Nursing Facility staff, participating in facility meetings and family conferences and communication and coordination with other providers. For community, community Nursing Home Certifiable 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.

(3) **Preventive Focus**. For nursing home 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 nursing home certifiable Enrollees, a preventive focus may include, but is not limited to, written and verbal reminders about immunizations, tobacco and alcohol use, medications and nutrition. Identification of selected diseases and adoption of protocols and best practices for prevention of deterioration and maintaining functioning are encouraged.

(4) **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 comprehensive assessment process. For nursing home Enrollees, advance directives may be addressed at care conferences. For community and community nursing home certifiable members, a best effort is made to document information in the Enrollee record and communication is made with the physician.

(E) **Comprehensive Care Plan Implementation**. For each Enrollee, the MCO shall implement the Comprehensive Care Plan based on the needs assessment, the establishment of goals and objectives, the monitoring of outcomes, follow up, and a process to ensure that Comprehensive Care Plan are revised as necessary. These Comprehensive Care Plans must be designed to accommodate the specific cultural and linguistic needs of MnDHO Enrollees. For nursing home residents, the physician and nurse practitioner, and care coordinator shall establish care plan goals with input from the Enrollee, family, and Nursing Facility staff. Communication with facility staff and Primary Care must be established to address risk areas and manage services as needed. For community nursing home certifiable members and community members, services shall be coordinated with providers based on the results of the comprehensive 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.

(F) **Comprehensive Care Plan Evaluation**. For nursing home Enrollees, routine care plan evaluations and an annual face to face comprehensive reassessment shall be conducted to support a proactive, preventive approach and planning for discharge as appropriate. More extensive evaluations may be required based on clinical needs or changes in condition. For community nursing home certifiable ‘home care’ Enrollees, a face to face comprehensive reassessment

shall be conducted annually or upon change of condition. For community CADI and TBI Enrollees, a comprehensive reassessment shall be conducted every twelve (12) months with a minimum of two (2) face to face contacts annually, including reevaluation or upon change of condition. For community members, a face-to-face LTCC comprehensive reassessment shall be conducted annually or with change in condition. A schedule for regular contact with the Enrollees by the coordinator shall be established in order to identify and monitor changes in condition.

(G) **Coordinator Responsibilities**. The MCO Coordinator shall have lead responsibility for creating and implementing the Comprehensive Care Plan unless otherwise designated by the MCO or a Care System. The Coordinator or nurse practitioner shall perform the activities specified in paragraphs 6.1.4(G)(1) through 6.1.4(G)(17) below:

(1) For all Enrollees, arrange for the initial comprehensive assessment, and periodic comprehensive 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 Comprehensive Care Plan based on relevant ongoing comprehensive assessment;

(4) Arrange and coordinate the provision of supports and services identified in the Enrollee's Comprehensive Care Plan, including knowledgeable and skilled specialty services and prevention and early intervention services;

(5) Assist the Enrollee 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 required by the STATE), and with other organizations that are providing supports (e.g. transportation);

(8) Solicit and analyze relevant information;

(9) Communicate effectively with the Enrollee and with other individuals participating in the Enrollee's Comprehensive Care Plan, including use of PCA service plan and process as required under section 6.16.

(10) Educate and communicate to the Enrollee about good health care practices and behaviors which put the Enrollee's health at risk;

(11) Be informed of basic Enrollee protection requirements, including data privacy;

(12) Inform, educate, and assist the Enrollee in identifying available services providers and accessing needed resources and services beyond the limitations of the Medical Assistance Benefit and Medicare Benefit sets;

(13) Coordinate the provision of services outside of the MCO benefit package;

(14) Ensure that both diagnostic and functional assessments are performed for each Enrollee;

(15) Include methods for communication, follow-up and appropriate referral of conditions and problems identified in risk assessments and screenings;

(16) Assist the Enrollee with the MCO appeals and grievances process and with the State fair hearing process, including completing forms and taking other procedural steps, and gathering any information or evidence in preparation for an Appeal or Hearing;

(17) Attempt to meet individual Enrollee needs and preferences for cultural competence in all assessments and service planning activities.

(H) **Other Care Coordination Requirements for MnDHO**. 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 among acute, subacute, rehabilitation, Nursing Facilities, and Home and Community-Based Service settings, and other community settings.

(2) **Range of Choices**. Procedures for ensuring access to a complete range of CADI, TBI, Home and Community-Based waiver services, Home Care Services, Nursing Facility services and providing appropriate choices among community, and Nursing Facility Providers to meet the individual needs of Enrollees who are found to require a Nursing Facility or Neurobehavioral Rehabilitative Hospital level of care. These procedures must include:

(a) methods for supporting and coordinating services with informal support systems provided by families, friends and other community resources.

(b) methods for informing individuals regarding eligibility for certain home and community based services.

(c) offering a choice of institutional or home and community–based services and a choice between services and Providers.

(d) 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 Home including consideration of Home Care and alternative Home and Community-Based Services. For purposes of this section, the word "assisting" includes, but not limited to, discharge planning and care coordination responsibilities described in section 6.1.3.

(3) **Referrals to Specialists**. Procedures and criteria for making referrals to specialists and sub-specialists, as specified in section 6.1.40.

(4) **Coordination with Social Service Needs**. A method for coordinating the medical needs of an Enrollee with his or her social service needs including coordination with Local Agency social service staff and other community resources. Coordination with Local Agency social service staff is required when an Enrollee is in need of the following services:

(a) Pre-petition screening;

(b) OBRA Level II screening;

(c) Spousal impoverishment or deeming 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;

(g) Targeted Mental Health Case Management, from January 1, 2009 through June 30, 2009;

(h) Case Management for people with Developmental Disability - Rule 185;

(i) Child Welfare Targeted Case Management;

(j) Adult Protection;

(k) Developmental Disability or mental health services not covered by Medical Assistance, but provided through the Local Agency and court-ordered treatment.

(l) The MCO shall coordinate with Local Agency human service agencies for assessment and evaluation related to judicial proceedings.

(5) Notification of Coordinator. The MCO or its subcontractor must provide to the Enrollee the name and telephone number of the coordinator assigned to the Enrollee within ten (10) days of a new assignment or change in case manager.

(a) 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 a member can call for care coordination assistance prior to the assignment and notification of the care coordinator/case manager required in (a).

(b) 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 the callers to make multiple phone calls to find the requested information..

(6) **Coordination with Veterans Administration**. The MCO shall make reasonable efforts to coordinate with services and supports provided by the Veteran's Administration (VA) for Enrollees eligible for VA services.

(7) **Assistance with other Support Programs**. Enrollees with HIV/AIDS and related conditions may have access to federally funded services under the Ryan White CARE Act, 42 U.S.C. § 300ff-21 to 300ff-29 and Public Law 101-381, Section 2. The coordinator should coordinate across systems for Enrollees who access community-based HIV case management services.

(8) **Identification of Special Needs**. The MCO shall have 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 for people with disabilities such as common 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

(9) **Time allotment**. The MCO shall ensure that sufficient time is provided for Coordination activities with regard to Enrollees with special needs or limited English proficiency.

(I) **Coordinator Caseload Ratios**. The MCO shall establish policies and criteria for Coordination case load ratios for coordinators serving all MnDHO Enrollees. The MCO will submit these policies and procedures to the STATE for review. Criteria used to develop ratios will include but not be limited to:

(1) Non-English speaking or need for translation,

(2) Case mix,

(3) Rate Cell designation,

(4) Need for high intensity acute care coordination,

(5) Mental health status/behavioral changes,

(6) Travel time and geographic locations, and

(7) Lack of family or informal supports.

(8) The MCO will follow its established and submitted policy in assigning case loads to 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 9.3.10.

6.1.5 Chemical Dependency (CD) Treatment Services. CD Treatment Services do not include detoxification (unless it is required for medical treatment). The MCO is responsible for all CD treatment services including room and board as determined necessary by the assessment. Notwithstanding Transition Services, section 6.21.2 below, CD services shall be provided in accordance with 42 CFR § 8.12 and Minnesota Statutes § 254B.05, subd. 1.

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

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

(1) Assessment of physical growth.

(2) Vision screening.

(3) Hearing screening.

(4) Health history.

(5) Developmental and behavioral assessment.

(6) Physical examination.

(7) Nutritional assessment.

(8) Immunization and review.

(9) Laboratory tests.

(10) Health education and anticipatory guidance.

(11) An initial examination by a dentist is required for each Enrollee beginning at age one (1).

(12) The MCO agrees to provide, or arrange to provide, dental services according to the C&TC dental periodicity schedule to each enrollee under age twenty-one, effective January 1, 2009 or upon federal approval of the C&TC dental periodicity schedule, whichever is later.

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

(C) The MCO must:

(1) Notify Enrollees under the age of twenty-one (21) of the availability of C&TC screening at least annually;

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

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

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

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

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

6.1.7 Circumcisions. Only circumcisions that are Medically Necessary are covered.

6.1.8 Chiropractic Services.

6.1.9 Clinic Services.

6.1.10 Community Health Worker Services.

6.1.11 Dental Services. Dental Services include dentures. Replacement of a dental prosthesis may be limited to one replacement every three years unless the MCO gives Service Authorization to a replacement within the three (3) year period. Coverage of orthodontics is limited to disfigurement of the face and/or impaired biting function.

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

6.1.12 Treatment of End Stage Renal Disease (ESRD).

6.1.13 Family Planning Services. Notwithstanding any other provision of this Contract, 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.

(A) 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, not including 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;

(4) testing for AIDS and other HIV-related conditions.

(B) 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.

(C) Pursuant to 42 CFR § 433.116(f)(2), the MCO shall not specify confidential services, as defined by the STATE, in any claims Notices sent to the Enrollee, including but not limited to Explanation of Benefit and/or Explanation of Medical Benefit Notices.

6.1.14 Mn DHO Assessment and Rate Cell Assignment.

(A) For MnDHO, the MCO shall complete a LTCC, health assessment and ensure completion of a comprehensive assessment for each new Enrollee. The MCO shall submit the LTCC and all supporting documentation to the STATE along with the request for a Rate Cell assignment. The MCO shall complete and submit the LTCC and all supporting documentation to the STATE whenever a Rate Cell change is requested.

(B) The MCO shall conduct additional comprehensive assessments as necessary to determine an Enrollee's need for services, supports, and as warranted by a change in condition.

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6.1.15 Home and Community-Based Waiver Services General Requirements. Upon federal approval of the current waiver application, the following HCBS Waiver services shall be replaced in this Contract by services and specifications substantially as described in Exhibit VII. In the event that CMS makes substantive modifications in the waiver requirements in its approval process, the STATE and MCO agree to work together to develop services and specifications that meet the CMS approval parameters.

(A) **Authority and Purpose**. Home and Community-Based Waiver Services (HCBS) are provided by Waivers authorized under § 1915(c) of the Social Security Act and federal waivers under 42 U.S.C. 1396n(c), and Minnesota Statutes, §§ 256B.49, and 256B.093.

(B) **HCBS Waiver services requirements include**:

(1) An individual written Community Support Plan must be developed for each enrollee as specified in section 6.1.16(B) below of this contract. Services included in the Community Support Plan must be necessary to meet a need identified in the enrollee's assessment and be provided 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 Community Support Plan that collectively represent a feasible alternative to institutional care. Services not specifically included in the Community Support Plan are not covered by the CADI or TBI Waiver.

(C) MnDHO Enrollees may qualify for either the CADI or TBI Waiver. In addition to meeting all other waiver eligibility criteria, in order for an Enrollee to be determined to need waiver services, the Enrollee must be receiving at least one billable waiver service every month, as documented in the service plan. To receive specific waiver services, or to relocate an Enrollee who is in a Nursing Facility, specialized Nursing Facility, or neurobehavioral rehabilitative hospital, a MnDHO Enrollee must be: 1) determined to meet the Level of Care Criteria specified for CADI (Nursing Facility), TBI-NF (specialized Nursing Facility) or TBI-NB (neurobehavioral rehabilitative hospital); and 2) if accessing the TBI waiver, is in need of a Covered Service that is only available through the TBI waiver. HCBS waiver services shall be provided pursuant to the current waiver plan approved by CMS when necessary to prevent or avoid institutional placement of community MnDHO Enrollees who have received a LTCC and who, but for the provision of such services, would require a Nursing Facility Level of Care..

(D) The MCO shall make a best effort to offer a choice of HCBS Providers within each of the home and community based services.

(E) Waiver services cannot be provided outside of Minnesota except when:

(1) the provider(s) is located within a Recipient’s local trade area in the states of North Dakota, South Dakota, Iowa, or Wisconsin and the service is provided in accordance with state and federal Medicaid regulations; or

(2) the Recipient is temporarily traveling outside of Minnesota but within the United States, and services are limited to direct care staff services that have been determined necessary in the Recipient's individual comprehensive assessment and are authorized in the Comprehensive Care Plan.

(3) The local trade area is defined in Minnesota Rules 9505.0175, subp. 22. For purposes of this provision, temporary travel is defined as a maximum of thirty (30) days per the Recipient’s waiver plan year. Temporary travel that may exceed thirty (30) days is subject to care coordinator approval, must be prior authorized, and may only be authorized for emergency situations (e.g., cancelled flights by airlines, family emergencies, etc.). In situations in which temporary travel may exceed thirty (30) days due to an emergency, the coordinator must be notified as soon as possible prior to the thirtieth (30th) day.

(4) All waiver plan requirements continue to apply to services provided outside of Minnesota including prior authorization, provider standards, Recipient health and safety assurances, etc. Travel expenses for Recipients and their companions (including paid or non-paid caregivers) such as airline flights, mileage, lodging, meals, entertainment, etc. are not covered.

(F) **Continuation of Previously Authorized Services**: The MCO shall provide Enrollees home and community based services that an Out of Plan Provider, another MCO, county or the STATE had Service Authorized before enrollment in the MCO until a Community Support Plan is in place. The Community Support Plan must take into account services previously authorized. 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.

(1) **Services and Items Not Covered**: Room and board, items of comfort or convenience, payments directly or indirectly to the Enrollee, the costs of facility maintenance, upkeep and improvement, and services provided, directly or indirectly, to members of the Enrollee’s immediate family are not covered in adult or child foster care, Customized Living, 24-Hour Customized Living, or residential care.

6.1.16 CADI and TBI Waiver Covered Services, and Provider Qualifications. Upon federal approval of the current waiver application, the following CADI and TBI Waiver services shall be replaced in this Contract by services and specifications substantially as described in Exhibit VII. In the event that CMS makes substantive modifications in the waiver requirements in its approval process, the STATE and MCO agree to work together to develop services and specifications that meet the CMS approval parameters.

(A) **Availability**: The following CADI/TBI services are available only to Enrollees who, but for the provision of such services, would require NF level of care, TBI-NF or TBI-NB, the cost of which would be reimbursed under the approved Medicaid State plan:

(1) **Case Management:** Case management services are encompassed in the Coordinator's functions consistent with section 6.1.3. Case managers must meet face-to-face with each Enrollee at least two times each year to assess and reevaluate the Community Support Plan.

(a) **Delegation:** The Case Manager may not delegate those functions that require professional judgment, including assessments, reassessments, and care plan development.

(i) Case Aides: Case aides shall perform only those tasks delegated and supervised by the case manager that do not involve professional expertise or judgment (e.g., case filing, contacts to vendors to schedule services, phone contacts). Case aides shall not conduct Enrollee assessments, reassessments, or care plan development. Case aides must be limited to delegated administrative functions under the oversight of the Case Manager.

(ii) Case Aide Provider Qualifications: Case Aides must be high school graduates with one year of experience as a Case Aide or in a closely related field. One year of education beyond high school, such as business school or college, may be substituted for the experience. The Case Aide must understand, respect, and maintain confidentiality in regard to all details of their work. Case Aides must be employed by the agency providing case management and receive oversight from the Case Manager.

(b) Providers of case management services must not have a financial interest in other services provided to an individual, unless the case management services are provided by the county agency.

(c) The MCO may not make payment for waiver case management services provided by more than one provider.

(2) **Adult Day Care:** Adult day care services must be designed to meet both the health and social services needs of the Enrollee. Services may be furnished two or more hours per day, one or more days per week, on a regularly scheduled basis. Service shall not be authorized for more than twelve (12) hours in a continuous 24-hour period. Coverage of meals must be in accordance with 42 CFR § 441.310 (a)(2)(ii). Therapies shall not be included in the Adult Day Care service.

(a) **Provider Qualifications:** Adult Day Care providers include hospitals, nursing homes, medical clinics, family homes, and free-standing centers.

Adult Day Care providers are governed by Minnesota Statutes, §§ 245A.01 through 245A.16 and must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730.

(3) **Customized Living:** Customized Living services are up to 24-hour supervision with regularly scheduled and individualized health related and supportive services provided to residents of a congregate living setting licensed as a home care provider. Individualized means that services are chosen and designed specifically for each resident's needs. Health related and supportive services are defined in Minnesota Statues, § 144D.01. Room and board costs are not covered by this service.

(a) If socialization is provided, it must be related to established goals and outcomes and not diversionary or recreational in nature.

(b) Customized Living services must be provided by the management of the congregate living setting or by Providers under contract with the management of the setting.

(c) **Capacity Limit**: The total number of persons living in the home, who are unrelated to the principal care provider, shall not exceed four (4) persons except when: 1) authorized by the MnDHO project coordinator in emergency situations when the setting is needed to avert an individuals placement in a regional treatment center or Nursing Facility; and 2) the one of following criteria is met:

(i) An unexpected loss of an essential caregiver.

(ii) A sudden loss of housing due to closure.

(iii) Loss of services or housing due to a natural disaster.

(iv) It is necessary to place siblings together.

(d) **Exception to Capacity Limit**: The exception for services delivered in a site with more than four (4) persons shall not exceed two years. Pending federal approval: This capacity restriction does not apply to people who are 55 years of age or older.

(e) **Items and Services Not Covered**: The following are not covered in Customized Living: room and board, items of comfort or convenience, payments directly or indirectly to the Enrollee, the costs of facility maintenance, upkeep and improvement, and services provided, directly or indirectly, to members of the Enrollee's immediate family. Homemaker and chore services are not covered for individuals receiving Customized Living or 24-Hour Customized Living.

(f) **Provider Qualifications**: Providers must be licensed, certified and registered as required by state law or rule.

(i) Customized Living service providers and 24-Hour Customized Living service providers must receive a class A or Class F Customized Living home care provider license.

(ii) Under Minnesota Rules, Chapters 4668 and 4669, and Minnesota Statutes, § 144A.4605, the Providers must be registered with the STATE under Minnesota Statutes, Chapter §144D (Housing with Services Registration Act) to provide Customized Living Services.

(iii) Customized Living service providers or 24-Hour Customized Living service providers who are not licensed under Minnesota Rule, parts 9555.5105 through 9555.6265 (adult foster care), and who provide services in settings of one to four residents, must comply with Minnesota Rules, parts 9555.6205, subparts 1 to 3, and parts 9555.6225, subparts 1,2,6, and 10.

(iv) In addition, staff providing supervision and supportive services must possess:

a Communication skills including the ability to read and write, follow written and verbal instructions, and converse on the telephone;

b Experience or training in caring for individuals with functional limitations;

c Ability to perform essential job functions;

d Self-direction to work under intermittent supervision, to deal with minor emergencies arising in connection with the assignment, and work under stress in a crisis situation;

e Understanding and respect regarding maintaining confidentiality; and

f A valid Minnesota driver's license and insurance coverage in accordance with state requirements, if they provide transportation to waiver recipients.

(g) Enrollees who receive Customized Living services cannot provide staff services in the same setting.

(4) **24-Hour Customized Living:** 24-Hour Customized Living services must meet the definition for Customized living. In addition, 24-Hour

Customized Living service providers must provide 24-hour supervision and must be registered as a "Housing with Services" establishment with the Minnesota Department of Health. Room and board costs are not covered by this service.

(a) 24-hour supervision means a service which includes ongoing awareness of the Enrollee's needs and activities. The supervision must be provided by an employee of the Customized Living provider, who is not a recipient of services and whose primary job responsibility is to provide supervision to Enrollees in the setting. The provider must furnish a means for Enrollees to summon assistance and an employee must be available to respond in person to the request within a reasonable amount of time. This service should be individualized as determined by: 1) the Enrollee's need for each service; 2) how frequently the Enrollee needs the service to be delivered; 3) locations where the supervision is required; 4) identification of supervision by family, friends, etc.; and 5) times of day that the supervision is most likely needed.

(b) Staff providing supervision must be adequately qualified to meet the needs and provide services as outlined in each Enrollee's housing with services contract and their individual care plan.

(c) **Provider Qualifications:** Same as Customized Living.

(d) Enrollees who receive Customized Living services cannot provide staff services in the same setting.

(e) **Capacity Limit**: The total number of persons (including Enrollees served in the waiver) living in the setting, who are unrelated to the principal care provider, shall not exceed four (4) persons except when authorized by the Commissioner.

(f) **Authorized Exception to Capacity Limit**: The STATE may authorize services provided in settings serving up to five individuals, living in the setting who are unrelated to the principal care provider, in emergency situations when the setting is needed to avert an individual's placement in a regional treatment center or nursing facility. This exception for services delivered in a site with more than four individuals shall not exceed two years. For purposes of this provision, emergency situations are defined as:

(i) An unexpected loss of an essential caregiver,

(ii) A sudden loss of housing due to closure,

(iii) Loss of services or housing due to a natural disaster,

(iv) It is necessary to place siblings together.

(g) **Exception to Capacity Limit**: The limit on the total number of individuals living in the setting does not apply to persons who are 55 or older.

(h) **Items and Services Not Covered**: The following are not covered in 24-Hour Customized Living: room and board, items of comfort or convenience, payments directly or indirectly to the Enrollee, the costs of facility maintenance, upkeep and improvement, and services provided, directly or indirectly, to members of the Enrollee's immediate family. Homemaker and chore services are not covered for individuals receiving Customized Living or 24-Hour Customized Living.

(5) **Consumer Directed Community Supports (CDCS):** Consumer Directed Community Support Services are an array of cost effective services and durable goods which are defined in an Enrollee's service plan, help prevent institutionalization and/or maintain independent living and are uniquely designed, chosen and controlled by the Enrollee within a budget developed by the Enrollee and the coordinator or MCO's designee. The Enrollee's Community Support Plan is the basis of authorization for all services to be covered by the MCO under Consumer Directed Community Support Services. Consumers must have a Community Support Plan that is developed through a person-centered process that addresses all the assessed needs of the individual. Consumers are required to develop their own Community Support Plan or have a person they select and/or hire to help them.

(a) Services include, but are not limited to, traditional CADI or TBI waiver services provided under this section including personal care, and can include other alternatives to current CADI or TBI waiver services that support the recipient. The Community Support Plan can be a mix of paid and non-paid services and formal and informal supports.

(b) The Community Support Plan must specify: 1) the goods and services that must be provided to meet the individual's needs; 2) safeguards to reasonably maintain the individual's health and welfare; and 3) how emergency needs of the individual will be met. The Community Support Plan must also specify the overall outcome(s) expected as the result of CDCS and how monitoring will occur.

(c) The Community Support Plan must specify provider qualifications including training requirements. The Community Support Plan must also specify the person responsible to assure that the qualification and training requirements are met and whether a criminal background study will be required for each service. If a criminal background study is required, the standards outlined in Minnesota Statutes, Chapter 245C, Department of Human Services Licensing Act, must be applied. An individual who is disqualified shall not be paid under CDCS. The

Enrollee must agree to and verify that the good or service was delivered prior to submission of the claim.

(d) Enrollees living in licensed foster care, settings licensed by STATE or MDH or registered as a housing with services establishment with MDH are not eligible for this service. Enrollees are not eligible for CDCS if they or their representative have at any time been assigned to the Restricted Recipient Program.

(e) The cost of background studies is not included in the Enrollee's budget amount but will be covered as a service expense through the county agency's waiver allocation. For MnDHO Enrollees, the cost will be covered as a service expense through the MCO. The Enrollee may revise the way that a CDCS service or support is provided without the involvement or approval of the county agency when the revision does not change or modify what was authorized by the case manager. If a revision results in a change or modification of the approved Community Support Plan, the Enrollee will work with the county agency to have the Community Support Plan reviewed and, if appropriate, authorized.

(f) Services must not duplicate other services provided, must be necessary to ensure health and safety, enable the Enrollee to function with greater independence, be of direct and specific benefit to the Enrollee's condition and/or be directly related to the support needed for the Enrollee to remain in the home, must not be covered by other funding sources and must be cost effective in comparison to alternative services.

(g) Services that require professional certification or license by Minnesota Statutes or federal standards, or are identified in the Enrollee's Community Support Plan as requiring a license or certification, must be provided by individuals or agencies who meet the qualifications. The service plan will also identify other persons providing flexible support services, be trained to meet the Enrollee's needs, and may be trained about and understand the Vulnerable Adult Act.

(h) The coordinator or other MCO designee must work with the Enrollee requesting this service to design an individual budget and Community Support Plan based on the Enrollee's need for Home and Community-Based Services, their personal preferences and available resources. Services must be authorized by the coordinator or other MCO designee as part of the Community Support Plan and must be directed at the desired personal outcomes specified in the Community Support Plan while assuring health and safety. Services must be paid through a fiscal intermediary enrolled with the STATE or other arrangements approved by the MCO. The Enrollee's budget will include all goods and services to be covered by the waiver and State plan home care services in a

twelve (12) month period, with the exception of required case management and criminal background studies. Budgets may include:

(i) Goods or services that augment State plan services, or provide alternatives to waiver or State plan services. The rates for these goods and services are negotiated and included in the Community Support Plan.

(ii) Goods or services provided by Medical Assistance Providers. The rates for these goods and services shall not exceed the rates established by the state for a similar service.

(iii) Therapies, special diets and behavioral supports that mitigate the individual's disability if they are not covered by the State plan and are prescribed by a physician enrolled as a MHCP Provider.

(iv) Fitness or exercise programs when the service is necessary and appropriate to treat a physical condition or to improve or maintain the individual's physical condition. The condition must be identified in the individual's Community Support Plan of care and monitored by a MHCP enrolled physician. Because children have other resources available to meet these needs, fitness and exercise programs are limited to adults.

(v) Expenses related to the development and implementation of the Community Support Plan will be included in the budget.

(vi) Costs incurred to managed the budget, advertise and train staff; pay employer fees (FICA, FUTA, SUTA, and workers compensation, unemployment and liability insurance) as well as employer share of employee benefits, and retention incentives. Detailed information on CDCS can be found in the approved waiver plan and the CDCS Lead Agency Manual on the STATE website.

(i) **Provider Qualifications for CDCS:** Providers are not eligible to provide CDCS services if any contract between the provider and the state or county agency or MCO has been terminated due to fraud or disqualification under the criminal background check according to the standards in Minnesota Statutes 245C, Department of Human Services Background Studies Act.

(j) **No Financial Interest**: Persons or organizations paid to assist in developing the CDCS care plan (e.g., flexible case managers) must not have any direct or indirect financial interest in the delivery of services in that plan. This does not preclude these persons or organizations from payment for work in providing care plan development services. This provision does not apply to: spouses, parents of minors, Legal Representatives, or case managers employed by county agencies. This

provision precludes Fiscal Entities (FEs) or their representatives from participating in the development of a care plan for Enrollees who are purchasing FE services from them.

(i) **Personal Assistance Provider Qualifications.** Services and supports included in this category do not require a professional license, professional certification, or other professional credentialing. The care plan will define the qualifications that the direct care worker or provider must meet.

(ii) **Treatment and Training Provider Qualifications**.

a For services and supports that require the person or entity providing the service or support to be professionally licensed, credentialed, or otherwise certified to perform the service under state law, the provider must meet all applicable standards. For services and supports that do not require professional licensing, credentialing, or certification, the care plan will define the qualifications that the direct care worker or provider must meet.

b For waiver services that require licensing under Minnesota Statutes 245.A.01 to 17, the same standard applies if the service is provided through CDCS. Minnesota Statutes 245.A.01 to 17 do not apply to CDCS services that do not otherwise require licensing.

(iii) **Home and Vehicle Modifications Provider Qualifications**. Providers of modifications must have a current license or certificate, if required by Minnesota Statutes or administrative rules, to perform their services. A provider of modification services must meet all professional standards and/or training requirements which may be required by Minnesota Statutes or administrative rules for the services that they provide. Home modifications must meet building codes and be inspected by the appropriate building authority.

(iv) **Transportation Provider Qualifications.** Standards for common carrier transportation are bus, taxicab, other commercial carrier, private automobile; county owned or leased vehicle. Private individuals may be designated to provide transportation when they meet the individual's needs and preferences in a cost-effective manner. Drivers must have a valid driver's license and meet state requirements for insurance coverage.

(v) **Fitness and Exercise Provider Qualifications.** Health clubs and fitness centers that provide fitness and exercise programs must meet all applicable state regulations for operation.

(vi) **Financial Sector Support Entities (FEs) Qualifications**. FEs are the CDCS Medicaid enrolled provider FEs who have any direct or

indirect financial interest in the delivery of personal assistance, treatment and training or environmental modifications and provisions provided to the Enrollee must disclose in writing the nature of that relationship, and must not develop the Enrollee's care plan. The department determines whether FEs meet the established criteria and the provider standards are met through a written readiness review submitted to the department by the FE prior to the FE providing services. Certified providers must successfully complete recertification reviews conducted by the department as determined by the department.

(vii) **Care Plan Support Qualifications**. Flexible case management supports are covered under this CDCS category. People who are paid through CDCS to assist with the development of the Enrollee's person-centered care plan must: be 18 years of age or older; successfully pass a training module approved or developed by the department on person-centered planning approaches including the vulnerable adult or maltreatment of minors act; provide a copy of their training certificate to the Enrollee; use the care plan template or alternative care plan format that includes all of the information required to authorize CDCS; follow the standards developed by the department; and, be able to coordinate their services with the required case manager to assure that there is no duplication between functions. Enrollee may require additional provider qualifications tailored to their individual needs. These will be defined in the Enrollee's care plan. The provider must provide the Enrollee with evidence that they provider meets the required qualifications. This includes providing a copy of training completion certificate(s) for any related training.

(viii) **Services Provided by Spouse or Parent**: Services and supports provided by a legally responsible person including biological and adoptive parents of Enrollees under 18: for an Enrollee's spouse or parent of a minor Enrollee to be paid under CDCS, the service or support must meet all of the following authorization criteria and monitoring provisions. The service must:

a Meet the definition of a service/support as outlined in the federal waiver plan and the criteria for allowable expenditures under the CDCS definition;

b Be a service/support that is specified in the individual plan of care;

c Be provided by a parent or spouse who meets the qualifications and training standards identified as necessary in the Enrollee's Community Support Plan;

d Be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the Department of Human Services for the payment of personal care attendant (PCA) services;

e Not be an activity that the family would ordinarily perform or is responsible to perform;

f Be necessary to meet at least one identified dependency in activities of daily living as assessed using the Long Term Consultation document.

g A parent, or parents in combination, or a spouse may not provide more than 40 hours of services in a seven day period. For parents, 40 hours is the total amount regardless of the number of child Enrollees who receive services under CDCS;

h The family member must maintain and submit time sheets and other required documentation for hours paid;

i Married Enrollees must be offered a choice of providers. If the Enrollee chooses a spouse as their care provider, the choice must be documented in the care plan;

(6) **Family Training and Education:** Training and education services for the Enrollee as well as for the families of Enrollees receiving services.

(a) Training and education includes instruction about treatment regimens and use of equipment specified in the Community Support Plan, and shall include updates as necessary to safely maintain the Enrollee at home. Training and education may include helping the Enrollee and/or his or her family members with crisis, coping strategies, stress reduction, etc. For purposes of this service, 'family' is defined as the people who live with or routinely provide care to the Enrollee, and may include a parent, spouse, children, relatives, foster family or in-laws. Family does not include people paid by or as a waiver provider to care for the Enrollee. Training and education may include helping the Enrollee and/or his or her family members with crisis, coping strategies, stress reduction, etc.

(b) Coverage for family support services is limited to training registration fees. Costs related to transportation, travel, meals, and lodging are not covered by the waiver. If any such costs are included in registration fees, they must be adjusted accordingly.

(c) **Provider qualifications**: Professionals such as licensed physicians, licensed nurses, licensed public health nurses, social workers, mental

health professionals; registered physical therapist, occupational therapist, respiratory therapist, speech pathologist or nutritional therapist.

(7) **Adult Foster Care:** Adult foster care is available to Enrollees 18 years of age and older. Adult foster care is defined as personal care and services, homemaker, chore, attendant care, behavioral aide services and companion services, medication oversight (to the extent permitted under State law) for up to four functionally impaired adults in a licensed home. Adult foster homes provide food, lodging, protection, supervision, and household services. They may also provide personal care, living skills assistance or training, and assistance safeguarding cash resources. The Community Support Plan cannot be duplicated by other Medicaid or Medicare services. Care direction must be provided by the Enrollee or by the foster care Provider with oversight by the coordinator.

(a) **Capacity Limit:** The total number of individuals living in the home, who are unrelated to the principal care provider, shall not exceed four (4) persons except when authorized by the MnDHO project coordinator.

(b) **Exception to Limit**: Pending federal approval, the limit on the total number of individuals living in the setting does not apply to Persons who are 55 or older.

(c) **Services and Items Not Covered**: The following are not covered in adult foster care:

(i) Room and board, items of comfort or convenience, payments directly or indirectly to the Enrollee, the costs of facility maintenance, upkeep and improvement, and services provided, directly or indirectly, to members of the Enrollee's immediate family.

(ii) Home maker, Customized Living, 24-Hour Customized Living and chore services are not covered for individuals receiving adult foster care services.

(iii) **Provider Qualifications:** Providers of adult foster care must be licensed under Minnesota Rules, parts 9555.5105 through 9555.6265. Settings must comply with the capacity limit of four persons, as specified in the waiver plan. Exceptions to the capacity limits must be approved by the MnDHO project coordinator and must also comply with other requirements in the waiver plan.

(8) **Home Delivered Meals:** A home delivered meal is an appropriate, nutritionally balanced meal that meets one-third of the current daily recommended dietary allowance (RDA) served in the home of an Enrollee as established by the Food and Nutrition Board of the National Academy of Sciences, National Research Council.

(i) Menu plans must be reviewed and approved by a Registered Dietician.

(ii) The need for a home delivered meal must be approved by the coordinator as part of the individual Community Support Plan. Agencies providing home delivered meals will be monitored by the coordinator. Home delivered meals will be provided to Enrollees who are unable to prepare their own meals and for whom there are no other persons available to do so, or where the provision of a home delivered meal is the most cost-effective method of delivering a nutritionally adequate meal. Modified diets, where appropriate, will be provided to meet the Enrollee's individual requirements.

(iii) **Provider Qualifications:** Hospitals, schools, restaurants or any entity providing home delivered meals must comply with all state and local health laws and ordinances concerning preparation, handling and serving of food as defined under Minnesota Rules, parts 4626.0010 through 4626.2025. Insulated hot and cold containers must be used on delivery routes to assure that food reaches Enrollees at appropriate temperatures.

(9) **Home Health Services, Extended:** Home health services include care by home health aides, registered nurses, licensed practical nurses, and therapists: Occupational, physical, respiratory, and speech. Home health services are defined in the Minnesota Medicaid State Plan, except the limitations on the amount, scope, and duration of the service do not apply. All safeguards and provider standards under the State Plan apply.

(i) Limitation on the amount, duration and scope of home health services will be specified in the individual Community Support Plan.

(ii) **Provider Qualifications:** Home health agencies as defined in Minnesota Rules, part 9505.0290. A Home Health Agency (HHA) must be certified under Title XVIII (Medicare) of the Social Security Act to provide home health services. Persons providing the direct services to the Enrollee must be qualified, certified, credentialed, and/or appropriately licensed in their specialty field according to Minnesota Statutes.

(10) **Homemaker Services:** Homemaker services provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for his or herself or others in the home. General household activities include meal preparation, routine household care, shopping and errands, assisting with daily activities (e.g., assistance with bathing, toileting, dressing), arranging transportation, providing emotional support and social stimulation, and monitoring safety and well being.

(a) **Provider Qualifications:** Providers of homemaker services must meet the requirements of Minnesota Statutes, §§ 144A.43 to 144A.46. Homemakers must meet the standards under Minnesota Rules, part 9565.1200, subp. 2 and are subject to criminal background checks as specified in Minnesota Statutes, Chapter 245C, Department of Human Services Background Studies Act. Homemakers shall meet such standards of education and training as are established by the STATE for the provision of these activities.

(b) Lead Agencies may grant a variance to the requirement that homemaker providers meet training requirements in Minnesota Rule, part 9565.1200 (governing provisions of homemaker services), when the individual's care plan specifically states that the homemaker is only providing light housekeeping and is not responsible for training or monitoring the well being of the individual. The workers providing homemaker services must have the ability to perform the duties expected and be a cost effective alternative to certified homemaker providers.

(c) **Independent Living Skills:** Independent Living Skills (ILS) is training provided one-on-one to an Enrollee to recover, maintain or optimize services community living skills. Independent Living Skills services may be provided in the Enrollee's home or in community settings typically used by the general public.

(i) Services must include clear and measurable outcomes which relate to the development or maintenance of community living skills such as self-care, communication skills, socialization, sensory/motor skills, and reduction/elimination of maladaptive behavior. Progress of outcomes must be documented and reviewed as indicated in the Enrollee's Community Support Plan.

(ii) **Provider Qualifications:** ILS services may be provided by employees of a:

a Medicare certified home health agency that is enrolled as an Medical Assistance provider;

b Rehabilitation agency that is enrolled as an Medical Assistance provider must meet the standards under Minnesota rules, parts 9505.0385 to 9505.0386;

c Comprehensive outpatient rehabilitation facility that meets the standards under Minnesota Rule 9505.0386 through 9505.0390;

d Community mental health programs that meet the standards under Minnesota Statutes, §§ 245.461 through 245.486 or 245.487 through 245.4888; or

e County agency.

(iii) Direct care workers must be supervised by an appropriately licensed health care provider and be determined by the supervisor to have the skills required to provide the Independent Living Skills Services identified in the individual's Community Support Plan. Workers must also have:

a General knowledge of disabilities and chronic illnesses which affect an individual's ability to live independently in the community;

b The ability to complete a needs assessment to determine what skills the individual must develop in order to live as independently as possible in the community;

c Knowledge of Independent Living Skills management including service planning, general knowledge of social services, record keeping, reporting requirements, and confidentiality;

d The ability to provide assistance, supervision, and training to individuals to develop independent living skills; and

e Completed a minimum of:

i Five (5) hours of classroom training in recognizing the symptoms and effects of certain disabilities and health conditions; and

ii Twenty (20) hours of classroom instruction in providing supervision of, training to, and assistance with Independent Living Skills services.

(11) **Environmental and Accessibility Adaptations:** Those physical modifications and adaptations to the home or vehicle that are necessary to reasonable ensure the health, welfare and safety of the individual with mobility problems or that enable the client to function with greater independence in the home.

(a) Such modifications and adaptations may include, but are not limited to, the installation of ramps and grab-bars, widening of doorways, modifications of bathroom facilities, installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the Enrollee. Environmental modifications also include modifications to vehicles and adaptive equipment (such as adaptive furniture and utensils.

(b) Vehicle modifications are modifications that will allow the Enrollee to function with greater independence in the community such as adapted seating, door widening, door handle replacement, wheel chair securing devices or wheel chair lifts etc. Coverage is limited to one operating vehicle and the Enrollee's primary residence. The limit of one vehicle does not prohibit coverage of vehicle modifications or adaptations when a vehicle must be replaced.

(i) **Services and Items Not Covered**: Modifications and adaptations that are of general utility, and are not of direct medical or remedial benefit to the individual Enrollee, such as carpeting, roof repair, central air conditioning, etc. are not covered. Modifications and adaptations that add to the total square footage of the home are not covered

(ii) Coverage is limited to one operating vehicle and the Enrollee's primary residence. The limit of one vehicle does not prohibit coverage for vehicle modifications or adaptations when a vehicle must be replaced.

(iii) **Provider Qualifications:** All services shall be provided in accordance with applicable State or local building codes. Providers of modifications must have a current license or certificate, if required by Minnesota Statutes or Administrative Rules, to perform their services. A provider of modification services must meet all professional standards and/or training requirements which may be required by Minnesota Statutes or Administrative Rules for the services that they provide. The MCO or its agent must enter into a contract or purchase agreement with Providers of this service.

(12) **Personal Care Assistant, Extended:** Personal care services include assisting an Enrollee with eating, bathing, dressing, personal hygiene, and activities of daily living. This service may also include meal preparation and such housekeeping tasks as bed making, dusting and vacuuming, which are incidental to the cares provided and essential to the health and welfare of the client. One PCA may care for up to three individuals at the same time provided their care needs can be adequately met and other statutory requirements are met.

(a) Personal Care Assistance services are defined in the Minnesota Medicaid State Plan, except the limitations on the number of units do not apply. In addition, care direction for those who cannot direct their own care may be provided by a family member, significant care giver (who is not the PCA), or the coordinator. All other safeguards and provider standards under the State Plan do apply. Limitations on the amount, duration, and scope of PCA services will be specified in the individual Community Support Plan.

(b) **Provider Qualification:** A personal care assistant (PCA) must be an employee of a personal care provider organization, or under contract. PCAs must be at least 18 years of age and must meet the standards under Minnesota Rules, Statutes, §§ 256B.0625 subd 19 c, 256B.0651, 256B. 0655 and Minnesota Rules, parts 9505.0335 and may receive supervision by an appropriate professional pursuant to Minnesota Statutes, § 256B.0625, subd. 19c.

(13) **Prevocational Services:** Prevocational services are designed to prepare individuals for paid or unpaid employment but are not job-task oriented. Services include teaching concepts such as compliance, attendance, task completion, problem solving, and safety.

(a) Prevocational services are provided to Enrollees who are not expected to be able to join the general work force or participate in transitional sheltered workshop services within one year (excludes supported employment programs). When compensated, Enrollees are paid at less than 50% of the minimum wage.

(b) **Provider Qualifications:** County agencies, rehabilitative agencies, comprehensive outpatient rehabilitation facilities, adult day care centers or programs, providers of vocational rehabilitation services, providers of training and habilitation services, and community health centers must be qualified as follows:.

(i) Adult day care centers must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730. Adult day care programs are established under Minnesota Statutes, §§ 245A.01 to 245A.17.

(ii) Providers of training and habilitation services must be licensed under Minnesota Statutes, Chapter 245B and Minnesota Rules, parts 9525.1580 and 9525.1600.

a Vocational rehabilitation services must be certified by the Commission of Accredited Rehabilitation Facilities (CARF) to provide employment related services.

b Rehabilitation agencies must meet the standards under Minnesota Rules, parts 9505.0385 through 9505.0386.

c Comprehensive outpatient rehabilitation facilities must meet the standards under Minnesota Rules, parts 9505.0386 through 9505.0390.

d Community mental health centers are defined under Minnesota Statutes, § 245.62 and must meet standards under Minnesota Rules, part 9505.0260 and parts 9520.0750 through 9520.0870.

(14) **Residential Care:** Residential care services are provided to individuals in a residential care home. Residential care homes are licensed as board and lodging establishments and are registered with the Minnesota Department of Health as providing specialized services according to Minnesota Statutes, § 157.17. Residential services are defined as "supportive services" and "health related services."

(a) Supportive services means the provision of up to 24-hour supervision and oversight. Supportive services include:

(i) Providing transportation (when provided by the residential care home only);

(ii) Socialization (when socialization is part of the Community Support Plan, has specific goals and outcomes established and is not diversional or recreational in nature);

(iii) Assisting Enrollee in setting up meetings and appointments;

(iv) Assisting Enrollee in setting up medical and social services;

(v) Providing assistance with personal laundry (such as carrying the Enrollee's laundry to the laundry room). Enrollees receiving residential care services cannot receive both personal care services and residential care services. Assistance with personal laundry does not include any laundry (such as bed linen) that is included in the room and board rate.

(b) **Limit**: Health related services are limited to minimal assistance with dressing, grooming and bathing and to providing reminders to Enrollees to take medications that are self-administered or providing storage for medications, if requested. Service direction must be provided by the Enrollee or by residential care home staff with oversight by the coordinator.

(c) **Services and Items Not Covered**: The following are not covered in residential care: room and board, items of comfort or convenience, payments directly or indirectly to the Enrollee, the costs of facility maintenance, upkeep and improvement, and services provided, directly or indirectly, to members of the Enrollee's immediate family. Personal care assistant services and chore services are not covered for Enrollees receiving residential care.

(d) **Capacity Limit**: The total number of individuals living in the setting shall not exceed four (4) persons.

(e) **Exception to Limit**: when authorized by the commissioner in emergency situations when: a) the setting is needed to avert an

individuals placement in a regional treatment center or Nursing Facility; and b) one of the following criteria is met:

(i) An unexpected loss of an essential caregiver.

(ii) A sudden loss of housing due to closure.

(iii) Loss of services or housing due to a natural disaster.

(iv) It is necessary to place siblings together.

(f) The exception for services delivered in a site with more than four (4) individuals shall not exceed two years. This capacity limit does not apply to people who are 55 years of age or older.

(g) **Provider Qualifications:** Residential care service providers must meet standards of licensure, certification or registration where they exist either in state law or administrative rule. Current standards for residential care services are in Minnesota Statutes, § 157.17. The residential care home must meet the appropriate local building codes and not serve more than four (4) individuals in a living setting. Vendors providing services prior to July 1, 2000 are not subject to this capacity limit.

(i) Residential services must be provided by the management of the residential care home. For staff providing assistance with dressing, grooming, bathing, or providing medication reminders or storage of medication, eight (8) hours of training and orientation by a registered nurse is required. If medications are to be distributed or stored, a registered nurse must provide supervision of this process. In addition, staff providing supervision, oversight and supportive services must possess:

a Communication skills including the ability to read and write, follow written and verbal instructions, and converse on the telephone;

b Experience or training in caring for individuals with functional limitations;

c The ability to perform essential job functions;

d Self-direction to work under intermittent supervision, to deal with minor emergencies arising in connection with the assignment, and work under stress in a crisis situation;

e Understanding and respect regarding maintaining confidentiality; and

f A valid Minnesota driver's license and insurance coverage in accordance with state requirements, if they provide transportation to waiver Enrollees.

(15) **Respite:** Services provided to individuals unable to care for themselves: furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care and who are not paid for their services.

(a) Respite may be provided in either an out-of-home setting or in the Enrollee's own home.

(b) Respite service is not available to Enrollees living in settings where Customized Living, 24-Hour Customized Living, residential care services, or foster care furnished by shift staff are provided. Respite care is limited to thirty (30) consecutive days per respite stay.

(c) **Provider Qualifications:** Out-of-home respite care must be provided in a facility such as a Medicaid certified hospital or Nursing Facility, licensed foster care home, camp, or community residential facility (e.g., board and lodge, housing with services establishment, etc.) which is licensed according to Minnesota Rules and Statutes. If respite care is provided in a non-Medical Assistance certified facility, that facility must meet applicable state licensure standards.

(i) In-home respite care providers must be individuals who meet the state qualifications of registered or licensed practical nurses, home health aides, or personal care assistants who have been specifically trained to provide care to the Enrollee. Respite care workers must have first-aid training and cardiopulmonary resuscitation training. A respite care worker who is a home health aide or personal care assistant must be under the supervision of a registered nurse. The registered nurse must assure that the respite care worker is able to read and follow instructions, able to write clear messages, and has the level of skill required by the Enrollee's needs.

(16) **Specialized Supplies and Equipment:** Supplies and equipment includes durable and non-durable medical supplies and equipment which provide a necessary adjunct to direct treatment of the Enrollee's condition. Supplies and equipment may also include devices, controls, or appliances, which enable the Enrollee 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.

(a) Emergency response systems and monitoring technology services do not affect licensing standards. Providers must continue to meet all applicable licensing requirements. If the monitoring technology is

intended to replace supervision services, a variance to the Provider's license may be required. The case manager must assure that the Provider obtains any necessary variances before authorizing services.

(b) Coverage for Specialized Supplies and Equipment also includes items necessary for life support, ancillary supplies necessary for the proper functioning of such items. Supplies and Equipment are defined in the Minnesota Medicaid State Plan, except under MnDHO limitations on the amount, scope, and duration of the services do not apply. All safeguards and provider standards under the State Plan do apply. The limitation for each Enrollee will be specified in the Community Support Plan and monitored by the coordinator. All prescription and over-the counter medications, compounds and solutions, and related fees including premiums and co-payments are not covered.

(c) **Provider Qualifications:** Home health agencies, pharmacies, and medical suppliers and other providers approved by the MCO.

(17) **Supported Employment:** Supportive Employment services consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment includes activities needed to sustain paid work by Enrollees receiving waiver services, including supervision and training.

(a) When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by Enrollees receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

(b) Supported employment services can be authorized by the coordinator as part of an Community Support Plan only when: (1) the Enrollee engages in paid employment in one of a variety of settings where persons without disabilities are also employed; (2) public funds are necessary for the purpose of providing ongoing training and support services throughout their period of employment; and (3) the Enrollee has the opportunity for social interactions with persons who do not have disabilities and who are not paid caregivers. Supported employment may include:

(i) Individualized assessment;

(ii) Individual and group counseling;

(iii) Job development;

(iv) Job placement activities which produce an appropriate job match for the Enrollee and the employer;

(v) On-the-job training for work and related work skills required for job performance;

(vi) Ongoing supervision and monitoring of the Enrollee's performance;

(vii) Long-term support services to assure job retention;

(viii) Training in related skills essential to obtaining and retaining employment such as the effective use of community resources;

(ix) Training in use of break and lunch areas; and, transportation between the Enrollee's home and work place when other forms of transportation are unavailable or inaccessible.

(c) **Provider Qualifications:** Same as Prevocational Services.

(18) **Transitional Support Services.** Transitional Support Services include one time expenses related to establishing community based housing for persons transitioning to an independent or semi-independent community residence from a certified Nursing Facility or other licensed setting.

(a) **Items and Expenses.** Items and expenses that may be covered are limited to:

(i) Lease or rental deposits;

(ii) Utility set-up fees and deposits;

(iii) One-time pest and allergen treatment of the home;

(iv) Window coverings;

(v) One-time household supplies; and

(vi) Essential furniture.

(b) One-time household supplies are limited to a maximum of $300 (of the $3,000) and include dishes, drinking glasses, flatware, pots and pans, sheets, towels, and cleaning supplies. Essential furniture is limited to a bed frame, mattress and spring, dresser, dining table and chairs, and a sofa. The cost of essential furniture may not exceed $1000 (of the $3000).

(c) The following are not covered: 1) Rent and mortgage payments; 2) food and clothing; and 3) recreational and diversionary items. Recreational and diversionary items include but are not limited to computers, VCRs,

DVD players, televisions, cable television access, etc. This service does not include services or items that are covered under other waiver services such as homemaker, home modifications and adaptations, or supplies and equipment.

(d) This service is limited to a maximum of $3,000 per Enrollee and must be identified in the Enrollee's Community Support Plan. To be eligible an Enrollee must:

(i) Be at least 18 years old

(ii) Not have another source to fund or attain the items or support;

(iii) Be moving from a living arrangement were these items were provided;

(iv) Be moving to a residence where these items are not normally furnished (e.g., items cannot be provided in a setting where the setting is otherwise responsible to provide them); and

(v) If the Enrollee is not presently using waiver services, he or she must be evaluated and the care coordinator must reasonably expect that the Enrollee will be eligible for and will open to the waiver within 180 days; the coordinator reasonably expects the Enrollee to remain enrolled in the waiver for no less than 180 days after moving from the licensed setting

(vi) .The coordinator must assure that the transitional support items are necessary and reasonable for the Enrollee to establish an independent or semi-independent household. The items must be listed in the Enrollee's individualized Community Support Plan. Used items may be purchased if they are determined safe by reasonable standards. If authorized, the coordinator must clearly define in the Enrollee's Community Support Plan what will be covered to assure that there is no duplication with other waiver or State plan services. Transitional services must be provided prior to or within 45 days of the Enrollee's move from the licensed setting The agency is not required to have contracts or purchase agreements with vendors for this service with the exception of those providing personal supports.

(19) **Additional Specifications for Support Services.** Supports are limited to a maximum of forty (40) hours of paid assistance to locate and secure a home for the Enrollee, move personal items from the licensed facility to the home, arrange for utilities to be connected, and purchase of one-time household supplies and essential furniture. The payment rate for this assistance shall not exceed the state Medicaid rate for Personal Care Assistance services. The total amount covered for this assistance is included in the $3000 maximum.

(a) **Provider Qualifications**: Providers of personal supports must, as determined by the Lead Agency, have:

(i) General knowledge of disabilities and chronic illnesses and their effect on an Enrollee's ability to live independently in the community;

(ii) The ability to assess the Enrollee's community-based housing needs;

(iii) Functional knowledge of housing options in the community desired by the Enrollee;

(iv) A sufficient understanding of housing procurement procedures and funding mechanisms to adequately advise the Enrollee regarding these matters;

(v) The ability to assist the Enrollee in attaining the services and supports that are covered by transitional services; and

(vi) A contract with the agency that outlines their service responsibilities including maintaining Enrollee confidentiality.

(20) **Transportation, Extended:** Transportation service is offered to enable the Enrollee to gain access to services, activities, and resources as specified in the Community Support Plan, in addition to and not to replace Medical Transportation provided under the acute care services, pursuant to the State Plan.

(a) The need for Extended Transportation Services must be documented in the Enrollee's Community Support Plan. This service is covered only when transportation is not available free of charge.

(b) **Provider Qualifications:** Providers of Common Carrier Transportation are bus, taxicab, other commercial carrier, private automobile, or a county-owned or leased vehicle. Special transportation: transport of an Enrollee who, because of physical or mental impairment, is unable to use a common carrier and does not require ambulance transportation.

(c) Private individuals may be designated to provide transportation when they meet the Enrollee's needs and preferences in a cost-effective manner. Drivers must have a valid driver's license and adequate insurance coverage, as required by Minnesota Statutes, Chapter 65B. Providers of special transportation, not excluded in Minnesota Statutes, § 174.30, must be certified by the Minnesota Department of Transportation under Minnesota Statutes, §§ 174.29 to 174.30.

(21) **Adult Day Care Bath:** An Enrollee may receive a bath provided by an adult day care provider. Provider Qualifications: Same as Adult Day Care.

(22) **Additional TBI Waiver Services**. The following TBI-Nursing Facility and TBI-Neurobehavioral Hospital services are only available to Enrollees who meet the eligibility requirement for the TBI-NF or TBI-NB waiver and who, but for the provision of such services, would require institutional TBI-NF or TBI-NB level of care, the cost of which would be reimbursed under the Medicaid State Plan.

(a) **Behavioral Programming**: Behavioral programming consists of individually designed strategies to decrease Enrollee severe maladaptive behaviors which interfere with the Enrollee's ability to remain in the community. Behavioral Programming includes: 1) a complete assessment of the maladaptive behavior(s); 2) development of a structured behavioral intervention plan; 3) implementation of the plan, on-going training and supervision to caregivers and /or behavioral aides; and 4) periodic reassessment of the behavioral plan. Specific details of services and Provider Qualifications are found in Exhibit VI.

(b) **Chore Services:** Chore services are used to maintain the Enrollee's home in a clean, sanitary, and safe environment. This includes heavy household chores such as washing floors, windows, and walls, tacking down loose rugs and tiles, moving heavy items in order to provide safe access inside the home and shoveling snow to provide access and egress. Chore Services can also include customary charges made for the delivery of grocery store products, no more than once every seven (7) days.

(i) These chore services will be provided only in cases where neither the Enrollee, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

(ii) **Provider Qualifications:** Providers must meet an Enrollee's needs and as specified in the Enrollee's Community Support Plan.

(c) **Adult Companion:** Companion services consist of non-medical care (i.e., supervision and socialization) provided to a functionally impaired adult. A companion may assist the Enrollee with such tasks as meal preparation, laundry and shopping but does not perform these activities as discrete services. A companion may also perform light housekeeping tasks which are incidental to the care and supervision of the Enrollee and also may accompany the Enrollee into the community.

(i) Companion services must be provided only in accordance with a therapeutic goal in the Community Support Plan.

(ii) **Provider Qualifications:** A companion must be able to read, write, and follow written and oral instructions. A companion must have had experience and/or training in homemaking skills, and/or in care of individuals with disabilities or brain injuries. He or she must have the ability to converse effectively on the telephone, to work under intermittent supervision, and to manage emergency situations effectively. A companion must understand, respect, and maintain confidentiality in regard to case details. Providers may accompany the Enrollee into the community. Providers cannot be the Enrollee's legal guardian or related to the Enrollee as spouse or other relative.

(d) Mental Health, Extended

(i) Services are defined in accordance with the State Plan, except that the limitation on the amount, duration, and scope of the service do not apply. All other safeguard and providers standards continue to apply.

(ii) **Provider Qualifications:** Providers must have the same qualifications as mental health providers enrolled in the Fee-for-service Medical Assistance program.

(e) **Night Supervision:** Night supervision services provides overnight assistance and monitoring of the Enrollee in his or her home for a period of no more than twelve (12) hours.

(i) Providers of night supervision must have the ability to provide a consistent approach when interacting with the Enrollee. This may include understanding and carrying out the Enrollee's behavior program, reinforcing independent living skills, and assisting with incidental daily activities.

(ii) **Provider Qualifications:** Night supervision providers must be at least eighteen (18) years old and have received a high school diploma. They must have had experience and/or a minimum of eight (8) hours training in caring for individuals with traumatic brain injury. They must have the ability to understand the recipient's programs and provide intervention when necessary. They must have good physical and mental health, and maturity of attitude towards work assignments. They must have the ability to converse on the telephone, work under intermittent supervision, deal with emergencies arising in connection with the assignment, and work under stress in a crisis situation. They must understand, respect and maintain confidentiality.

(f) **Structured Day Program (SDP):** Structured day program (SDP) services are directed at the development and maintenance of community living skills.

(i) SDP services must include intensive therapeutic interventions and take place in a non-residential setting separate from the home in which the Enrollee lives. Services will normally be furnished two or more hours per day, for one or more days per week, on a regularly scheduled basis. Structured day program services include supervision and specific training to allow Enrollees to attain their maximum potential. SDP services may include social skills training, sensory/motor development, reduction/elimination of maladaptive behavior. Services aimed at preparing the Enrollee for community reintegration (e.g., teaching concepts such as compliance, attending, task completion, problem solving, safety, money management, etc.) are also included. Physical, occupational, speech, and cognitive rehabilitation therapy will be provided in addition to the SDP if needed.

(ii) The structured day program may serve two types of Enrollees: 1) those who will benefit from continued rehabilitation; and 2) those who need a very structured environment due to severe behavior problems which prevent the client from participating in adult day care or other day programs.

(iii) **Provider Qualifications:** Structured day program services may be provided by the following:

a Rehabilitation agency that is certified by Medicare to provide restorative and specialized maintenance therapy.

b Comprehensive outpatient rehabilitation facility that is a nonresidential facility established and operated exclusively to provide diagnostic, therapeutic, and restorative rehabilitation services.

c Provider of adult day care services must be licensed under Minnesota Rules, parts 9555.9600 through 9555.9730.

d Provider of vocational rehabilitation services which is certified by the Commission on Accredited Rehabilitation Facilities (CARF).

e Community mental health centers as defined under Minnesota Statutes, § 245.62, which must meet standards under Minnesota Rules, parts 9520.0750 through 9520.0870.

(B) **Community Support Plan**. For each Enrollee who is screened and determined to require HCBS waiver services or Home Care Services as described in the State Plan, the MCO shall complete and implement a Community Support Plan that meets, at a minimum, the requirements of section Article. 2(31). The Community Support Plan shall be completed and

implemented within thirty (30) days of the LTCC assessment. The Community Support Plan must: 1) be developed by the Enrollee with assistance from the MCO; 2) be based upon Enrollee's assessed needs and interdisciplinary consultation; and 3) must be developed in consultation with other care disciplines in consultation with the Enrollee or the Enrollee's family and primary caregiver when appropriate. The Enrollee or Authorized Representative must sign the Community Support Plan and a form indicating that an explanation and choice of home and community based and consumer directed support services have been provided. A copy of the Community Support Plan will be given to the Enrollee. The Community Support Plan must: 1) meet federal requirements; 2) be in place before starting waiver services; and 3) be provided to the STATE upon request. The Community Support Plan must contain an emergency back up plan. In all cases, the Enrollee's Community Support Plan must address health and safety needs. This includes a determination by the case manager that the Provider is able to reasonably meet the needs identified in the Enrollee's community support plan.

(C) **Eligibility and Limitations**.

(1) The MCO shall provide CADI and TBI waiver services necessary to prevent or avoid institutionalization placement (in a Nursing Facility, specialized Nursing Facility, or neurobehavioral rehabilitative hospital) or to relocate Enrollees residing in institutional settings. HCBS shall also be provided to convert Enrollees residing in Nursing Facility or neurobehavioral rehabilitative hospitals to allow them to return to a community setting, and shall provide transitional services. The MCO must determine whether or not the Enrollee's needs can safely be met through the provision of HCBS services and must develop and implement a Community Support Plan based on information in the LTCC Screening Assessment and Comprehensive Care Plan.

(2) HCBS services will not be furnished to an Enrollee before a Community Support Plan is in place or while the Enrollee is an inpatient of a hospital, Nursing Facility except for respite care and transitional services as provided for in section 6.1.12(B)(1)(q). However, the MCO retains responsibility for providing Medically Necessary health care services including Home Care Services which may exceed the cost of appropriate institutional level of care in some cases.

(D) **Long Term Care Consultation (LTCC)**. The MCO shall provide:

(1) LTCC Screening as outlined in section 6.1.3 shall be utilized and results reported to the STATE.

(2) Initial evaluation of Level of Care to determine eligibility for CADI or TBI Waiver services must be performed, using the Long Term Care Consultation Form and criteria, within ten (10) working days after a request

for such evaluation by the Enrollee, or referral by other competent provider, such as a physician, discharge planning team or social worker.

(3) Such assessment shall be conducted by a Qualified Professional as defined in Article 2, Definition (129), using the Minnesota Long Term Care Consultation and Assessment Form (DHS-3428) to determine eligibility for Nursing Facility placement and/or CADI/TBI Waiver services according to the Level of Care Criteria, and pursuant to Minnesota Statutes, §256B.0911.

(4) The STATE will audit LTCC documents and TBI documents to ensure that the assessment of the Enrollee clearly indicates that she or he meets Level of Care Criteria, and to ensure consistency between the Enrollee's level of care and the services to be provided. If the review reveals placement of an Enrollee in an inappropriate Rate Cell, the screening will be returned by the STATE to the MCO to be returned to the screening agency for re-evaluation, then resubmitted to the STATE. If after a review of the resubmitted Screening Document the STATE determines that the Enrollee does not meet the Nursing Facility Level of Care Criteria, the Rate Cell will be assigned prospectively by the STATE. All LTCC Screening and TBI-NB 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 screening documents performed outside of the MnDHO project.

(5) When an Enrollee is determined to require a Nursing Facility, specialized Nursing Facility, or neurobehavioral hospital level of care, the Enrollee will be:

(a) Informed of feasible alternatives to the institution, including Home Care and Waiver Services;

(b) Offered a Community Support Plan consistent with the screening assessment which is designed to meet the needs of the individual and protect their 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.

(E) **OBRA (Omnibus Reconciliation Act) Screening**. For MnDHO, the Long Term Care Consultation shall include the completion of the questions on the OBRA Level I screening form. If mental illness (MI) or mental retardation (MR) diagnoses is indicated, the MCO must refer the Enrollee to the Local Agency for further OBRA Level II screening.

6.1.17 Home Care Services Covered under Minnesota Statutes, 256B.0625, subds. 6a, 7 and 19a and c, §§ 256B.0651, and § 1861(m) of the Social Security Act.

(A) Such services include:

(1) Skilled Nursing visits provided by a certified Home Health Care Agency, for Medical Assistance, up to the service limit described in Minnesota Statutes, § 256B.0651, Subd. 6(a), and for Medicare, so long as the Enrollee meets Medicare criteria. These services include telehomecare skilled nursing visits as authorized by Minnesota Statutes, § 26B.0653, subd. 1(b).

(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(a).

(3) Personal Care Assistant Services, up to the service limits established in Minnesota Statutes, § 256B.0655, including but not limited to subds. 2 and 6 (flexible use of hours), and 7 (Fiscal Intermediary and PCA choice option).

(a) The MCO must ensure that PCA providers keep specific documentation on file for each Enrollee, including but not limited to a physician statement of need, service plan, care plan and timesheets. The MCO shall also ensure PCA services are provided in accordance with Minnesota Statutes, § 256B.0655, including but not limited to, the limitations and Service Authorization for the option for flexible use of PCA hours, and as described in The Disability Services Program Manual (DSPM) on the STATE website. If the STATE provides the MCO notice that an individual is ineligible to participate as a PCA in MHCP, the MCO will ensure that funds received by the MCO from the STATE are not used to pay the individual for PCA services.

(b) Qualified Professional supervision of PCA Services as defined in Minnesota Statutes, § 256B.0625, subd. 19c and described in Minnesota Statutes, § 26B.0655, subd. 13.

(c) The MCO is responsible for reviewing the PCA assessment and service plan, and authorizing the amount, duration and frequency of the PCA services. If the MCO authorization requires changes to the assessed hours in the service plan, the MCO is responsible for assuring that the service plan is updated to reflect new changes. The MCO must assure that the Provider and the Enrollee are notified in writing of the changes in the service plan, including reasons for any changes. The MCO will collaborate with the STATE through the DHS PCA Managed Care Workgroup to develop PCA service plan templates and processes for updating the service plan consistent with DHS bulletin 08-25-06.

(4) Private Duty Nursing Services, for Medical Assistance, up to the limits established in Minnesota Statutes, § 256B.0654, subd. 2. 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, or legal guardian.

(5) 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.

(6) Medical Equipment and Supplies, pursuant to section 6.1.20.

(B) For Enrollees who are ventilator-dependent, the limits described in A-F above do not apply; the limits for these Enrollees are as described in Minnesota Statutes, § 256B.0651, subd. 6(b).

(C) If the MCO requires Service Authorization for Home Care Services, it shall comply with section 6.20 of this Contract.

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:

(A) Will be provided with a hospice election process that is similar to the hospice election process used by a Medicare certified hospice agency; and

(B) Will be provided with the same choice and amount of services that would be available through a Medicare certified hospice agency.

6.1.19 Inpatient Hospital Services. Coverage for inpatient hospital services shall not exceed the actual semi-private room rate, unless a private room is determined to be Medically Necessary by the MCO. The MCO shall use the same criteria as the STATE to determine Medical Necessity when reviewing for authorization Enrollee's initial admission and continued services in a Neurobehavioral Rehabilitation Hospital (NBR). The criteria will be provided to the MCO by the STATE.

6.1.20 Interpreter Services. The MCO shall provide sign and spoken language interpreter services that assist Enrollees in obtaining their program's covered health services, to the extent that interpreter services are available to the MCO or its subcontractor when services are delivered. The intent of the limitation, above, is that the MCO should not delay the delivery of a necessary health care service, even if through all diligent efforts, no interpreter is available. This does not relieve the MCO from using all diligent efforts to make interpreter services available. The MCO is not required to provide an interpreter for activities of daily living in institutional and residential facilities, but is responsible to provide an interpreter for medical services provided by the MCO

outside of the residential facility and the per diem in institutional facilities under this Contract.

6.1.21 Laboratory, Diagnostic and Radiological Services.

6.1.22 Medical Emergency, Post-Stabilization Care, and Urgent Care Services. Pursuant to 42 CFR § 438.114, Medical Emergency, Post-Stabilization Care and Urgent Care services must be available twenty-four (24) hours per day, seven (7) days per week, including a twenty-four (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. The MCO shall not require an Enrollee to receive a Medical Emergency or Post-Stabilization Care Service within the MCO's network, as specified in section 6.20.2. For Medical Emergency services the MCO shall not:

(A) Require Service Authorization as a condition of providing a Medical Emergency service;

(B) Limit what constitutes a Medical Emergency condition based upon lists of diagnoses or symptoms;

(C) Refuse to cover Medical Emergency services based upon the emergency room provider, hospital, or fiscal agent not notifying the MCO of an Enrollee's screening and treatment within ten (10) calendar days of the Enrollee requiring Emergency Services.

(D) Hold the Enrollee liable for payment concerning the screening and treatment necessary to diagnose and stabilize the condition; or

(E) Prohibit the treating provider from determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that the determination of the treating provider is binding on the MCO for coverage and payment purposes.

6.1.23 Medical Equipment: Assistive Technology.

(A) **Philosophy of Care**. The MCO shall administer a program of assistive technology and service that is based on an independent living philosophy. The program shall consider the unique needs and capabilities of Enrollees, including developmental and lifestyle factors.

(B) **Assessment and Comprehensive Care Plan**. The MCO shall assess the Enrollee's need for Assistive Technology Devices and Services. Assistive technology needs, routine maintenance, specifications for obtaining interim or replacement devices, and method for obtaining back-up technology, if needed, shall be included in the service plan.

(C) **Covered Benefits**. The MCO shall provide, at minimum, the Assistive Technology Devices and Services covered under the State Medical Assistance Plan, as defined in Minnesota Rules, Part 9505.0310, (commonly known as "Rule 47"). The use of such devices and services shall meet Medical Necessity standards, and may be subject to Service Authorization criteria by the MCO.

(D) **Seamless Access**. To the extent possible, and with consideration of health, safety, and staffing limits, Enrollees who have been authorized for assistive devices shall have access to such throughout the continuum of care and service delivery system.

(E) **New Orders and Transition**. The MCO shall provide a timely response to new orders for assistive technology. During times of transition from one device to another, for whatever reason, the MCO shall make every reasonable effort to ensure that Enrollees do not experience any period of time without access to the assistive technology which they need.

(F) **Adequate Supplies**. The MCO shall ensure that assistive technology suppliers under contract will have an adequate supply of life-dependent assistive technology and services and shall have adequate capability to put life dependent assistive technology into timely service.

(G) **Substitution**. The Enrollee and the service coordinator must be consulted with regard to any substitution of assistive technology. Any substitution of Assistive Technology Devices is considered a reduction of services and is subject to notice and appeal rights.

(H) **Additional and Alternative Devices and Services**. In addition, the MCO may elect to provide alternative and/or additional benefits in the area of Assistive Technology Devices and Services. This may include additional/alternative technology and devices as well as additional/alternative suppliers. For example, the MCO may choose to consider Enrollee-designed, home-made devices, or non-traditional suppliers of such things as batteries and tires. The MCO may explore the option to recycle or refurbish used assistive technology equipment.

6.1.24 Durable Medical Equipment and Supplies. Medical Supplies and Equipment includes durable and non-durable medical supplies and equipment that provide a necessary adjunct to direct treatment of the recipient's condition. Supplies and equipment may also include devices, controls, or appliances, which enable the client to increase his or her ability to perform activities of daily living, or to perceive, control, or interact with the environment or communicate with others. This also includes ancillary supplies necessary for the appropriate use of such equipment. All safeguards and provider standards apply.

(A) Covered medical supplies, equipment, and appliances suitable for use in the home are those that are:

(1) Medically necessary;

(2) Ordered by a physician;

(3) Documented in a plan of care that is reviewed and revised as medically necessary by the physician at least once a year; and

(4) Provided to the Enrollee at the Enrollee's own place of residence that is a place other than a nursing facility.

(5) Medical equipment that is not covered in the facility per diem rate, but must be modified for the Enrollee, or the item is necessary for the continuous care and exclusive use of the Enrollee to meet the Enrollee's unusual medical need according to the written order of a physician, will be separately reimbursed by the MCO.

(6) Medical equipment includes replacement of lost, stolen or irreparably damaged hearing aids for an Enrollee who is twenty-one (21) years of age or older, but may be limited to two replacements in a five year period.

6.1.25 Medical Transportation Services. Also see section 6.5 for Common Carrier Transportation Services. Medical transportation services includes:

(A) Ambulance services required for Medical Emergency Care;

(B) Special transportation services for a an Enrollee who is physically or mentally incapable of transport by taxicab or bus.

6.1.26 Mental Health Services. In approving and providing mental health services, the MCO shall use a definition of Medical Necessity that is no more restrictive than the definition of Medical Necessity found in Minnesota Statutes, § 62Q.53 or described in section 2.78. Mental health services must be provided in accordance with Minnesota Rules, Part 9505.0323 (Medical Assistance payment for outpatient mental health services). Mental health services should be directed at rehabilitation of the client in the least restrictive clinically appropriate setting. For adult Mental Health Services, these services include:

(A) **Adult Mental Health Services**. Mental health services must be provided in accordance with Minnesota Rules, Part 9505.0323 (Medical Assistance payment for outpatient mental health services). Mental health services should be directed at rehabilitation of the client in the least restrictive clinically appropriate setting. Services include:

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

will require behavioral health Providers performing diagnostic assessments to:

(a) Screen all adult clients upon initial access of behavioral health services for the presence of co-occurring mental illness and substance use disorder using a screening tool of the Providers' choice, but must meet the following criteria:

(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 both adults and adolescents; and

(iii) Tool can be used in either interview or self-report format.

(c) The STATE recommends the following 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 provided during a short-term stay in an intensive residential therapy setting (IRTS) 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.

   (a) The MCO may participate in revising standards and guidelines for Adult Rehabilitative Mental Health Services (ARMHS), Intensive Residential Treatment (IRT) and Assertive Community Treatment (ACT) in order to establish consistent standards and guidelines for behavioral health Providers.

(7) Day treatment

(8) Partial hospitalization.

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

(10) Inpatient and outpatient treatment.

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

(12) Neuropsychological assessment.

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

(14) Medication management.

(15) 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.

(16) 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.

(17) Consultation provided by a psychiatrist via telephone, e-mail, facsimile, or other means of communication, to Primary Care Providers. The consultation must be documented in the patient record maintained by the Primary Care Provider. Consultation provided without the Enrollee being present is subject to federal limitations and data privacy provisions and must have the Enrollee's prior consent; and

(18) Upon federal approval, mental health outpatient treatment benefits for consistent with DHS guidelines and protocols, dialectical behavior therapy (DBT) for adults age eighteen (18) and older diagnosed with severe symptoms and significant dysfunction consistent with the current DSM criteria for a Borderline Personality Disorder.

(19) The MCO may participate in a workgroup with DHS to establish standards and guidelines for DBT.

(B) **Adult Mental Health Targeted Case Management (AMH-TCM).** Effective July 1, 2009, the MCO shall make available to enrollees, MH-TCM services that comply with Minnesota Rules, Parts 9520.0900 to 9520.0926 (Rule 79) that establish standards and procedures for providing case management services to adults with serious and persistent mental illness (SPMI) as authorized by Minnesota Statutes, §§ 245.461 to 245.486.

(1) The MCO may offer substitute models of mental health targeted case management services to enrollees who meet SPMI criteria with the consent of the individual, if the substitute model includes all four activities that comprise the CMS definition for targeted case management services, including:

(a) Comprehensive assessment of the Enrollee to determine the need for any medical, educational, social or other services;

(b) Development of a specific care plan that:

(i) Is based on the information collected through the assessment;

(ii) Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;

(iii) Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and

(iv) Identifies a course of action to respond to the assessed needs of the eligible individual.

(c) Referral and related activities to help the Enrollee obtain needed services including activities that help link an individual with:

(i) Medical, social, educational providers; or

(ii) Other programs and services capable of providing needed services, such as making referrals to providers, and scheduling appointments for the individual.

(d) Monitoring and follow-up activities, including necessary Enrollee contact to ensure the care plan is implemented, and adequately addresses the Enrollee's needs. These activities and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:

(i) Services are being furnished in accordance with the individual's care plan;

(ii) Services in the care plan are adequate; and

(iii) If there are changes in the needs or status of the individual, necessary adjustments must be made to the care plan and to service arrangements with providers.

(C) All MH-TCM services must meet the following quality standards:

(1) Assure adequate access to MH-TCM for all eligible Enrollees pursuant to Minnesota Rules parts 9520.0900 to 9520.0903.

(a) The MCO agrees to work with the STATE to provide adequate access to AMH-TCM. This includes limiting the case manager average caseload as specified in Minnesota Rules, part 9520.0903, subp. 2, in order to attend to the outcomes specified for case management services as specified in Minnesota Rules, Part 9520.0905.

(b) The STATE acknowledges that MH-TCM Providers may provide services to Enrollees for multiple health plans and fee-for-service, and agrees to monitor caseload ratios and will provide feedback to the MCOs regarding the caseload ratios of all contracted case management Providers.

(2) Provide face-to-face contact with the Enrollee at least once per month, or as appropriate to Enrollee need pursuant to Minnesota Rules 9520.0914, subp. 2. B.

(3) Case Managers for AMH-TCM services must meet the qualifications and supervision requirements listed in Minnesota Statutes, § 245.462, subds. 4 and 4(a), and Minnesota Rules, Part 9520.0912.

(D) 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.

(E) **Children's Mental Health Services**. All mental health professional services for Children up to age twenty-one (21) shall be delivered by the MCO in a manner so as to establish or sustain the Enrollee at a level of mental health functioning appropriate to the Enrollee's developmental level. This includes:

(1) Diagnostic assessment, psychological testing with an explanation of findings in order to establish or rule out the appropriate mental psychiatric diagnosis and develop the individual treatment plan. A diagnostic assessment must include the direct assessment of the Enrollee. The MCO will require behavioral health Providers performing diagnostic assessments to:

(a) Screen all adolescent clients upon initial access of behavioral health services for the presence of co-occurring mental illness and substance use disorder using a tool that meets the criteria listed in section 6.1.20(A)(1)(a); or use one of the following nationally recognized screening 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 CRAFFT; 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 Pediatric Symptom Checklist (PSC) or other mental health tools recommended by DHS.

(2) Providing subacute psychiatric care for Children under the age of twenty-one (21).

(3) Providing Children's Therapeutic Services and Supports pursuant to Minnesota Statutes, § 256B.0943, including:

(a) Day treatment services;

(b) Therapeutic services in preschools;

(c) Skills training; and

(d) Mental health behavioral aide (MHBA) services.

(4) Children's Mental Health Crisis Response Service pursuant to Minnesota Statutes, § 256B.0944;

(5) Individual, family, and group therapy and multiple family group psychotherapy, including counseling related to adjustment to physical disabilities or chronic illness;

(6) Inpatient and outpatient treatment;

(7) Assessment of Enrollees whose health care seeking behavior and/or mental functioning suggests underlying mental health problems;

(8) Neuropsychological assessment;

(9) Neuropsychological rehabilitation and/or cognitive remediation training for Enrollees with a diagnosed neuropsychological or neurodevelopmental disorder who can benefit from cognitive rehabilitation services;

(10) Medication management;

(11) Provide 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;

(12) 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;

(13) Consultation provided by a psychiatrist via telephone, e-mail, facsimile, or other means of communication, to Primary Care Providers, including pediatricians. The consultation must be documented in the patient record maintained by the Primary Care Provider. Consultation provided without the Enrollee being present is subject to federal limitations and data privacy provisions and must have the Enrollee's consent;

(14) Provide Children's residential mental health treatment consistent with Minnesota Statutes § 256B.0945. Access to this level of care must include:

(a) Level of care determination, employing the Child and Adolescent Service Intensity Instrument (CASII) or equivalent measures of symptom severity and functional impact;

(b) Timely and cooperative decision-making with counties, and

(c) Consistent with STATE guidelines for admission, continued stay and discharge, as published in DHS Bulletin # [Placeholder].

(15) The MCO agrees to work with the STATE in implementing Assertive Community Treatment for Transition Youth and Treatment Fostercare services should legislative and federal authority allow their inclusion in the MHCP benefit set;

(16) The MCO agrees to work with the STATE in implementing Evidence-Based Practices (EBPs), and particularly the Minnesota Model of research-informed practice elements and specific constituent practices in this database;

(17) The MCO must assure that Mental Health Professionals 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.

(18) **Children's Mental Health Targeted Case Management (CMH-TCM).** Effective July 1, 2009, 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 Children with Severe Emotional Disturbance (SED) as authorized by Minnesota Statutes, §§ 245.487 to 245.4889 and § 256B.0625, subd. 20.

(a) The MCO may offer substitute models of mental health targeted case management services to Enrollees who meet SED criteria with the consent of Enrollee if the substitute model includes all four activities that comprise the CMS services definition for targeted case management services, including:

(i) A comprehensive assessment of the Enrollee to determine the need for any medical, educational, social or other services,

(ii) The development of a specific care plan that:

a Is based on the information collected through the assessment;

b Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;

c Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and

d Identifies a course of action to respond to the assessed needs of the eligible Enrollee.

(iii) Referral and related activities to help the Enrollee obtain needed services including activities that help link an individual with:

a Medical, social, educational Providers; or

b Other programs and services available for providing needed services, such as making referrals to Providers for needed services and scheduling appointments for the individual, and

(iv) Monitoring and follow-up activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. These activities, and contact, may be with the individual, his or her family members, Providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:

a Services are being furnished in accordance with the in Enrollee's care plan;

b Services in the care plan are adequate; and

c If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with Providers.

(v) In addition, all CMH-TCM services must meet the following quality standards:

a Assure adequate access to MH-TCM for all eligible Enrollees pursuant to Minnesota Rules parts 9520.0900 to 9520.0903;

i The MCO agrees to work with DHS to provide adequate access to CMH-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 9520.0904.

ii The STATE acknowledges that MH-TCM Providers may provide services to Enrollees for multiple health plans and fee-for-service, and agrees to monitor caseload ratios and will provide feedback to the MCOs regarding the caseload ratios of all contracted case management Providers.

b Offer face-to-face contact with the Child, or if more appropriate, the Child's parent(s) or guardian(s) at least once a month pursuant to Minnesota Rules, 9520.0914 subp. 2. A.

(vi) Case Managers for CMH-TCM services must meet the qualifications and supervision requirements listed in Minnesota Statutes, 245.4871, subd. 4., and Minnesota Rules, Part 9520.0912

(F) **Court Ordered Treatment**. The following procedures apply to mental health services that are court-ordered for adult or child Enrollees.

(1) The MCO must provide all court-ordered mental health services pursuant to Minnesota Statutes, §§ 62Q.535, subds. 1 and 2; 253B.045, subd. 6; and 260C.201, subd. 1, 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 care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist. The MCO shall assume financial liability for the evaluation that includes diagnosis and an individual treatment plan, if the evaluation has been performed by one of the Participating Providers.

(2) The court-ordered mental health services shall not be subject to a separate Medical Necessity determination by the MCO as provided for in section 6.6.1 of this Contract. However, the MCO may make a motion for modification of the court-ordered plan of care, including a request for a new 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, or his or her designee, of the center or facility, no longer certifies that the Enrollee is in need of continued treatment at a hospital level of care, 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.

(G) Civil Commitment .

(1) The MCO shall:

(a) Work with hospitals in the MCO's network to develop procedures for prompt notification by the hospital to the MCO upon admission of an Enrollee for psychiatric inpatient services;

(b) Work with county pre-petition screening teams to develop procedures for notification within seventy-two (72) hours by the pre-petition screening team to the MCO when an Enrollee is the subject of a pre-petition screening investigation;

(c) Provide expedited determination of eligibility for MH-TCM for MCO Enrollees who are referred to the health plan as potentially eligible for MH-TCM; and

(d) Assign mental health case management as court ordered services for Enrollees with mental illness who are committed, or for Enrollees whose commitment has been stayed or continued.

(2) The Mental Health 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:

(i) Testifying in court, and

(ii) Preparing and providing requested documentation to the court;

(b) Report to the court within the court-required timelines regarding the Enrollee's care plan status and recommendations for continued commitment, including, as needed, requests to the court for revocation of a provisional discharge;

(c) Provide input only for pre-petition screening, court-appointed independent examiners, substitute decision-makers, or court reports for Enrollees who remain in the facility to which they were committed;

(d) Provide AMH-TCM coverage which includes discharge planning for up to one hundred and eighty (180) days prior to an Enrollee's discharge from an Inpatient Hospitalization in a manner that works with, but does not duplicate, the facility's discharge planning services; and

(e) Ensure continuity of health care and case management coverage for Enrollees in transition due to change in benefits or change in residence.

6.1.27 Nursing Facility (NF) Services. See section 4.22 for SNF/NF Benefit.

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

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

(B) Prenatal Care Services. The MCO must perform the following tasks:

(1) All pregnant Enrollees must be screened during their initial prenatal care office visit. The purpose of the screening is to determine the Enrollee's risk of poor pregnancy outcome as well as to establish an appropriate treatment plan, including enhanced health services if the Enrollee is an at-risk Pregnant Woman as defined in Minnesota Rules, Part 9505.0353. A referral to the Women, Infants, Children Supplemental Food and Nutrition Program (WIC) must be made when WIC assessment standards are met.

(2) Those women who are identified as at-risk, according to an approved STATE assessment form, must be offered enhanced prenatal services. Enhanced prenatal services include: at-risk antepartum management, Care Coordination, prenatal health education, prenatal nutrition education, and a postpartum home visit.

6.1.29 Outpatient Hospital Services, including Emergency Care.

6.1.30 Personal Care Attendant (PCA) Services as specified in section 6.1.17(A)(3).

6.1.31 Physician Services and physician supervision according to 42 CFR § 417.416. Physician Services include Telemedicine Consultation. Coverage of Telemedicine Consultations is limited to three Telemedicine Consultations per Enrollee per week.

6.1.32 Podiatric Services.

6.1.33 Prescription Drugs and Over-the-Counter Drugs.

(A) Covered prescription and over-the-counter drugs that are: 1) prescribed by a Provider who is licensed to prescribe drugs within the scope of his or her profession; 2) dispensed by a Provider who is licensed to dispense drugs within the scope of his or her profession; and 3) contained in the Medical Assistance Drug Formulary or that are the therapeutic equivalent to Medical Assistance formulary drugs, except those drugs covered under the Medicare Prescription Drug Program under Medicare Part D for Medicare eligible Enrollees.

(B) For Dual Eligibles, 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, § 1395-8(d)(2)(E), which are covered by Part D, shall not be covered.

(C) Pursuant to Minnesota Statutes, § 256B.0625, Subd. 13(c), the MCO may allow pharmacists to prescribe over-the-counter drugs.

(D) If the MCO chooses to have a drug formulary or policies which are more restrictive than the STATE's Drug Formulary or policies, the MCO shall provide any necessary drug at its own cost to Enrollees on behalf of whom the STATE intervenes, following the STATE's review by a pharmacist and physician. If the STATE does such an intervention, it shall also initiate a corrective action plan to the MCO, which the MCO must implement.

(E) Upon request of the STATE, the MCO shall submit a copy of the MCO'S drug formularies including the SNP's Medicare Part D formulary. The MCO may fulfill this requirement by making the drug formulary available on the MCO's website and providing the link to the STATE.

(F) The MCO agrees to offer SNP formularies appropriately tailored to the special needs of Dual Eligibles in that the number and types of drugs required to be prior authorized are comparable to that currently required under the Medicaid program. The STATE may review public information about the MCO SNP Medicare Part D formularies and may discuss problems or concerns with coverage and prior authorization with the MCO.

(G) The MCO agrees to coordinates the provision of both Medicare and Medicaid drug coverage so that coverage is as seamless as possible for the Enrollee.

(H) The MCO assures that their pharmacy benefits manager (PBM) will administer Medicaid drugs according to Medicaid requirements and shall not apply Medicare rules to Medicaid 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, inadequacies mean 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. 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, 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.

(N) Medication Therapy Management (MTM) Care Services. Medication Therapy Management (MTM) Care Services are covered pursuant to Minnesota Statutes, § 256B.0625, subd. 13h and the Medication Therapy Management Services listed on the STATE's MHCP Enrolled Providers website. MTM services are covered except for Enrollees receiving drugs covered by Medicare Part D, for whom MTM services are covered by Medicare.

6.1.34 Prosthetic and Orthotic Devices. Prosthetic and Orthotic devices include related medical supplies.

6.1.35 Public Health Services. Public health clinic services and public health nursing clinic services as they are described in Chapter 8 of the Provider Manual which is incorporated by reference and made a part of this Contract, as applicable.

6.1.36 Reconstructive Surgery. Reconstructive surgery, as described in Minnesota Statutes, § 62A.25, subd. 2, and the Women's Health and Cancer Rights Act of 1998 (WHCRA), Pub. L. No. 105-277.

6.1.37 Rehabilitative and Therapeutic Services (both evaluation and treatment) including:

(A) Physical therapy (including specialized maintenance therapy, pursuant to Minnesota Rules, Part 9505.0390);

(B) Speech therapy (including specialized maintenance therapy), pursuant to Minnesota Rules, Part 9505.0390);

(C) Occupational therapy (including specialized maintenance therapy, pursuant to Minnesota Rules, Part 9505.0390);

(D) Audiology;

(E) Respiratory therapy; and

(F) Relocation targeted case management services pursuant to Minnesota Statutes, § 256B.0621 Subd 2(4).

6.1.38 Second Opinion. MCOs must provide, at the MCO expense, a second medical opinion within the health plan upon Enrollee request pursuant to Minnesota Rules, Part 9500.1462, item A.

6.1.39 Skilled Nursing Facility (SNF) Services. Medical or nursing care services provided in a Medicare certified Nursing Facility that are furnished under physician orders that:

(A) Require the skills of technical or professional personnel, and

(B) Are provided either directly by or under the supervision of such personnel and are required and provided on a daily basis as required under § 1819 of the Social Security Act and 42 CFR § 409.32 and 409.33.

Medicare covers inpatient care in a SNF for up to one hundred (100) days of post-hospital care for each Benefit Period. Also see section 4.22 for SNF/NF Benefit. The three day prior hospital stay requirement under 42 CFR § 409.30 is waived.

6.1.40 Specialty Care. To achieve both quality and cost-effective care, the MCO's managed care system must provide facilitated access to specialty services, while still allowing the MCO to retain some oversight on utilization. The MCO's system must include the following elements:

(A) **Limited Referral**. The MCO shall establish guidelines by which an Enrollee may access a course of specialty care.

(B) **Standing Referral**. The MCO shall establish guidelines by which an Enrollee may apply for a standing referral to a specialist, if such a standing referral is necessary for appropriate services. Guidelines for standing referrals must specify the necessary criteria and conditions which must be met for an Enrollee to obtain a standing referral.

(C) **Out-of-Network Specialists**. The MCO shall have a process to review requests for access to out-of-network specialists, centers of excellence, and experts, and approve, if such access is Medically Necessary and meets the MCO's Service Authorization guidelines. This will include the provision of out-of-area transportation.

(D) **Specialists as Primary Care Providers**. In consultation with the Enrollee or the Enrollee's family the MCO shall evaluate the need, in individual cases, for permitting a specialist to function as an Enrollee's Primary Care Provider.

(E) **Referrals for Rare and Low Prevalence Conditions**. The MCO shall include in its' managed care system a process to review authorized referrals to out of network Providers for rare and low prevalence conditions, so that Enrollees have access to appropriate expertise for such conditions.

6.1.41 Transplants. Covered transplants include: cornea, heart, kidney, liver, lung, pancreas, heart-lung, intestine, intestine-liver, pancreas-kidney, pancreatic islet cell, stem cell, bone marrow and other transplants that are listed in the Provider Manual, covered by Medicare, or recommended by the STATE's medical review agent. All organ transplants must be performed at transplant centers meeting United Network for Organ Sharing (UNOS) criteria or at Medicare approved organ transplant centers. Stem cell or bone marrow transplant centers must meet the standards established by the Foundation for the Accreditation of Cellular Therapy (FACT).

6.1.42 Tuberculosis Related Services. Includes Case Management and Directly Observed Therapy (DOT), which consists of the 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's as a preferred 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..

6.1.43 Vaccines and Immunizations. Covered vaccines and immunizations include, but are not limited to, recommendations by the Minnesota Department of Health. This includes, but is not limited to, the human papilloma virus (HPV) immunizations for female Enrollees ages eighteen (18) to twenty-six (26) and Zostavax for Enrollees ages sixty (60) and over.

6.1.44 Vision Care Services. Vision care services include vision examinations, eyeglasses, and optician, optometrist and ophthalmologist services. Eyeglasses, sunglasses and contact lenses shall be provided only if prescribed by or through the MCO participating physicians or participating optometrists. The MCO must make available a reasonable selection of eyeglass frames, but is not required to make available an unlimited selection. Replacement of lost, stolen or irreparably damaged eyeglasses, sunglasses, and contact lenses may be covered upon a showing of Medical Necessity and may be limited to the replacement of the same frames.

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 Substitute Health Services if such services are, in the judgment of the MCO, medically

appropriate and cost-effective. Substitute Health Services submitted as encounter data will be considered in calculations of MCO costs.

6.2.1 Timely Payment of Substitute Health Services. The MCO shall have a mechanism for timely payment of Substitute Health Services provided in section 6.2 and consumer directed community support services in section 6.1.12(B)(1)(e). Substitute Health Services submitted as encounter data will be considered in calculations of MCO costs pursuant to section 4.19.

6.3 Additional Services Permitted. The MCO may provide or arrange to have provided services in addition to the services described in Article 6, as permitted by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services under § 1915(a) of the Social Security Act, 42 U.S.C. 1315 et. seq., for Enrollees for whom, in the judgment of the MCO's Care Coordination 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 Non-Traditional, Ancillary, and Needs-Driven Support Services Permitted. The MCO may provide or arrange to have provided highly-individualized informal or non traditional support services in addition to the services described in Article 6. The provision of such services may or may not be Medically Necessary. However, the provision of any such services shall not affect the calculation of capitation rates pursuant to Article 4.

6.5 Common Carrier Transportation Services.

6.5.1 General. In addition to the transportation services specified in section 6.1.21, and except for the services described in section 6.5.2, the MCO shall provide Common Carrier Transportation to its Enrollees for the purpose of obtaining covered health care services. Payment for these services is included in the capitation rates in Exhibit II for transporting an Enrollee to or from the site of a non-Emergency service covered under this Contract in the metropolitan counties of the Service Area, pursuant to Minnesota Statutes, § 256B.691.

6.5.2 Common Carrier Transportation that is Not the Responsibility of the MCO. The Local Agency shall remain responsible for reimbursing the Enrollee for private automobile transportation to non-Emergency Covered Services, and meals and lodging as necessary. The MCO shall not be responsible for providing Common Carrier Transportation in any situation where the Enrollee has access to private automobile transportation to a non-Emergency service covered under this Contract. The MCO shall not be responsible for providing Common Carrier Transportation when an Enrollee chooses a non-Emergency Primary Care Provider located thirty (30) miles from the Enrollee's home, unless the MCO approves the travel because the non-Emergency service required is not available within thirty (30) miles from the Enrollee's residence. Providing non-emergency transportation to medical services located outside of Minnesota that have been approved by the MCO is the responsibility of the transportation coordinator within the Metro Area and remains the responsibility of the Local Agency outside of the Metro Area.

6.6 Limitations on MCO Services.

6.6.1 Medical Necessity. Unless otherwise provided in this Contract, the MCO shall be responsible for the provision and cost of health care services as described in Article 6 only when such services are deemed to be Medically Necessary by the MCO. Home and community based services, and services mandated by state or federal law are excluded from the MCO's Medical Necessity determination.

6.6.2 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.

6.7 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.

6.7.1 Abortion Services.

6.7.2 Case Management Services and Certain Mental Health Services.

(A) **Child Welfare Targeted Case Management** - Enrollees ages 18-21, pursuant to Minnesota Statutes, § 256B.094.

(B) **Mental Health Targeted Case Management (Rule 79).** MH-TCM services for persons with Serious and Persistent Mental Illness, pursuant to Minnesota Rules Parts 9520.0900 through 9520.0926; and mental health targeted case management for Children with Severe Emotional Disturbance according to Minnesota Rules Part 9505.0322, are not covered from January 1, 2009 through June 30, 2009. SPMI Enrollees receiving the benefit set described in section 6.1.4(H)(4)(g) above of this Contract may be entitled to receive mental health targeted case management (MH-TCM) services through Local Agencies or the Local Agencies' contracted vendors until June 30, 2009. The MCO must provide MH-TCM as of July 1, 2009.

(C) Housing associated with Intensive Residential Treatment Services (IRTS) is not covered.

6.7.3 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.

6.7.4 Experimental or Investigative Services.

6.7.5 Services Provided at 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.

6.7.6 State and Other Institutions. All claims arising from services provided by a State regional treatment center, a state-owned long term care facility, or an institution for mental disease (IMD), are not covered unless the services are approved by the MCO, the services are covered by Medicare, or unless the services are court-ordered pursuant to Minnesota Statutes, §§ 62Q.535, 253B.045, subd. 6, or § 260C.201, subd. 1.

6.7.7 Fertility Drugs and Procedures. Fertility drugs are not covered when specifically used to enhance fertility. The following procedures also are not covered: in vitro fertilization, artificial insemination, and reversal of a voluntary sterilization.

6.7.8 Sex Reassignment Surgery.

6.7.9 IEP and IFSP Services. Medically Necessary Medical Assistance services that would otherwise be covered by this Contract that are provided by the school districts or their contractors and are either: (A) identified in an Enrollee's Individual Education Plan (IEP), or (B) Individual Family Service Plan (IFSP), are not covered.

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

6.7.11 Out of Country Care. Emergency Care or other health care services received from Providers located outside the United States and Canada are not covered. For the purpose of this section, United States includes the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

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

6.7.13 Nursing Facility Per Diem Services. Nursing Facility per diem services are not covered, except as provided for in section 4.22 for 180-day Nursing Facility coverage.

6.7.14 Drugs Covered under the Medicare Prescription Drug Benefit Drugs covered under the Medicare Prescription Drug Program are not covered for Enrollees who are eligible for Medicare.

6.7.15 Other. All other exclusions set forth in Minnesota Statutes, §§ 256B.0625 and 256B.69; and Minnesota Rules, Part 9505.0170 through 9505.0475, and Part 9500.1450 through 9500.1464.

6.8 Enrollee Liability.

6.8.1 Except for section 4.17, the MCO will not bill or hold the Enrollee responsible in any way for any charges or deductibles, for Medically Necessary Covered Services or services provided as Substitute Health Services to Covered Services as part of the MCO's Care Management Plan. The MCO shall ensure that its subcontractors also do not bill or hold the Enrollee responsible in any way for any charges or deductibles for such services. The MCO shall further ensure that an Enrollee will be protected against liability for payment when:

(A) The MCO does not receive payment from the STATE for the Covered Services;

(B) A health care Provider under contract or other arrangement with the MCO fails to receive payment for Covered Services from the MCO; and

(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.

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

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

6.9 Designated Source of Primary Care. The MCO shall have written procedures that ensure each Enrollee has an ongoing source of Primary Care appropriate to his or her needs and a Provider formally designated as primarily responsible for coordinating the health care services furnished to the Enrollee.

6.10 Primary Care Provider. The MCO will reasonably provide each Enrollee with a choice of a Primary Care Provider who will supervise and coordinate the Enrollee's care.

6.11 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 Around-the-Clock Access to Care. The MCO shall make available to Enrollees access to Medical Emergency Services, Post-Stabilization Care Services and Urgent Care on a 24-hour, seven-day-per-week basis. The MCO must provide a 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.

6.13 Access to Care 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 Service, pursuant to the following standards:

6.13.1 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.

6.13.2 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.

6.13.3 Emergency Care/Shock Trauma. All Emergency Care must be provided on an immediate basis, at the nearest equipped facility available, regardless of MCO contract affiliation.

6.13.4 Hospitals. Transport time: Not to exceed thirty (30) minutes, or the STATE's Generally Accepted Community Standards.

6.13.5 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.

6.13.6 Pharmacy Services. Travel Time: Not to exceed sixty (60) minutes, or the STATE's Generally Accepted Community Standards or other applicable standards.

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

6.14 Serving Minority and Special Needs Populations. The MCO must offer appropriate services for the following special needs groups. Services must be available within the MCO or through contractual arrangements with Providers to the extent that the service is a Covered Service pursuant to this Article.

6.14.1 Abused Adults, Abusive Individuals: Services for this group includes comprehensive assessment and diagnostic services and specialized treatment techniques for victims and perpetrators of maltreatment (physical, sexual, emotional).

6.14.2 Enrollees with Language Barriers: Services for this group include interpreter services, bilingual staff, culturally appropriate assessment and treatment. The enrollment form will indicate whether the Enrollee needs the services of an interpreter and what language 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 pursuant to section 6.1.16. 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 6.1.16.

6.14.3 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.

6.14.4 Lesbians, Gay Men, Bisexual and Transgender Persons: Services for this group include sensitivity to critical social and family issues unique to lesbians, gay men, bisexual, and transgender persons.

6.14.5 Persons with a Hearing Impairment: Services for this group include access to TDD and hearing impaired interpreter services.

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

6.14.7 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.

6.15 Enrollee Education. The MCO will ensure that Enrollees are advised of the appropriate use of health care and the contributions they can make to the maintenance of their own health.

6.16 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.

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

6.18 Services Received at Indian Health Service and 638 Facility Providers. American Indian Medical Assistance and GAMC Recipients, living on or off the reservation, will have direct out-of-network access to Indian Health Service (IHS) facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, §§ 450f through 450n, or title III of the Indian Self-Determination Act, Public Law Number 93-638 (638 Facilities or providers), for services that would otherwise be covered under Minnesota Statutes, § 256B.0625, even if such facilities are not Participating Providers. The MCO shall not require any Service Authorization or impose any condition for an American Indian to access services at such facilities.

6.18.1 Referrals from IHS and 638 Facility/Providers. When a physician in a facility described in section 6.26 refers an American Indian Enrollee to a Participating Provider for services covered under this Contract, the MCO shall not require the Enrollee to see a Primary Care Provider prior to the referral. The Participating Provider to whom the IHS or 638 physician refers the Enrollee may determine that services are not Medically Necessary or not covered.

6.18.2 Payment for IHS and 638 Facility Services. The STATE shall pay 638 Facilities described in section 6.26 directly on a fee-for-service basis for services provided to American Indian Enrollees. The STATE shall send an electronic report of the American Indians enrolled in the MCO on a monthly basis, as part of the enrollment data, using the most complete and accurate means available to the STATE. The STATE shall provide the MCO with a statement of encounters by Enrollees

electronically, on a quarterly basis, by the 15th day of the month following the end of the calendar quarter, which shall describe the date of service, the Recipient, and the diagnosis code.

6.18.3 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.

6.19 Service Authorization and Utilization Review.

6.19.1 General Exemption for Medicaid Services. The MCO is exempt from STATE Service Authorization and second surgical opinion procedures at Minnesota Rules, Parts 9505.5000 through 9505.5105, and from certification for admission requirements at Minnesota Rules, Parts 9505.0500 through 9505.0540.

6.19.2 Medical Necessity Standard. The MCO may require Service Authorization for services, except for Medical Emergency services. Service Authorization shall be based on Medical Necessity, pursuant to section 2.78. In the case of mental health services, service authorization shall also be based on Minnesota Statutes, § 62Q.53, and for CD services, Minnesota Rules, Parts 9530.6600 through 9530.6655..

6.19.3 Utilization Review. The MCO, and if applicable its subcontractor, must have in place and follow written policies and procedures for utilization review that: (1) reflect current standards of medical practice in processing requests for initial or continued Service Authorization of services; and (2) meet the requirements as specified in Minnesota Statutes, §§ 62M.05 and 62M.09. The MCO's policies and procedures shall ensure the following:

(A) Consistent application of review criteria for authorization decisions;

(B) Consultation with the requesting Provider when appropriate;

(C) Decisions to deny an authorization request or authorize it in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's health condition; and

(D) Notification to the requesting Provider and written notice to the Enrollee of the MCO's decision to deny or limit the request for services in accordance with sections 8.2.1 and 8.2.2.

6.19.4 Denials Based Solely on Lack of Service Authorization. Pursuant to Minnesota Statutes, § 62D.12, Subd. 19, the MCO shall not deny or limit coverage of a service which the Enrollee has received solely on the basis of lack of Service Authorization, to the extent that the service would otherwise have been covered by the MCO had Service Authorization been obtained.

6.20 Time Frame to Evaluate Requests for Services.

6.20.1 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, pursuant to section 8.2.2(C). The MCO must communicate its decision on all requests for services to the Enrollee or his or her Authorized Representative and the appropriate provider as expeditiously as the Enrollee's health condition requires, but no later than the evaluation determination.

6.20.2 Request for Urgent Services. If the need is Urgent Care Services or for services appropriate to decrease the possibility of institutionalization, the MCO must evaluate the request for services and communicate its decision to the Enrollee or Authorized Representative and the Provider within an expedited time frame appropriate to the type of service and the need for service that has been requested by the Enrollee or requested on the Enrollee's behalf. In no circumstances shall the review exceed seventy-two (72) hours.

6.20.3 Request for Long Term Care Consultation (LTCC). The MCO must provide for a Long Term Care Consultation within ten (10) business days of an Enrollee request.

6.20.4 Request for Mental Health and/or Chemical Dependency (CD) Services. The MCO must provide Mental Health and/or CD services in a timely manner. Enrollees requiring CD crisis 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 weeks.

6.21 Out of Network and Transition Services.

6.21.1 Out of Network Services. The MCO shall cover Medically Necessary Out-Of-Plan or Out of the 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: i) an MCO Provider assumes responsibility for the Enrollee's care; ii) the MCO reaches an agreement with the treating Provider concerning the Enrollee's care; iii) the MCO has contacted the treating Provider to arrange for a transfer; or iv) the Enrollee is discharged.

(C) The Enrollee is Out of the Service Area and requires Urgent Care; or

(D) The Enrollee is Out of the Service Area and in need of non-Emergency medical services that are or have been prescribed, recommended or are currently being provided by a Participating Provider. The MCO may require Service Authorization. When the Enrollee is authorized for Out of Plan care or

Out of Service Area care, the MCO shall reimburse the non-Participating Provider for such services.

(E) The Enrollee moves Out of the Service Area as defined in section 2.132 of this Contract and this change is entered on MMIS after the Cut-Off Date, and a payment has been or will be made to the MCO for coverage for the Enrollee for that same or next month, the MCO shall reimburse the Medicare or Medical Assistance fee-for-service rate or billed charges, whichever is less, any services provided by non-Participating Providers to the Enrollee during the balance of the month or the month after which the Enrollee has moved for which the MCO received a capitation payment from the STATE. The MCO may condition reimbursement of these Out-Of-Plan services on the Enrollee's requesting MCO approval or Service Authorization to receive such services except for Emergency Care.

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

6.21.2 Specific Transition Services. The MCO is responsible for care in the following situations where an Enrollee is in transition between plans..

(A) **Services Previously Service Authorized**. The MCO shall provide Enrollees Medically Necessary Covered Services, including State Plan home care services and CADI/TBI waiver covered services, that an Out of Plan Provider, another MCO, or the STATE had Service Authorized before enrollment in the MCO until a Comprehensive Care Plan is in place. The care plan must take into account services previously service authorized. The MCO may require the Enrollee to receive the services by an MCO Provider, if such a transfer would not create undue hardship on the Enrollee, and is clinically appropriate. Transition services relating to orthodontia care, mental health services, at-risk pregnancy services, and chemical dependency services are covered as described in the below paragraphs of this section.

(B) **Orthodontia Care**. The MCO shall provide for Enrollees, orthodontia care if: (1) an Out of Plan Provider or the STATE has Service Authorized such care; (2) the care falls under an established plan of care; and (3) the Care Plan has a definitive end date. Payment to the prior Provider must be at least equivalent to the STATE Medical Assistance fee-for-service rate for orthodontia care. In the alternative, the MCO may transfer the Enrollee to an MCO Provider, if such a transfer would not create undue hardship on the Enrollee, and is clinically appropriate.

(C) **At-Risk Pregnancy**. When the Recipient enrolls in the MCO while in her third trimester of pregnancy, and her non-participating physician has reported her pregnancy to be at-risk on a standardized prenatal assessment, the MCO must authorize the care by non-Participating Providers for services related to prenatal care and delivery, including inpatient hospital costs for the mother and

Child. The MCO need not authorize payment for services by a non-Participating Provider if the non-Participating Provider does not accept from the MCO the Medical Assistance rate that would be paid if the Enrollee was not enrolled in the MCO. As a condition of payment, the MCO must require the non-Participating Provider to agree in writing to refrain from billing the Recipient for any portion of the cost of the authorized service. The MCO may not offer a non-Participating Provider less than the comparable Medical Assistance fee-for-service payment. The MCO is not responsible for additional out-of-plan care for the mother and Child after discharge from the hospital.

(D) **Chemical Dependency (CD) Treatment Services**.

(1) The MCO shall assume responsibility for all treatment and treatment-related room and board effective upon the date of the Recipient's enrollment into the MCO. Except for inpatient hospital-based programs, enrollment into the MCO will not be delayed._The MCO shall provide coverage for services that were authorized by the CCDTF or any other STATE-contracted MCO prior to the Recipient's enrollment in the MCO , unless the MCO completes a new Rule 25 assessment or re-assessment, which identifies a different level of need for services.

(E) **Mental Health Services**. At the time of initial enrollment in MnDHO, the MCO shall consider the individual Enrollee's prior use of mental health services and develop a transitional plan to assist the Enrollee in changing mental health Providers, should this be necessary, and develop a plan to assure the need for continuity of care for any Enrollee or family who is receiving ongoing mental health services.

(F) **Enrollee Change of Minnesota Health Care Program**. 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.

(4) The MCO must notify any affected Enrollee of his or her right to choose to remain with their original Participating Providers.

(G) **Pharmacy**. Upon the Enrollee's enrollment in the MCO, the MCO shall continue payment of all drugs the Enrollee is taking upon under a current prescription, except for those drugs covered by Medicare Prescription Drug Program 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 who have been identified to the MCO by an appropriate representative as requiring such continuation.

6.21.3 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 rate for emergency services furnished by non-Participating Providers. For all other services, pursuant to Minnesota Rules, Part 9500.1460, Subpart 11a, the MCO is not obligated to reimburse the non-Participating Provider more than the comparable Medical Assistance or Medicare fee-for-service rate or its equivalent, unless another rate is required by law.

6.22 Residents of Nursing Facilities in Need of Medical Services. If a medical service eligible for coverage under this Contract has been ordered by a participating physician or dentist for an Enrollee residing in a Nursing Facility, the MCO is responsible for providing the Medically Necessary service and covering the cost of the service required by the physician's or dentist's order.

6.23 Access to Culturally and Linguistically Competent Providers

(A) 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. The MCO will incorporate into care planning consideration of individual needs and wishes for culturally appropriate services.

(B) 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.

(C) 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.

6.24 Public Health Goals. The MCO shall engage in the following public health activities, toward the achievement of public health goals:

(A) **Response to Violence**. By compiling and analyzing data from Minnesota Pregnancy Assessment Forms (MPAF) to determine the exposure of pregnant women to violence, the MCO will report its progress toward the goal of having one hundred percent (100%) of participating medical clinics include assessments for family violence in their protocols, and the MCO's progress toward having participating medical clinics create care plans that connect Enrollees to community resources.

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

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

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

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

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

6.25 At Risk of Nursing Facility Placement Services. For MnDHO, 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 Nursing Home Certifiable Enrollee into a Nursing Facility.

Article. 7 Quality Assessment and Improvement Program

7.1 Quality Assessment and Performance Improvement Program. The MCO shall provide for a Quality Assessment and Performance Improvement Program consistent with federal requirements under Title XIX of the Social Security Act, 42 CFR § 438, Subpart D, and as required pursuant to Minnesota Statutes, Chapters 62D, 62M, 62N, and 256B.692 and related rules, including Minnesota Rules, Part 4685.1100 to 4685.1130, and applicable NCQA "Standards and Guidelines for the Accreditation of Health Plans" as specified in this Contract.

(A) The Quality Assessment and Performance Improvement Program must also meet the quality review requirements for Medicare Advantage contractors specified in Title XVIII, § 1852(e) of the Social Security Act (42 U.S.C.

1395w-22) and the implementing regulations at 42 CFR § 422.152 through 158.

(B) The MCO must also comply with the applicable requirements of CMS "Quality Framework" for HCBS services, as incorporated into the Waiver Quality Assurance Plan submitted to the STATE semi-annually beginning October 15, 2009 and every other year thereafter.

7.1.2 Scope and Standards. The MCO must incorporate into its quality assessment and improvement program the standards as described in 42 CFR § 438 for 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.

7.1.3 Information System. 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.

7.1.4 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 underutilization and overutilization of services. The MCO must submit a written utilization management program description to the STATE upon request.

(A) **Ensuring Appropriate Utilization**. The MCO shall facilitate the delivery of appropriate care and monitor the impact of its utilization management program to detect and correct potential under- and overutilization. The MCO shall:

(1) Choose the appropriate number of relevant types of utilization data, including one type related to behavioral health to monitor.

(2) Set thresholds for the selected types of utilization data and annually quantitatively analyze the data against the established thresholds to detect under- and overutilization.

(3) Analyze data not within thresholds using qualitative methods, such as case file review, to identify possible explanations for results that are not within thresholds..

(4) Analyze data not within threshold by medical group or practice.

(5) Take action to address identified problems of under- and overutilization and measure the effectiveness of its interventions.

7.1.5 Special Health Care Needs. The MCO must have effective mechanisms that assess the quality and appropriateness of care furnished to Enrollees with special health care needs. All Enrollees covered by the Contract are considered to meet the STATE's criteria for special needs.

(A) Identification and Assessment. Pursuant to section 6.1.4(C) 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) Comprehensive 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 section 6.1.4(C) and 6.1.4(D). The Care Plan must be:

(1) Developed by the Coordinator in conjunction with the Enrollee's Primary Care Provider and with Enrollee participation, and in consultation with any specialists caring for the Enrollee.

(2) Approved by the MCO in a timely manner, if approval is required by the MCO.

(C) Access to Specialist. 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. The MCO must submit to the STATE a written update of the process used whenever the MCO makes material changes to the described method(s).

(D) Items Required for Review and Evaluation by the STATE. The MCO shall produce the following items that will be reviewed and evaluated by the STATE: the Care Plan, Care System audit reports and audit protocols as required in Sections 9.3.10, and the Waiver Quality Assurance Plan Survey.

The MCO must submit to the STATE written Care Plan and Care System audit reports and audit protocols semi-annually beginning October 15, 2009 and every other year thereafter

7.1.6 Practice Guidelines. The MCO shall adopt preventive and chronic disease practice guidelines appropriate for Enrollees with physical disabilities.

(A) **Adoption of Practice Guidelines**. The MCO shall: 1) adopt guidelines based on valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field; 2) consider the needs of the MCO Enrollees; 3) adopt guidelines in consultation with contracting Health Care Professionals; and 4) review and update them periodically, as appropriate.

(B) **Dissemination of Guidelines**. The MCO shall ensure that guidelines are disseminated to all affected Providers and, upon request, to Enrollees and Potential Enrollees.

(C) **Application of Guidelines**. The MCO shall ensure that these guidelines are applied to decisions for utilization management, Enrollee education, coverage of services, and other areas to which there is application and consistency with the guidelines.

(D) **Audit of Provider Compliance**. The MCO shall audit a reasonable sample of its Providers (by physician or clinic) to determine Provider compliance with the practice guidelines the MCO has chosen as priority to audit, using an appropriate data source. The MCO shall incorporate into, or include as an addendum to, the MCO's Annual Quality Assessment and Performance Improvement Program Evaluation (as required in section 7.1.8) a written summary that shall include:

(1) How the MCO implemented section 7.1.5, (A through C),

(2) A description of all adopted guidelines, source of guidelines, date the guideline was reviewed and/or revised, including which guidelines are in place, and identify those guidelines that are applicable to, and/or modified for Enrollees under this Contract;

(3) Results of the audit, and

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

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

7.1.7 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. Waiver services Providers and Personal Care Provider Organizations are exempt from this requirement.

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

(B) **Process for Credentialing and Recredentialing**. The MCO must follow a documented process for credentialing and recredentialing of those Providers who are subject to the credentialing and recredentialing process and have signed contracts or participation agreements with the MCO.

(C) **Discrimination Against Providers Serving High-Risk Populations**. The MCO is prohibited from discriminating against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

(D) **Sanction Review**. Prior to entering into or renewing an agreement with a Provider, the MCO shall ensure that the Provider:

(1) Has not been sanctioned for fraudulent use of federal or state funds by the U.S. Department of Health and Human Services, pursuant to 42 U.S.C. § 1320 a-7(a), or by the State 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 nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines interpreting such order; and

(3) Is not an affiliate of such a Provider.

(4) The MCO shall not knowingly contract with such a Provider.

(E) **Restricting Financial Incentive**. The MCO may not give any financial incentive to a health care Provider based solely on the number of services denied or referrals not authorized by the Provider, pursuant to Minnesota Statutes, § 72A.20, subd. 33 and as required under 42 CFR § 422.208.

(F) **Provider Discrimination**. The MCO shall not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of the Provider's license or certification under applicable State law, solely on the basis of such license or certification. This section shall not be construed to prohibit the MCO from including Providers only to the extent necessary to meet the needs of the MCO's Enrollees or from establishing any measure designated to maintain quality and control costs

consistent with the responsibilities of the MCO. If the MCO declines to include individuals or groups of Providers in its network, it must give the affected Providers written notice of the reason for its decision.

(G) **Affiliated Provider Access Standards**. The MCO shall require its Providers to meet the access standards required by section 6.12 of this Contract, and applicable state and federal laws. The MCO shall monitor, on a periodic or continuous basis, but no less than every twelve (12) months, the Providers' adherence to these standards.

7.1.8 Annual Quality Assurance Work Plan. On or before May 1st of Contract Year, the MCO shall provide the STATE with an annual written work plan that details the MCO's proposed quality assurance and performance improvement projects for the year. This report shall follow the guidelines and specifications contained in Minnesota Rules, Part 4685.1130, subpart 2 and current NCQA "Standards and Guidelines for the Accreditation of Health Plans".

(A) The work plan shall specifically address people with physical and developmental disabilities enrolled in MnDHO. If MnDHO quality improvement activities are incorporated into the broader quality assurance work plan, MnDHO activities must be distinct and identifiable within that plan. If the MCO chooses to substantively amend, modify or update its work plan at anytime during the year, it shall provide the STATE with material amendments, modifications or updates in a timely manner. The work plan must include specific references to activities that are to be conducted during the year and impact the MnDHO population.

(B) MnDHO MCO/SNPs may combine their Medicare and Medicaid Quality Assurance Work Plans to the extent specifically applicable to the MnDHO population and to the extent the combined plan meets the STATE's requirements. If the MnDHO Dual Eligible MCO/SNP submits a separate Work Plan to CMS, the MCO will provide a timely copy to the STATE.

(C) Performance measures will be developed in collaboration with the STATE, MCO, care systems, and stakeholder group (composed of advocacy and clinical professionals experienced in serving people with disabilities) for implementation in calendar year 2010. The workgroup will consult with the STATE's Health Services Advisory Council in developing these performance measures.

7.1.9 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 HCBS Waivers" 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 evaluation must also include an analysis on the impact and effectiveness of MnDHO's Care Coordination activities. The MCO must submit the written evaluation to the STATE by May 1st of the Contract Year. For MnDHO MCO/SNPs, this evaluation may be combined with the required Medicare evaluation provided:

(A) It is conducted at the Dual Eligible SNP plan level;

(B) Is applicable to the MnDHO population; and

(C) Meets the above criteria.

7.2 Performance Improvement Projects (PIP). The MCO agrees to operate ongoing PIPs that incorporate the standards and guidelines outlined by CMS, with modifications as defined by the STATE. The MCO must conduct performance improvement projects designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction.

7.2.1 Comply with Protocols. The MCO must conduct the PIP in accordance with state and federal protocols. Projects must comply with 42 CFR § 438.240(b)(1) and (d) and CMS protocol entitled "Conducting Performance Improvement Projects."

7.2.2 Use of Medicare PIPs. The MCO may use their Medicare performance improvement projects to meet Medicaid requirements if they are conducted and reported at the Dual Eligible SNP plan level, applicable to the MnDHO population enrolled, and all other requirements (7.2.1-7.2.6) below are met. To the extent that additional, different, or separate PIPs are developed and reported to CMS, the MnDHO SNP will provide the STATE with copies of PIP proposals to CMS and PIP reports submitted to CMS within fifteen (15) days of submission.

7.2.3 New Performance Improvement Project Proposal. The MCO, in collaboration with the STATE and the care system, will confer on potential performance improvement projects. By September 1st of the Contract Year, the MCO must submit to the STATE, for review and approval, a written description of the PIP the MCO proposes to conduct beginning the first quarter of the next calendar year. The project proposal(s) must be consistent with CMS published protocol, entitled "Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects" and STATE requirements. The new PIP proposal must include steps one through seven of the CMS protocol. This PIP must be targeted to the MCO's MnDHO population.

7.2.4 Performance Improvement Project Interim Progress Assessment. By December 1st of the Contract Year, the MCO must produce an interim PIP report for each current project.

(A) The interim project report must include any changes to the project(s) protocol steps one through seven and steps eight through ten, as appropriate.

(B) If the MCO makes changes to the STATE approved PIP success measures, the MCO shall submit changes to the STATE for approval.

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

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

7.2.6 Performance Improvement Project Lifecycle. The project lifecycle must be based upon the project's measurement periodicity, such that, there are two measurement periods after the project has been demonstrated to have obtained a statistically significant improvement (p value or 0.05 or less). Implementation of the project must begin within the first quarter of the year following project approval.

7.2.7 Termination of a Performance Improvement Project. In the rare event that a project, after extensive MCO efforts to assess and correct barriers, fails to achieve statistical significance, the MCO may submit a written request to review the project with the STATE. The request must demonstrate:

(A) Why the project was unable to result in significant improvement, sustained over time;

(B) The MCO's efforts to resolve project barriers; and

(C) 3) An explanation of why these barriers were not addressed during the original proposal.

The MCO is encouraged to provide information on how the project may have achieved "meaningful improvement" as defined by NCQA in the written termination request. MnDHO SNPs will provide timely notice to the STATE of the termination of any Medicare PIP applicable to the enrolled MnDHO population.

7.2.8 Performance Improvement Project Categories. The MCO agrees to work with the STATE on developing PIPs for MnDHO Enrollees.

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.

7.3.1 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.

7.3.2 Waiver. 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 MCO shall include MnDHO Enrollees in its annual Enrollee satisfaction survey, and must provide the STATE with a copy of the survey results in a timely manner, and must separately report the results for these Enrollees. This also includes results of surveys conducted by the Care System. The MCO shall meet the obligations of conducting an annual Enrollee satisfaction survey by the following methods:

7.4.1 Enrollee Disenrollment Survey. Enrollee disenrollment, as measured by an ongoing survey conducted by the STATE, or its designee, in the manner required by Minnesota Statutes, Chapter 62J. The MCO shall cooperate with the STATE, or its designee, in data collection activities as directed by the STATE. If the MCO or any of its contracted Care Systems conduct an Enrollee disenrollment survey that involves MnDHO Enrollees, the MCO must provide the STATE with a copy of the survey results in a timely manner.

7.4.2 Feedback The MCO will have a process to obtain periodic feedback from members on satisfaction with care, problem identification and suggestions for improving the delivery system. This process must include a way to use this information to improve access to and quality of the care delivered to members with disabilities. The process may be carried out through a combination of focus groups, member satisfaction surveys or other methods. The methods chosen must be specified in the MCO's Quality Improvement Plan. Results of consumer feedback activity mechanisms shall be shared with the STATE.

7.4.3 Additional Surveys When the MCO, or its subcontractor, conducts an Enrollee satisfaction survey involving MnDHO Enrollees, information on the framing of the questions, sampling techniques used, survey methodology, response rates, survey results and analysis of results must be reported to the STATE when completed. If the MCO or any of its contracted Care Systems conduct an Enrollee satisfaction survey that involves MnDHO Enrollees, including the Medicare Consumer Assessment of Health Plans Satisfaction (CAHPS), the MCO must provide the STATE with a copy of the survey results in a timely manner.

7.4.4 STATE's Survey The MCO agrees to work with the STATE, as necessary, for the STATE's survey of HCBS consumers. The STATE will consult with the MCO on the survey tool.

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 U.S.C. § 1396a(a)(30) and 42 CFR § Part 438; 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 including policies and procedures of MCO's subcontractor for Care Coordination, 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 a Medicaid review by the STATE, its agent or EQRO when the following required terms are met:

(A) Complies with federal requirements (42 CFR § 438.360);

(B) CMS or accrediting standards are comparable to standards established by the STATE and identified in the STATE's Quality Strategy;

(C) MCOs must have received an NCQA accreditation rating of excellent, commendable or accredited, and

(D) All Medicare or accrediting reports related to the services provided under this Contract, findings and results are provided to the STATE within thirty (30) days of receipt.

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.

7.5.3 Review of EQRO Annual Technical Study Report Prior to Publication. The STATE shall allow the MCO to review a final draft copy of the Technical Report prior to the date of publication. The MCO shall provide the STATE any written comments about the report, including comments on its scientific soundness or statistical validity, within thirty (30) days of receipt of the final draft report. The STATE shall include a summary of the MCO's written comments in the final publication of the report, and may limit the MCO's comments to the report's scientific soundness and/or statistical validity.

7.5.4 EQR 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 9.4.10.

7.7 Annual Performance Measures.

(A) The MCO will provide the STATE the following within thirty (30) days of submittal to NCQA: 1) HEDIS report submitted to CMS for the MnDHO SNP in an Excel spreadsheet format; and 2) the documentation submitted to CMS for SNP: Improving Member Satisfaction (Element A and Element B) of the MnDHO SNP 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 MnDHO SNP Structure and Process Measures reported by NCQA.

7.8 Coordination for MnDHO.

7.8.1 MCO Collaboration. The MCO shall collaborate with the STATE and other MCOs to promote 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 Coordination conducted by the STATE, CMS or their contractors.

7.8.3 Care Plan Audits. The MCO shall audit a sample of Care Plans for MnDHO Enrollees. The sample must follow appropriate sampling methodology. The MCO must use a protocol submitted to and approved by the STATE that follows the standard protocol developed by the work group and incorporates requirements for HCBS 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 by September 15th of each year. . The EQRO will audit a sample of care plans for Waiver Enrollees from each MCO in 2011.

7.8.4 Annual HCBS Waiver Quality Assurance Plan. The MCO will submit the Annual HCBS Waiver Quality Assurance Plan, using the tool designated by the STATE, by October 15, 2009, and every other year thereafter.

7.9 Annual Reporting of Utilization Data. The MCO shall submit to the STATE on May 1st of each year, utilization data from the previous year, including, but not limited to, the following:

(A) Hospital Admission Rates reported by the following categories: (1) non-NHC persons in the community; (2) NHC persons in the community, including Conversions; and (3) persons residing in nursing facilities.

(B) Nursing Home Admission Rates reported by: (1) Non-NHC persons in the community; and (2) NHC persons in the community.

(C) Length of Hospital Stay reported by: (1) Non-NHC persons in the community; (2) NHC persons in the community, including Conversions; and (3) persons residing in nursing facilities.

(D) Home health care services reported by: (1) number of skilled nursing visits per member month; (2) number of personal care service hours per member month; and (3) number of home health aide visits per member per month for the following categories: (a) Non-NHC person in the community; (b) NHC persons in the community, including Conversions.

(E) Emergency Room Visits reported by: (1) Non-NHC persons in the community; (2) NHC persons in the community, including Conversions; and (3) persons residing in nursing facilities.

7.10 Enrollment Data by Care System. By the thirtieth (30th) day of the month following each quarter, the MCO shall submit to the STATE enrollment data for each delegated Care System by Rate Cell Category and Care System.

7.11 Cooperation with Independent Assessment. The MCO will cooperate with any independent assessment of the MnDHO program 1915(c) waivers conducted by the STATE, its contractors, or CMS.

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

7.13 Evaluation Plan. The STATE and the MCO shall cooperatively develop and carry out a MnDHO evaluation plan, which includes some of the components described in Article 7.

7.14 Workgroup Participation. The MCO is encouraged to appoint representatives to participate in the STATE's workgroups as follows:

(A) Care Coordination

(B) Clinical Practice and Performance Measurement. This group will provide input on geriatric clinical practice that includes implementing practice models based on Medical Home concepts, identifying best clinical practices and related performance measurement, integration of new Medicare SNP measures and protocol requirements and ongoing implementation of the Comprehensive Elder Health Evaluation (CEHE) incentive.

(C) Quality Technical Committee covering EQR activities, surveys, Quality Strategy, and

(D) The collaborative quality improvement committee, covering measurement alignment, collaborative and priority initiatives

7.15 Pay for Performance. The MCO shall cooperate with the STATE to develop and implement a Pay for Performance model for rewarding Providers and a model for rewarding Enrollees.

7.16 MN Community Measurement (MNCM). The STATE will work with MDH and the marketplace of purchasers and Providers on development and application of the Minnesota Community Measurement Project.

7.17 Medicare Medication Therapy Management Programs. The MnDHO SNP will provide the STATE with a an update of its current Medicare Medication Therapy Management programs and protocols by upon request of the STATE each Contract Year.

Article. 8 The Grievance and Appeals Systems.

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. This system must include a Medicare process for Medicare covered services and a Medicaid process, and Enrollees shall have the right to choose which or both processes to pursue. The overall system must:

(A) Assure compliance with Medicare and Medicaid requirements; and

(B) Preserve Enrollees' access to all appropriate levels of Medicare and Medicaid appeals; and

(C) To the extent possible, integrate both processes to make the system easier to navigate for the Enrollee.

8.1.2 Timeframes for Disposition. The MCO must dispose of each Grievance and resolve each Appeal, and provide notice, as expeditiously as the Enrollee's health condition requires, but no later than timeframes set forth in this Article. In instances where the MCO's integrated system described in 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 and 256.045, Subd. 3a (excluding the reference to Minnesota Statute, § 62D.11); and 42 CFR §§ 422, Subpart M, and 438, Subpart F.

8.1.4 STATE Approval Required. The MCO's Grievance System is subject to approval of the STATE. This requires that:

(A) Any proposed changes to the Grievance System must be approved by the STATE prior to implementation.

(B) The MCO must send written notice to Enrollees of significant changes to the Grievance System at least thirty (30) days prior to implementation.

(C) The MCO must provide information specified in 42 CFR § 438.10(g)(1) about the Grievance System to Providers and subcontractors at the time they enter into a contract.

(D) Within sixty (60) days after the execution of a contract with a Provider (e.g. hospitals, individual Providers, and clinics), the MCO must inform the provider of the MnDHO program, 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; for example, 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 Grievances Resolution. The MCO may extend the timeframe for resolution of a Grievance by an additional fourteen (14) days for resolution of a Grievance by an additional 14 days if the Enrollee or the Provider requests the extension, or if the MCO justifies that due to a need for additional information, the extension is in the Enrollee's interest. The MCO must provide written notice to the Enrollee of the reason for the decision to extend the timeframe if the MCO determines that an extension is necessary. The MCO must issue a 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 an 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

(1) the denial of an expedited resolution of an Appeal or

(2) a Grievance that involves clinical issues, then 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 resolution, 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 the Minnesota Department of Health.

(B) When a Grievance is filed in writing, the MCO must notify the Enrollee in writing of its disposition. The written notice must include the results of the MCO investigation, the MCO actions relative to the Grievance, and options for further review through the Managed Care Ombudsman, and the Minnesota Department of Health.

8.3 Denial, Termination, or Reduction (DTR) Notice of Action to Enrollees. If the MCO denies, reduces or terminates services or claims that are: 1) requested by an Enrollee; 2) ordered by a Participating Provider; 3) ordered by an approved, non-Participating Provider; 4) ordered by a care manager; or 5) ordered by a court, the MCO must send a DTR notice to the Enrollee that meets the requirements of this section.

8.3.1 General DTR Requirements.

(A) Written Notice. The DTR must meets the language requirements of 42 CFR § 438.10(c).The DTR must also:

(1) Be understandable to a person who reads at the7th grade reading level;

(2) Be available in alternative formats as required by section 3.3.2(B).

(3) Be approved in writing by the STATE, pursuant to section 3.3.5.

(4) Maintain confidentiality for Family Planning Services (i.e. ensure that all information related to Family Planning is provided only to the Enrollee, in a confidential manner).

(5) Be sent to the Enrollee.

(6) 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 a sample DTR notification and/or member rights form that will be used by the subcontractor and a sample written explanation of the MCO and state Grievance System. STATE approval will only be granted for major MCO subcontractors, as determined by the STATE, who provide a single type of health service or provide a care system of integrated services.

(B) Content of DTR. The DTR must include:

(1) The Action that the MCO has taken or intends to take;

(2) The type of service or claim that is being denied, terminated, or reduced;

(3) A clear detailed description in plain language of the reason(s) for the Action;

(4) The reasons for the Action;

(5) The specific federal or state regulations that support or require the Action, whichever applies. Nothing in this section prevents the MCO from providing additional more specific information;

(6) The Date the DTR was issued;

(7) The effective date of the Action if it results in a reduction or termination of ongoing or previously authorized services;

(8) 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;

(9) The first date of service, if the Action is for denial, in whole or in part, of payment for a service;

(10) A language block in a format determined by the STATE; with a phone number at the MCO where Enrollees may call to receive help in translation of the notice; and

(11) A phone number at the MCO where Enrollees may call to obtain information about the DTR.

(12) The Notice of Member Rights that must include but is not limited to:

(a) The Enrollee's right (or provider on behalf of Enrollee with the Enrollee's written consent) to file an Appeal with the MCO;

(b) The requirements and timelines for filing an MCO Appeal pursuant to 42 CFR § 438.402;

(c) The Enrollee's right to file a request for a State Fair Hearing without first exhausting the MCO's Appeal procedures, or up to thirty (30) days after the MCO's final determination;

(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, how to request that benefits be continued, and under what circumstances the Enrollee may have to pay for these services if the Enrollee files an Appeal at the MCO or requests a State Fair Hearing, and;

(g) The Enrollee's 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, the 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 8.4.1 of the Contract, and provide an explanation of the Appeal process. This

notification may be through Provider contracts, Provider manuals, or through other forms of direct communication such as Provider newsletters.

(D) Notice to Enrollee of Right to Quality Improvement Organization Review. The MCO shall ensure that the Enrollee is notified of the right to request an immediate Quality Improvement Organization (QIO) review if the Enrollee believes she or he is being prematurely discharged from the hospital pursuant to 42 CFR § 422.620 and § 422.622. This requirement is limited to premature hospital discharges and supersedes the otherwise required STATE DTR notice requirement specified in section 8.2 of this Contract.

(E) The MCO shall ensure that the Enrollees receive notification of termination of Medicare services provided by a skilled nursing facility, home health agency or comprehensive outpatient rehabilitation facility in accordance with 42CFR § 422.624. The 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 8.2 of this contract.

8.3.2 Timing of the DTR Notice.

(A) Previously Authorized Services. For previously authorized services, a denial, termination or reduction of the level of service of previously authorized requires the MCO to 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, 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, 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 8.2.2(D).

(D) **Expedited Authorizations**. For expedited Service Authorizations, the MCO must provide the decision as expeditiously as the Enrollee's health condition requires, not to exceed seventy-two (72) hours of receipt of the request for the service. Expedited Service Authorizations are for cases where the Provider indicates or the MCO determines that following the standard timeframe could seriously jeopardize the Enrollee's life or health, or ability to attain, maintain or regain maximum function.

(E) Extensions of Time. The MCO may extend the timeframe by an additional fourteen (14) days for resolution of a standard authorization if the Enrollee or the Provider requests the extension, or if the MCO justifies a need for additional information and how the extension is in the Enrollee's interest. The MCO must provide written notice to the Enrollee of the reason for the decision to extend the timeframe, and the Enrollee's right to file a Grievance if he or she disagrees with the MCO's decision to extend. The MCO must issue a determination no later than the date the extension expires. The STATE may review the MCO's justification upon request.

(F) Delay in Authorizations. For Service Authorizations not reached within the timeframe specified in 42 CFR § 438.210(d)(1), the MCO must provide a notice of denial on the date the timeframe expires.

(G) The MCO shall not continue the service if the service is a Medicare-only covered service per Title XVIII of the Social Security Act.

(H) The termination of Consumer Directed Community Support (CDCS) services to HCBS 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 HCBS 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.

8.3.3 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, 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: (A) the Enrollee withdraws the Appeal; or (B) 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) The termination of Consumer Directed Community Support (CDCS) services to CADI and TBI waiver participants is subject to State Fair Hearing and Notice requirements. However, continuation of benefits is not required for CDCS services during the State Fair Hearing process. If the Enrollee is still eligible for CADI or TBI 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). 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. The Enrollee may also request a State Fair Hearing. 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 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 was received.

8.4.2 Medicare Requests for Hearing. The Enrollee may choose the Medicare process of the MCO's system for Medicare covered services as required in 8.1.1. The MCO must follow 42 CFR 422.600 through 616, which includes Enrollee access to review by an independent review entity, Administrative Law Judge, Medicare Appeals Council and Judicial Review.

8.4.3 Timeframe for Resolution of Standard Appeals. The MCO must resolve each Appeal as expeditiously as Enrollee's health requires, and not to exceed thirty (30) days after receipt of the Appeal

8.4.4 Timeframe for Resolution of Expedited Appeals.

(A) The MCO must resolve and provide written notice of resolution for both oral and written Appeals as expeditiously as the Enrollee's health condition requires, but not to exceed seventy-two (72) hours after receipt of the Appeal. The MCO shall notify the enrollee and attending health care professional by

telephone of its determination as mandated by Minnesota Statutes, § 62M.06, subd. 2(b).

(B) If the MCO denies a request for expedited Appeal, the MCO shall transfer the denied request to the standard Appeal process, preserving the first filing date of the expedited Appeal. The MCO must notify the Enrollee of that decision orally within twenty-four (24) hours of the request and follow up with a written notice within two days.

(C) When a decision to deny 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 that the attending health care professional has 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 (10) days.

(C) The MCO must give Enrollees any reasonable assistance required in completing forms and taking other procedural steps, including but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.

(D) The MCO must ensure that the individual making the decision was not involved in any previous level of review or decision-making.

(E) If the MCO is deciding an Appeal regarding denial of a service based on lack of Medical Necessity, the MCO must ensure that the individual making the decision is a Health Care Professional with appropriate clinical expertise in treating the Enrollee's condition or disease, as provided for in Minnesota Statutes, §§ 62M.06, 62M.09 and 42 CFR § 438.406(a)(3)(ii).

(F) The MCO must provide the Enrollee with a reasonable opportunity to present evidence and allegations of fact or law, in person, by telephone, as well as in writing. For expedited Appeal resolutions, the MCO must inform the Enrollee of 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 written notice of resolution for all Appeals and must include in the text of the notice: A) the results of the resolution process and date it was completed; and B) the Enrollee's right to request a State Fair Hearing if the resolution was adverse 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 decisions, the written notice of resolution shall be sent to the Enrollee and the attending health care professional.

(C) The MCO shall 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 72 hours after receiving the expedited appeal.

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. The MCO may bill the Enrollee if the MCO's denial is upheld and the Enrollee already received the service.

8.4.11 Additional Levels of Resolution. This section does not prohibit an MCO from offering additional levels of internal resolution mechanisms so long as the minimum requirements set forth herein are complied with.

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, State Fair Hearings and Appeals.

8.6 Reporting of Grievances to the STATE. The MCO shall send a quarterly report of all oral and written Grievances in a format determined by the STATE and per STATE specifications. The report is due on or before the 15th day of the month following the end of the quarter, for all oral and written Grievances resolved in the previous quarter. If the 15th day of the month falls on a weekend or holiday, the report is due to the STATE on the following business day. The report may be submitted on disk or e-mail attachment. Oral and written Grievances must be identified separately in order to track both types of filed Grievances.

8.7 Reporting of DTRs to the STATE The MCO must submit to the STATE a quarterly electronic DTR compilation report, which meets the following requirements:

8.7.1 In ASCII format, with data elements specified by the STATE, including the PMI number and major program of each Enrollee; and

8.7.2 The report is due quarterly, on or before the 15th day of the month following the end of the quarter, for all DTRs issued in the previous quarter. If the 15th day of the month falls on a weekend or holiday, the report is due to the STATE on the following business day. The STATE must approve the initial sample DTR report format and any subsequent changes prior to the actual quarterly report.

8.8 Reporting of Appeals to the STATE. The MCO shall send a quarterly electronic report of all oral and written Appeals in a format determined by the STATE and per STATE specifications. The report is due on or before the 15th day of the month following the end of the quarter, for all oral and written Appeals resolved in the previous quarter. If the 15th day of the month falls on a weekend or holiday, the report is due to the STATE on the following business day.

8.9 Submission of Part D Grievances and Appeals. The MCO will send to the STATE a copy of its Part D Grievance and Appeals summary report for MnDHO Duals within thirty (30) days of its availability.

8.10 State Fair Hearings.

8.10.1 Matters heard by State Fair Hearing Referee. Pursuant to Minnesota Statutes, § 256.045, the State Fair Hearing Referees may review any Action by the MCO, as Action is defined in 42 CFR § 438.400(b) and section 2.3 of the contract.

8.10.2 Standard Hearing Decisions.

(A) The Enrollee, or the Provider acting on behalf of the Enrollee with the Enrollee's written consent, may file a request for a State Fair Hearing within thirty (30) days of receipt of the Notice of Action or Appeal decision and within ninety (90) days, if there is good cause for the delay pursuant to Minnesota Statutes, § 256.045.

(B) The STATE must take final administrative action on any request for a State Fair Hearing within ninety (90) days of the following, whichever is earlier:

(1) The date the Enrollee filed an Appeal of the same issue with the MCO, excluding the days it subsequently took for the Enrollee to file the request for a State Fair Hearing with the STATE; or

(2) The date the request for a State Fair Hearing was filed.

(C) The MCO must cooperate with the STATE in determining the date the Enrollee filed an Appeal with the MCO, including but not limited to:

(1) The MCO shall name a specific contact for the State Fair Hearing Office to contact for information about a) an Appeal of the same issue filed at the MCO, b) dates Appeals were filed, and c) the date of resolution of the Appeal.

(2) The MCO shall respond with the following information about an Appeal within one working day of receiving the request from the State Fair Hearing Office: a) whether an Appeal was filed with an MCO, b) the date the Appeal was filed, c) the resolution of the Appeal, d) and the date it was resolved.

(3) The MCO shall notify the STATE and the State Fair Hearing Office of changes to the name or phone number of the contact within one working day of any change.

8.10.3 Costs of State Fair Hearing. The MCO shall provide reimbursement to the Enrollee for transportation, Child care, photocopying, medical assessment outside the MCO's network, witness fee, and other necessary and reasonable costs incurred by the Enrollee or former Enrollee in connection with a request for State Fair Hearing. Necessary and reasonable costs shall not include the Enrollee's legal fees and costs, or other consulting fees and costs incurred by or on behalf of the Enrollee.

8.10.4 Expedited Hearing Decisions.

(A) The STATE must take final action within three (3) working days of receipt of the file from the MCO on a request for an expedited State Fair Hearing, or a request from the Enrollee which meets the criteria of 42 CFR § 438.410(a).

(B) The MCO must send the file to the State Fair Hearing Office as expeditiously as the Enrollee's health requires, and not to exceed one (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 pursuant to Minnesota Statutes, § 256.045, subd. 3a, before the date of the proposed action in either the MCO's Notice or the MCO's Appeal decision, the MCO, in accordance with 42 CFR § 438.420(b), may not reduce or terminate the service until the STATE issues a written decision in the State Fair Hearing, or the Enrollee withdraws the request for a State Fair Hearing.

(B) In the case of a reduction or termination of ongoing services under section 8.2.3 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 or her contract with the MCO to order such services. The notice required by section 8.2.1(B). shall include this right.

8.10.6 Compliance with State Fair Hearing Resolutions.

(A) Compliance with Decisions. The MCO must comply with the decision in the State Fair Hearing promptly and as expeditiously as Enrollee's health condition requires.

(B) MCO's Responsibility for Payment of Services. If the MCO's Action is not sustained by the State Fair Hearing decision, the MCO must promptly pay for any services the Enrollee received that are the subject of the State Fair Hearing.

(C) Enrollee's Responsibility for Payment of Services. If the MCO's action is sustained by the State Fair Hearing decision, the MCO may institute procedures to recover from the Enrollee the cost of medical services furnished solely by reason of section 8.7.5 of this Contract.

8.10.7 Representation of MCO Determinations. The MCO agrees that it is the responsibility of the MCO to represent and defend all MCO determinations at the State Fair Hearing and at any subsequent judicial reviews involving that determination. The MCO must receive the advice and consent of the STATE before appealing any subsequent judicial decisions adverse to the Commissioner's Order. The MCO agrees that the STATE shall provide necessary information, but that the STATE shall not assume any costs associated with such representation. The STATE shall notify the MCO in a timely manner of any State Fair Hearings that involve the MCO.

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.

8.11 Second Opinions in the Appeals Process.

8.11.1 At the request of the State human services judge, the MCO shall provide for a second medical opinion within 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.

8.11.2 The MCO shall provide for a second medical opinion for mental health conditions pursuant to Minnesota Statutes, § 62D.103.

8.11.3 The MCO shall provide for a second opinion for chemical dependency services as provided for in Minnesota Statutes, § 62D.103 and Minnesota Rules, Part 9530.6655. To the extent these laws are in conflict, the MCO shall apply Minnesota Rules, Part 9530.6655 to Enrollees under this Contract. The MCO shall inform the Enrollee in writing of the Enrollee's right to make a written request for a second assessment at the time the Enrollee is assessed for a program placement.

8.12 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.

8.12.1 Notice to Enrollees. The MCO must notify Enrollees in writing of placement in the Restricted Recipient Program. The notice must be sent thirty (30) days prior to placement. The notice to the Enrollee must state:

(A) Placement in the Restricted Recipient Program will not result in a reduction of services or loss of eligibility or disenrollment from the MCO;

(B) The factual basis of the allegations against the Enrollee;

(C) The right to dispute the MCO's factual allegations; and

(D) The right to request an Appeal with the MCO and request a State Fair Hearing, and the right to request a State Fair Hearing without first exhausting the MCO's Grievance and Appeal procedures; and

(E) The Enrollee's rights listed in the "Member Rights for Placement in the Restricted Recipient Program" document..

8.12.2 Enrollee's Right to Appeal. An Enrollee may Appeal or request a State Fair Hearing to dispute placement in the Restricted Recipient Program. If the Enrollee Appeals or requests a State Fair Hearing prior to the date of the proposed placement, the MCO may not impose the placement until the Appeal or State Fair Hearing is resolved in the MCO's favor. If the Enrollee does not Appeal within thirty (30) days of the date of notice, placement will occur and the designated Providers will be assigned.

8.12.3 Reporting of Restrictions.

(A) Until the MCO has access to enter data directly into MMIS, within five (5) working days of placement in the Restricted Recipient Program, the MCO must report to the STATE, the names and PMI numbers of all Enrollees placed in the Restricted Recipient Program, the date of placement, placement reason codes, and the names of the designated Providers with their addresses and Provider numbers. This information shall be reported to the STATE within five (5) working days of the Enrollee's placement in the Restricted Recipient Program.

(B) Once the MCO has access to enter data directly into MMIS, the MCO shall enter into MMIS the names and PMI numbers of all Enrollees placed in the Restricted Recipient Program, the date of placement, placement reason codes, and the names of the designated Providers with their addresses and Provider numbers. This information shall be entered into MMIS within five (5) working days of the Enrollee's placement in the Restricted Recipient Program.

8.12.4 Program Administration. The MCO will administer the Restricted Recipient Program consistent with Restricted Recipient Program criteria and process developed jointly with the MCOs and Minnesota Rules, Parts 9505.2160 through 9505.2245. The Restricted Recipient Program criteria and process are posted on the STATE's public website.

Article. 9 Required Provisions.

9.1 Compliance with Federal, State and Local law. The MCO and its subcontractors shall comply with all applicable federal and state statutes and regulations, as well as local ordinances and rules now in effect and hereinafter adopted, including but not limited to Minnesota Statutes, §§62J.695 through 62J.76 (Patient Protection Act), Minnesota Statutes, §62Q.47 (mental health parity), Minnesota Statutes, §62Q.53 (mental health Medical Necessity), Minnesota Statutes, §§62Q.56 and 62Q.58 (Continuity of Care and Care Coordination) and Minnesota Statutes, §62Q.19 (essential community providers).

9.1.1 Licensing and Certification for Non-County Based Purchasing Entities. The 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(B). and 5.2.4. In the event any certificate is canceled, revoked, suspended or expires during the term of this Contract, the MCO agrees to so inform the STATE immediately.

9.1.2 HMO and CISN Requirements For County Based Purchasing Entities. The MCO shall comply with state statutes and regulations applicable to health maintenance organizations (HMO)s or community integrated service networks (CISNs), including: (A) Minnesota Statutes, §62A.0411 (48-hour hospital stay for maternity patients); (B) Minnesota Statutes, §62J.695 to 62J.76 (Patient Protection Act); and (C) Minnesota Statutes, §62D.03, 4(a)-(d), (h)-(i), (k), (m)-(n), (p), (r)-(s) & (u), 62D.041, subd. 3 & 9, 62D.06-.08, 62D.11, 62D.123, 62M.04-12, 62N.28, 62N. 29, 62N.31 & 72A.201, and Minnesota Rules 4685.0300, subparts 2(A) & (B), 4685.1010, 4685.1115, 4685.1120, 4685.1900 & 4685.3300, subpart 9. (HMO and CISN requirements to the extent the Commissioner of Health has interpreted them to apply to county-based purchasers).

9.2 MCO Solvency Standards. 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 changes in the MCO or the Contract, that its provision against the risk of insolvency is adequate to ensure that its Enrollees will not be liable for the MCO's debts if it becomes insolvent. All MCOs must meet the solvency standards established by the State for Health Maintenance Organization (HMO) or be licensed or certified by the State as a risk-bearing entity.

9.3 Subcontractors.

9.3.1 Written Agreement. All subcontracts must be in writing and must include a specific description of payment arrangements. All subcontracts are subject to STATE and CMS review and approval, upon request by the STATE and/or CMS. Payment arrangements must be available for review upon request by the STATE and/or CMS. All contracts must include:

(A) **Disclosure of Transactions**. MCO must include in each Provider contract a duty to report information related to business transactions in accordance with 42 CFR § 455.105(b). These transactions include:

(1) The ownership of any subcontractor with whom the Provider 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 between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the five (5) year period ending on the date of the request.

(3) For purposes of section 9.3.1(A), "subcontractor" means 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 patients. See 42 CFR § 455.101.

(B) **Disclosure of Ownership Information**. The MCO before entering into a contract must request all information required to be disclosed under 42 CFR

§ 455.104. Updated disclosure information must be received and reviewed prior to each contract renewal. The required information must include:

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

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

(3) The name of any other organization in which a Person with an Ownership or Control Interest in the Disclosing Entity also has an ownership or control interest.

(4) For purposes of section 9.3.1(B), "subcontractor" means 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 patients. See 42 CFR § 455.101.

9.3.2 MCO Disclosure Reporting. The MCO must be able to submit to the STATE on September 1st of Contract Year, a letter of assurance stating that the following information has been requested of all subcontractors, and reviewed by MCO prior to MCO and subcontractor contract renewal:

(1) Disclosure of transactions of all subcontractors as provided in the Subcontractor agreement as mandated in section 9.3.1(A), and

(2) Disclosure of ownership as disclosed to the MCO in the subcontractor credentialing application as mandated in section 9.3.1(B).

9.3.3 Providers Without Numbers. The MCO shall submit to the STATE, in a format provided by the STATE, a form for each Provider who does not already have a STATE provider number NPI, or UMPI pursuant to section 3.6.1.

9.3.4 Proof of Status. The MCO must submit, upon STATE request, proof of subcontractor status prior to submission of the PCNL.

9.3.5 Provision of MnDHO 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 MnDHO, and shall communicate the MCO's efforts upon request by the STATE.

9.3.6 Audit. The MCO shall require that all subcontractors shall provide CMS, the Comptroller General, or their designee, 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 9.5.5 of this Contract.

9.3.7 Federal Law. All contracts and subcontracts shall comply with 42 CFR §434.6(b) for Medical Assistance services, 42 CFR § 422.502 for Medicare services and 42 CFR § 438.6(l) for those requirements that are appropriate to the service or activity delegated under the subcontract.

9.3.8 Health Care Services. Notwithstanding section 9.4.1, the MCO may contract with Providers of health care services to provide services to Enrollees of the MCO. Subcontracts with other Providers of health care services shall not abrogate or alter the MCO's primary responsibility for performance under this Contract.

9.3.9 Subcontractual Delegation. The MCO oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor. The MCO shall:

(A) Prior to any delegation, evaluate the prospective subcontractor's ability to perform the activities to be delegated.

(B) Have a written agreement that: 1) specifies the activities and report responsibilities delegated to the subcontractor; and 2) provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

(C) Monitor at least annually the subcontractor's performance through a formal review process that results in a written report.

(D) Upon request by the STATE, provide a copy of the formal delegation review process for approval.

(E) By January 15th of 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 onsite.

9.3.10 Annual Reviews of Care System Subcontractors. By September 15th of the Contract Year, the MCO shall conduct a review of each Care System with whom the MCO has a subcontract for Enrollees covered under this Contract. Written audit reports of each Care System must be submitted to the STATE in accordance with section 7.8.

(A) Annual reviews and written reports must include: 1) a description of the organizational, service delivery, and case management structures; 2) the Care System's risk sharing arrangement with the SNP or MCO; 3) the process used by the MCO to conduct the review; 4) any deficiencies and/or concerns raised during the review; and 5) any corrective actions taken by either the MCO or by the Care System to address deficiencies and/or concerns raised during the review. Annual reviews and written reports must include Care Plan audits as specified under this section. The review must address the Care System's compliance with subcontract requirements such as those described in the State's "Protocol for Annual Reviews of Care System Subcontractors".

(B) The MCO/SNP will work with the STATE and other MCO/SNPs on methods for coordinating County Care Coordination System and 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" and the Waiver Quality Assurance Plan Survey referenced in section 7. 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 reviews that can vary based on performance indicators.

9.3.11 Contracting Requirements for FQHCs and RHCs. If the MCO negotiates a provider agreement or subcontract with a federally qualified health center (FQHC) as defined in § 1905(l)(2)(B) of the Social Security Act, 42 U.S.C. § 1396d(l)(2)(B), the negotiated payment rates must be comparable to the rates negotiated with other subcontractors who provide similar health services. The STATE may require the MCO to contract with an FQHC or Rural Health Clinic (RHC) that has been designated under Minnesota Statutes, § 62Q.19 as an essential community provider. The MCO is not required to pay any settle-up payments in addition to the negotiated payment rate.

9.3.12 Contracting Requirements for Nonprofit Community Health Clinics, Community Mental Health Centers, and Community Health Services Agencies. The MCO shall contract with nonprofit community health clinics (community health clinic), as defined in Minnesota Statutes, Chapter 145A, including all FQHCs that are also nonprofit community health clinics, community mental health centers, or community health services agencies (community health boards), as defined in Minnesota Statutes, § 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 shall provide the MCO with a list of all nonprofit community health clinics, community mental health centers, and community health services agencies within the MCO's Service Area.

9.3.13 Contracting Requirements for Essential Community Providers. The MCO shall offer to contract with any designated essential community Provider, as described in a listing provided by the STATE, located within its Service Area, pursuant to Minnesota Statutes, § 62Q.19.

9.3.14 Enrollees Held Harmless.

(A) Except for Medical Assistance copays pursuant to section 4.17, the MCO shall ensure that the Enrollee is not held responsible for any fees associated with the Enrollee's medical care received from the MCO subcontractor or an Out-of-Plan Provider with whom the MCO has negotiated a rate for providing the Enrollee services covered under this Contract.

(B) The MCO shall ensure, through its provider contracts, that Providers: 1) notify Enrollees in writing of Enrollee liability for non-covered services; and 2) prior to performance of the service, receive written authorization from the Enrollee for the non-covered service.

(C) Where an Enrollee receives Medical Emergency Services, Post-Stabilization Care Services or Urgent Care Out of Area or Out of Plan, the MCO shall pay the Out of Area or Out of Plan Provider on the condition that the Provider holds 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 or radiologist).

9.3.15 Exclusions of Individuals and Entities.

(A) The MCO must search the Medicare Exclusion Database (MED) or the OIG List of Excluded Individuals/Entities (LEIE) database monthly, and require all subcontractors to search the MED and the LEIE for any Providers, agents, Persons with an Ownership or Control Interest and Managing Employees to verify that these persons:

(1) Are not excluded from participation in Medicaid under Sections 1128 or 1128A of the Social Security Act.

(2) Have not been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or programs under title XX of the Social Security Act.

(B) The MCO must require subcontractors to assure to the MCO that no agreements exist with an excluded entity or individual for the provision of items or services related to the MCO's obligation under this contract

(C) The MCO shall require all subcontractors to report to the MCO within five (5) days any information regarding individuals or entities specified in (A) above, who have been convicted of a criminal offense related to the involvement in any program established under Medicare, Medicaid, the title XX services program, or that have been excluded from participation in Medicaid under §§ 1128 or 1128A of the Social Security Act.

(D) The MCO shall report this information to the STATE within seven (7) days of the date the MCO receives the information.

(E) The MCO must also promptly notify the STATE of any action taken on a subcontract under this section.

(F) In addition to complying with the provisions of section 9. 3.17, the MCO shall not enter into any subcontract that is prohibited, in whole or in part, under § 4704(a) of the Balanced Budget Act of 1997 or under Minnesota Statutes, § 62J.71.

9.3.16 Financial Incentives. The MCO may not give any financial incentive to a health care provider based solely on the number of services denied, limited or discontinued, or referrals not authorized by the provider, pursuant to Minnesota Statutes, § 72A.20, subd. 33 and as required under 42 CFR § 422.208 and 438.210(e).

9.3.17 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 Article. 2(85), and in subcontracts for the delivery of mental health services that the subcontractor additionally follow the Medical Necessity definition found in Minnesota Statutes, § 62Q.53. Subcontracts shall include the definition found in Article. 2(85), and the definition found in Minnesota Statutes, § 62Q.53 where applicable.

9.3.18 Payment. The MCO agrees to pay health care Providers on a timely basis consistent with the claims payment procedure described in § 1902(a)(37)(a) of the Social Security Act (42 U.S.C. 1396a(a)), and 42 CFR § Parts 447.45 and 447.46.

9.3.19 Complaint Reporting. The MCO shall require Primary Care Providers to report quality of care complaints pursuant to Minnesota Rules, Part 4685.1110, subpart 9, and Care Systems to report any complaints relating to MnDHO Enrollees to the MCO on a quarterly basis.

9.3.20 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.

9.3.21 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 Medicare rate. 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 HCBS Waiver Provider Subcontracting.

(A) The MCO shall make best efforts to develop contracts and negotiate rates with all MnDHO Waiver Service Providers. The MCO must utilize the States' standard Waiver contracting template as a base for these contracts for services, except for extended Waiver services. The STATE will designate those contract elements that must be included and will notify the MCO of these elements by March 1, 2009. New or renegotiated MCO waiver provider contracts must include these contract elements after April 1, 2009. Other waiver contracts must be updated to include the elements of the standardized template by December 31, 2009. The MCO must implement a plan for oversight of Waiver Providers, including mechanisms for verification that Waiver Providers meet the Waiver Provider requirements. The oversight plan must include procedures for ongoing monitoring of Waiver providers and services, and the MCO must notify the STATE of this plan.

(B) The MCO may have an agreement with willing local agencies to utilize Waiver Providers approved and contracted by the local agency. Under this agreement, the MCO will work with the local agency to utilize local agency rates or develop alternatives to those rates. If the agreement does not include a plan for oversight of Waiver Providers, including mechanisms for verification that Waiver Providers meet Waiver Provider requirements and procedures for ongoing monitoring of Waiver Providers and services, the MCO must implement an oversight plan that includes such mechanisms and must notify the state of this plan.

(C) Nothing in this section shall preclude MCOs from paying Waiver Providers on a non-participating basis when the MCO determines that is necessary. The MCO must notify the STATE of its plan for oversight of Waiver services administered by Waiver Providers who are paid on a non-participating basis. This plan must include mechanisms for verification that Waiver providers meet Waiver Provider requirements and procedures for on-going monitoring of Waiver Providers and services. The MCO must use the rates or rate methodology established by the Local Agency, or may use the annual rate limits published by the STATE.

(D) The MCO must include in its payment arrangements for Waiver Providers mechanisms that require the Provider to cooperate with the MCO's process for Provider collection of Waiver Obligations, if any.

(E) Where counties require that MCOs have formal agreements 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. The MCO must use the State's template for Waiver contracts as the base format for these contracts.

9.3.23 Provider and Enrollee Communications. The MCO may not prohibit, or otherwise restrict, a Health Care Professional acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee, with respect to the following:

(A) The Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

(B) Any information the Enrollee needs in order to decide among all relevant treatment options.

(C) The risks, benefits, and consequences of treatment or non-treatment.

(D) The Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

9.3.24 Relationships with Providers. Pursuant to 42 CFR § Subpart E, the MCO shall comply with all applicable provider requirements in that section, including, but not limited to: 1) provider certification requirements; 2) anti-discrimination requirements; 3) provider participation and consultation requirements; 4) the prohibition on interference with provider advice; 5) limits on provider indemnification; 6) rules governing payments to providers; and 7) limits on Physician Incentive Plans.

9.3.25 Automatic Termination of Subcontract Clause. The following provision is required to be included in all contracts and subcontracts entered into by the MCO, with the exception of contracts for the purchase of items and equipment, including leases of real property which exceed the term of this contract, unless CMS agrees to its omission. 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:

"In the event the Medicare contract between CMS and the MCO is terminated or non-renewed, the contract between the STATE and **______________** (*insert 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."

9.3.26 Business Continuity Plan (BCP). By December 1st of the Contract Year, the MCO shall ensure that its subcontractors that provide Priority Services have in place a written Business Continuity Plan (BCP) that complies with the requirements of Article 20.

9.4 Maintenance, Inspection and Retention of Records.

9.4.1 Quality, Appropriateness and Timeliness of Service. 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. 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. The MCO must provide that the STATE and CMS may evaluate, through inspection or other means, the enrollment and disenrollment records when there is reasonable evidence of need for such inspection.

9.4.4 Records. The MCO shall provide that the STATE, CMS, or the Comptroller General, or their designees, may audit or inspect any books, documents, financial records, papers and records of the MCO and its subcontractors or transferees that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the Contract.

9.4.5 Timelines. The MCO must provide that the STATE and CMS's right to inspect, evaluate and audit shall extend through ten (10) years from the date of the final settlement for any Contract Year unless: A) the STATE or CMS determines there is a special need to retain a particular record or records for a longer period of time and the STATE or CMS notify the MCO at least thirty (30) days prior to the normal record disposition date; B) there has been a termination, dispute, Fraud, or similar default by the MCO, in which case the record retention may be extended to ten (10) years from the date of any resulting final settlement; or C) the STATE or CMS determined that there is a reasonable possibility of Fraud and the record may be reopened at any time. Records to be retained include, but are not limited to, medical, claims, Care Management, and Service Authorization records.

9.4.6 Record Maintenance. The MCO agrees to maintain such records and prepare such reports and statistical data as may be deemed reasonably necessary by the STATE and CMS. It is further agreed that all records must be made available to authorized representatives of the STATE and CMS during normal business hours and at such times, places, and in such manner as authorized representatives may reasonably request for the purposes of audit, inspection, examination, and for research as specifically authorized by the STATE to the MCO in fulfillment of the STATE or federal requirements. It is understood and agreed that the MCO shall be afforded reasonable notice of a request by an authorized representative of the STATE or CMS to examine records maintained by the MCO or its agents, unless otherwise provided by law.

9.4.7 Record Retention. 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 individual Enrollees terminate enrollment in MnDHO and in the MCO, and prior to final settlement, the MCO shall, upon request by the STATE, provide to the STATE copies of all information that may be necessary to determine responsibility for outstanding claims of Providers, and to ensure that all outstanding claims are settled promptly.

9.6 Trade Secret Information. The STATE agrees to protect from dissemination information submitted by the MCO to the STATE that the MCO can justify as trade secret information, pursuant to Minnesota Statutes, § 13.37, subd. 1(b). Protected information may be Marketing plans and Materials, rates paid to providers, Medicare bid information or any other information. The MCO must identify information as trade secret prior to or at the time of its submission for the STATE to consider classifying it as non-public. If information identified by the MCO as trade secret is subject to a data practices request or otherwise subject to publication, and if the STATE determines that the MCO's trade secret identification is colorable, the STATE shall provide the MCO an opportunity to justify in writing that the information meets the requirements of Minnesota Statutes, § 13.37. Trade secret information may be shared with CMS. The STATE must notify CMS that such information is considered trade secret. Pursuant to Minnesota Rules, Part 9500.1459, rates paid to the MCO, the STATE's rate methodology, and this Contract are not trade secrets.

9.7 Date of Issue of Enrollee Material. The MCO shall submit to the STATE upon request, written confirmation of the dates on which the MCO issues all new Enrollee materials required by section 3.2.12. The MCO must notify the STATE and provide a brief explanation in writing within two working days if the MCO cannot comply with the time frame specified in section 3.2.12.

9.8 Data Sharing with Local Agency Welfare and Public Health Offices. The STATE authorizes the MCO to enter into data sharing agreements with Local Agency welfare and public health offices for the purpose of administering the C&TC program and county

outreach for C&TC. The STATE shall provide, upon request, a model data sharing agreement and technical assistance with establishing the agreement.

9.9 Reporting of Time-Sensitive Data. The STATE may collect data or contract with external vendors for studies, including but not limited to, data validation, service validation, and quality improvement.

9.9.1 Notice. The STATE will give the MCO at least forty-five (45) days notice. The notice will include the time-sensitive nature of the data, and data specifications for the required data.

9.9.2 Data Specification Issues. The MCO must notify the STATE within one week of any issues concerning the data specifications.

9.9.3 Timely Submission. If the MCO is not able to submit all required data by the deadline, the MCO may request a delay. The STATE shall not grant a delay if such delay would result in the STATE's inability to evaluate the MCO's performance or data in the contracted study.

9.9.4 Requirements. The MCO must submit accurate and complete data within the time period that meet the data specifications.

9.10 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.

9.11 Liability. The STATE and MCO agree that, to the extent provided for in state law, each shall be responsible for the loss, damage or injury arising from its own negligence in performing this Contract.

9.12 Severability. If any provision or paragraph of this Contract is found to be legally invalid or unenforceable, such provision or paragraph shall be deemed to have been stricken from this Contract and the remainder of this Contract shall be deemed to be in full force and effect.

9.13 Workers' Compensation. In accordance with the provisions of Minnesota Statutes, § 176.182, the MCO shall provide acceptable evidence of compliance with the workers' compensation insurance coverage requirement of Minnesota Statutes, § 176.181, subd. 2.

9.14 Affirmative Action. The MCO certifies that it has received a certificate of compliance from the Commissioner of Human Rights pursuant to Minnesota Statutes, § 363A.36. County administered MCOs are exempt from this statute.

9.15 Voter Registration. The MCO certifies that it will comply with Minnesota Statutes, § 201.162.

9.16 Fraud and Abuse Requirements.

9.16.1 Integrity Program.

(A) **Administrative and Management Procedures**. The MCO shall have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against Fraud, Abuse and Improper Payments. The arrangements or procedures shall include the following:

(1) Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable Federal and State standards;

(2) The designation of a compliance officer and a compliance committee that are accountable to senior management of the MCO;

(3) Effective training and education for the compliance officer and the MCO's employees;

(4) Effective lines of communication between the compliance officer and the MCO's employees;

(5) Enforcement of standards through well-publicized disciplinary guidelines;

(6) Provision for internal monitoring and auditing, including monitoring and auditing of subcontracted services to detect Fraud, Abuse and Improper Payments;

(7) Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to this Contract;

(8) Provision for profiling Provider services and Enrollee utilization that identifies aberrant behavior and/or outliers;

(9) Policies and procedures that safeguard against unnecessary or inappropriate use of services and against excess payments for services;

(10) Policies and procedures that safeguard against failure by subcontractors or Participating Providers to render Medically Necessary items or services that are required to be provided to an Enrollee covered under this Contract; and

(11) Provision for identifying, investigating, and taking corrective action against fraudulent and abusive practices by Providers, subcontractors, and Enrollees, MCO employees, officers and agents.

(12) A method to verify whether services under this Contract, paid for by the MCO, were actually furnished to the Enrollees as required in 42 CFR § 455.1(a)(2)

(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 of the Contract, detailing the MCO's integrity program, including investigative activities, 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 9.17.1(A)(1), and must specifically describe the activities it has undertaken to safeguard against Fraud and Abuse by personal care assistant (PCA) providers, as required by section 9.17.4.

(E) **Violation Report Process**. The MCO shall establish and adhere to a process for reporting to the STATE, CMS and/or the Office of Inspector General for the U.S. Department of Health and Human Services, credible information of violations of law by the STATE, the MCO, Participating Providers, subcontractors, or Enrollees, for a determination as to whether criminal, civil, or administrative action may be appropriate. If the MCO has reason to believe that an Enrollee has defrauded the Medicaid program, the MCO shall refer the case to an appropriate law enforcement agency as mandated in 42 CFR § 455.15(b)

(F) **Quarterly Reporting of Actions Terminating Provider Participation**. The MCO shall report quarterly to the STATE the name, specialty, and address (in a form approved by the STATE) of each provider whose participation status the MCO has taken action to terminate or not renew during the previous quarter.

9.16.2 Fraud and Abuse by MCO and/or its Subcontractors, and/or Participating Providers.

(A) The MCO's officers understand that this Contract involves the receipt by the MCO of state and federal funds, and that they are, therefore, subject to criminal prosecution and/or civil or administrative actions for any intentional false statements or other fraudulent conduct related to their obligations under this Contract.

(B) The MCO and its subcontractors shall, upon the request of the Minnesota Medicaid Fraud Control Unit (MFCU) of the Minnesota Attorney General's Office, make available to MFCU all administrative, financial, medical, and any other records that relate to the delivery of items or services under this Contract. The MCO shall allow the MFCU access to these records during normal business hours, except under special circumstances when after hours

admissions shall be allowed. Such special circumstances shall be determined by the MCFU.

(C) The MCO shall report to the STATE and the MFCU any suspected Fraud and/or Abuse by Providers within twenty-four (24) hours after the MCO knows or has reason to believe of such suspected Fraud and/or Abuse. The MCO shall cooperate fully in any investigation of the suspected Fraud and/or Abuse by the STATE and MFCU and in any subsequent legal action that may result from those investigations.

9.16.3 Fraud and Abuse by Recipient. The MCO shall report to the STATE any suspected Fraud and/or patterns of Abuse by Recipients.

9.16.4 Fraud and Abuse by PCA Providers.

(A) The STATE has determined that enrollment of individual PCA Providers in the fee-for-service system will allow the STATE to safeguard against unnecessary or inappropriate use of PCA services and against excess payments. The MCO shall ensure that PCA Providers that are not under continuous direct supervision have a background study completed prior to providing any PCA services.

(B) The MCO may work with the STATE to utilize the STATE's licensing system for these purposes, but any process utilized by the MCO must review using the same standards as the STATE's licensing system.

(C) Effective March 1, 2009, the MCO shall require that PCA provider agencies submit claims to the MCO using one date of service per claim line, per PCA.

9.16.5 False Claims.

(A) If the MCO receives or makes Medicaid payments totaling five million dollars ($5,000,000.00) 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, contractors and agents that includes detailed information pertaining to the False Claims Act 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.

(B) In addition, the MCO must include in any Employee handbook(s) specific discussions of the following:

(1) The False Claims Act, 31 U.S.C. §§ 3729 through 3733;

(2) Administrative remedies for false claims and false statements established under 31 U.S.C. §§3801, et seq.;

(3) 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; and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

9.17 Data Certifications. As a condition for receiving payment the MCO shall certify its data and documents that are utilized by the STATE in determining payments made to the MCO.

9.17.1 Data Submitted to the STATE. The MCO shall provide to the STATE a certification that accompanies its submission of the data indicated below. The MCO may submit a separate written Data Certification, due by the 5th day of the following month for any submissions in the previous month, which identifies each and every data submission, the date it was submitted, and certifies all data submitted. The following data must be certified:

(A) Encounter data;

(B) Data submission as requested by the STATE for the development of rates;

(C) Tobacco-related health care expenditures; and

(D) Any other data or document determined by the STATE to be necessary to comply with 42 CFR § 438.604.

9.17.2 Financial Filing with MDH. The MCO shall also certify to the STATE that its annual statutory financial filing with the Minnesota Department of Health (MDH) represents only costs related to services covered under the State Plan, Home and Community Based Services (HCBS), or costs related to providing those services, such as the MCO's administrative costs. If the MCO does not in its statutory filing distinguish these costs from the cost of services provided as additional services, the MCO must then certify what percentage of the expenses stated in its financial filing are for State Plan services. The MCO must provide this certification no later than May 1st of the Contract Year.

9.17.3 Requirements. Each certification shall meet the following requirements:

(A) Include an attestation as to the accuracy, completeness and truthfulness of the data or documents being submitted.

(B) Provide that the attestation is based upon the best knowledge, information and belief of the one certifying on behalf of the MCO.

(C) Be certified by 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 9.18.1.

9.18 Compliance with CMS Medical Assistance Payment Regulation. As required by 42 CFR § Part 434.67(e), Medical Assistance payments under this Contract will be denied for new Enrollees when, and so long as, Medical Assistance payments for those Enrollees are denied by CMS pursuant to 42 CFR § 434.67(e).

9.19 Compliance with Public Services Act. The MCO shall comply with:

9.19.1 Sections 1318(a) and (c) of the Public Health Services Act that pertain to disclosure of certain financial information;

9.19.2 Sections 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

9.19.3 The reporting requirements in 42 CFR § 422.516 that pertain to the monitoring of an organization's continued compliance.

9.20 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 subcontractors that payments they receive are, in whole or in part, from federal funds.

9.21 Formal Presentations. The MCO shall provide to the STATE copies of any formal presentation by the MCO or its Administrative Services Organization (ASO), including reports, statistical or analytical materials, papers, articles, professional publications, speeches, or testimony (except testimony before the Minnesota Legislature), that is based on information obtained through the administration of this Contract.

9.22 Exclusions and Convicted Persons The MCO:

(A) Shall not pay for any items or services furnished, ordered or prescribed by excluded individuals or entities, pursuant to 42 CFR § 1001.1901.

(B) 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) 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) Shall not have any agents, Managing Employee, or Persons with an Ownership or Control Interest 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) 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; and

(2) Any occurrence of an excluded, convicted, or unlicensed entity or individual who applies to participate as a Provider.

(F) 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 §§ 455,106(b)(2) and 1002.3(b)(3).

Article. 10 Assignment. The MCO shall neither assign nor transfer any rights or obligations under this Contract without the prior written consent of the STATE.

Article. 11 Third Party Liability and Coordination of Benefits.

11.1 Agent of the STATE. Pursuant to 42 CFR § 433, subpart D and Minnesota Statutes, sections 256B.042, subd. 2; 256B.056, subd. 6; 256.015, subd. 1; and 256B.37, subd. 1, the STATE hereby authorizes the MCO as its agent to obtain third party and Medicare reimbursement by any lawful means including asserting subrogation interest, filing liens, asserting independent claims, and to coordinate benefits, for MCO Enrollees.

11.2 Third Party Recoveries. The MCO must take reasonable measures to determine the legal liability of third parties to pay for services furnished to MCO Enrollees. To the extent permitted by state and federal law, the MCO shall use Cost Avoidance and/or Post Payment Recovery Processes, as defined in Article 2 of this Contract, to ensure that primary payments from the liable third party are utilized to offset medical expenses.

11.2.1 Known Third Parties. The STATE shall include information about known third party resources on the electronic enrollment data given to the MCO twice a month.

11.2.2 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 business days of verification of such information. The MCO shall report any known change to health insurance information in the same manner.

11.2.3 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.

11.2.4 Retention of Recoveries. The MCO is entitled to retain any amounts recovered through its efforts, provided that:

(A) Total payments received do not exceed the total amount of the MCO's financial liability for those services provided by the MCO to the Enrollee;

(B) STATE fee-for-service and reinsurance benefits have not duplicated this recovery; and

(C) Such recovery is not prohibited by federal or state law.

11.2.5 Return of Payments. The MCO may require its capitated Providers to return any third party payments to the MCO.

11.2.6 Unsuccessful Efforts. If the MCO is unsuccessful in its efforts to obtain necessary cooperation from an Enrollee to identify potential third-party resources after sixty (60) days of such efforts, the MCO may inform the STATE in a format to be determined by the STATE that efforts have been unsuccessful.

11.3 Coordination of Benefits. For Enrollees who have private health care coverage, the MCO must coordinate benefits in accordance with Minnesota Rules, Part 9505.0070 and Minnesota Statutes, § 62A.046. Coordination of benefits includes paying any applicable co-payments or deductibles on behalf of an Enrollee, except for Medical Assistance copayments pursuant to section 4.17. For Enrollees who are also eligible for Medicare, coordination of benefits includes paying any applicable copayments, coinsurance or deductibles on behalf of an Enrollee up to the Medicare allowed amount.

11.3.1 Cost Avoidance.

(A) **General**. Except as described in paragraph B, the MCO shall cost-avoid all claims or services that are subject to third-party payment to the extent permitted by state and federal law, and may deny a service to an Enrollee if the MCO is assured that a third party (i.e., other insurer) will provide the service. The MCO must determine whether it is more cost-effective to provide the service or pay the co-pays, coinsurance and deductibles to a Non-Participating Provider. If the MCO refers an Enrollee to a third-party insurer for a service that the MCO covers, and the third-party insurer requires payment in advance of all co-payments, coinsurance and deductibles, the MCO shall make such payments in advance or at the time such payments are required.

(B) **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.

11.3.2 Post Payment Recoveries.

(A) Recoveries to be Pursued by the MCO. The MCO shall recover funds Post Payment in cases where the MCO was not aware of third-party coverage at the time services were rendered or paid for, or the MCO was not able to cost avoid (payment was not available at the time the claim was filed). The MCO shall identify all potentially liable third parties and pursue reimbursement from them. Potentially liable third party coverage sources include, but are not limited to: Uninsured/Under insured motorist insurance, First and third party liability insurance, awards as a result of a tort action, Workers' Compensation, Medical payments insurance for accidents (otherwise known as "med pay" provisions or benefits of policy), Long Term Care Insurance and Indemnity/accident insurance. The MCO shall develop procedures to identify trauma diagnoses and investigate potential liability.

(B) Recoveries Not be Pursued by the MCO. The MCO shall not pursue reimbursement under estate recovery or medical support recovery provisions. This applies to recoveries of medical expenses paid for an Enrollee when the following subsequent recovery actions are taken by a Local Agency or the STATE: 1) Medical Assistance lien or estate recovery; 2) Special Needs or Pooled Trusts; 3) annuities; or 4) from a custodial or non-custodial parent under a court order for Medical Support.

11.4 Reporting of Recoveries.

11.4.1 The MCO shall report on the encounter claim all third party liability payments (including Medicare reimbursement) as required in section 3.5.2.

11.4.2 The MCO shall, on a quarterly basis, also disclose to the STATE all cost avoided and recovered amounts made from private insurance carriers, Medicare, and other responsible third parties, using a format provided by the STATE. This report is due by the 20th of the month following the end of the quarter. The MCO shall also report an estimate of Medicare payment, however, the MCO may base the estimate on the methodology used for submitting bids to CMS to derive the amount.

11.5 Causes of Action. If the MCO becomes aware of a cause of action to recover medical costs for which the MCO has paid under this Contract, the MCO shall file a lien, assert a claim or a subrogation interest in the cause of action. The MCO shall follow the STATE's policy guidelines in settlement of any claim.

11.6 Determination of Compliance. The STATE may determine whether the MCO is in compliance with the requirements in this Article by inspecting source documents for: (1) appropriateness of recovery attempt; (2) timeliness of billing; (3) accounting for third party payments; (4) settlement of claims; (5) other monitoring deemed necessary by the STATE.

Article. 12 Governing Law, Jurisdiction and Venue. This Contract, and amendments and supplements thereto, will be governed by the laws of the State of Minnesota. Venue for all legal proceedings arising out of this contract, or breach thereof, will be in the state or federal court with competent jurisdiction in Ramsey County, Minnesota.

12.1 Compliance with State and Federal Law.
The MCO shall comply with all applicable state and federal laws and regulations in the performance of its obligations under this Contract. Any revisions to applicable provisions of federal or state law and implementing regulations, and policy issuances and instructions, except as otherwise specified in this Contract, apply as of their effective date. If any terms of this Agreement are determined to be inconsistent with rule or law, the applicable rule or law provision shall govern. In the performance of obligations under this Contract, the MCO agrees to comply with provisions of the following laws:

12.2 Constitutions The Constitutions of the United States and the State of Minnesota.

12.3 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) Age Discrimination Act of 1975 and pertinent regulations at 45 CFR Part 91.

(E) Certificates Of Compliance For Public Contracts, Minnesota Statutes, §363A.36.

(F) Title IX of the Education Amendments of 1972.

(G) The Americans with Disabilities Act. In fulfilling the duties and responsibilities of this Contract, the MCO shall comply with P.L. 101-336, Americans with Disabilities Act of 1990, 42 U.S.C. §12101, et seq., and regulations promulgated pursuant to it. The MCO also shall comply with 28 CFR §35.130(d), which requires the administration of services, programs, and

activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

(H) Any other laws, regulations, or orders that prohibit discrimination on grounds of race, sex, color, age, religion, health status, physical disability, sexual orientation, national origin, or public assistance status.

12.4 State Law. 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.

12.5 Medicaid Laws. Title XIX of the Social Security Act (42 U.S.C. § 1396 et. seq.), applicable provisions of 42 CFR Part 431.200 et. seq. and 42 CFR Part 438; waivers or variances approved by CMS; the Rehabilitation Act of 1973.

12.6 Environmental Requirements. The MCO shall comply with all applicable standards, order or requirements issued under Section 306 of the Clean Air Act (42 USC §1857(h)), Section 508 of the Clean Water Act (33 U.S.C §1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Part 15).

12.7 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.

12.8 Anti-Kickback Provisions. The MCO shall be in compliance with the Copeland "Anti-Kickback" Act, 18 U.S.C. § 874, as supplemented by Department of Labor regulations, 29 CFR Part 3, "Contractors and Subcontractors on Public Building or Public Work financed in whole or in part by Loans or Grants from the United States," as applicable.

12.9 Davis-Bacon Act. The MCO shall be in compliance with the Davis-Bacon Act, as amended (40 U.S.C. §§ 276a to 276a-7), as supplemented by Department of Labor regulations (29 CFR Part 5), as applicable.

12.10 Contract Work Laws. The MCO shall be in compliance with the Contract Work Hours and Safety Standards Act (40 U.S.C. §§ 327-330), as supplemented by Department of Labor regulations (29 CFR Part 5), as applicable.

12.11 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.

12.12 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.

12.13 Medicare Revenue Enhancement Program (MREP). The MCO shall cooperate with the STATE's Medicare Revenue Enhancement Program (MREP) to ensure that Skilled Nursing Facility days are covered pursuant to Medicare guidelines. Cooperation includes, but is not limited to, filing requests for redetermination for which the STATE must be allowed up to one hundred and twenty (120) days from the date of denial.

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 3.5.1(B). The MCO shall be in compliance with these requirements consistent with the applicable effective dates contained in state or federal law.

13.1.1 Business Associate and Trading Partner. The Parties agree:

(A) The STATE makes available and/or transfers to the MCO certain information in connection with the provision of services provided by the MCO on behalf of the STATE and in making available and transferring certain information discloses to the MCO certain Protected Health Information (PHI) as defined in 45 CFR § 164.501. PHI is considered "private data on individuals" (as defined in Minnesota Statutes, § 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) Both the STATE and the MCO are a "Covered Entity" as the term is defined in the Privacy Regulation; and because the MCO receives PHI from the STATE, it also is 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) 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) Unless otherwise provided for in this Contract, capitalized terms in this section have the same meaning as set forth in the Privacy Regulation.

13.2 Duties Relating to Protection of Information.

13.2.1 Proper Handling of Information. MCO shall be responsible for ensuring proper handling and safeguarding by its employees, subcontractors, and authorized agents of Protected Information collected, created, used, maintained, or disclosed on behalf of STATE. This responsibility includes ensuring that employees and agents comply with and are properly trained regarding, as applicable, the laws listed in section 13.5.1.

13.2.2 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.

13.2.3 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.

13.2.4 Additional Privacy and Security Safeguards. MCO shall comply with the requirements set forth below regarding "Use of Information."

13.3 Use of Information.

13.3.1 MCO shall:

(A) Not use or further disclose Protected Information created, collected, received, stored, used, maintained or disseminated in the course or performance of this Agreement other than as permitted or required by this Agreement or as required by law, either during the period of this agreement or hereafter.

(B) Use appropriate safeguards to prevent use or disclosure of the Protected Information by its employees, subcontractors and agents other than as provided for by this Agreement. This includes, but is not limited to, having implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentially, integrity, and availability of any protected information that it creates, receives, maintains, or transmits on behalf of STATE.

(C) Report to STATE any Privacy Incident or Security Incident of which it becomes aware. The MCO shall comply with any corrective actions required by the STATE as a result of the Privacy Incident or Security Incident. Such corrective action may include, but are not limited to:

(1) conducting an internal investigation of the incident;

(2) providing the STATE a report summarizing the MCO's internal review and investigative findings of the incident;

(3) disclosing the breach to any Enrollee 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.

(D) Consistent with this Agreement, ensure that any agents (including contractors and subcontractors), analysts, and others to whom it provides Protected Information, agree in writing to be bound by the same restrictions and conditions that apply to it with respect to such information.

(E) Mitigate, to the extent practicable, any harmful effects known to it of a use, disclosure, or breach of security with respect to Protected Information by it in violation of this Agreement.

(F) 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, or receipt of written request by the STATE.

(G) 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.

(H) 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.

(I) Comply with any and all other applicable provisions of the HIPAA Privacy Rule and Security Standards, including future amendments thereto.

(J) 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.

(K) Either 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 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.

13.3.2 The STATE shall:

(A) Only release information that it is authorized by law or regulation to share with MCO.

(B) Obtain any required consents, authorizations or other permissions that may be necessary for it to share information with MCO.

(C) 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.

(D) Not request MCO to use or disclose Protected Information in any manner that would not be permitted under law if done by STATE.

13.4 Disposition of Data upon Completion, Expiration, or Agreement Termination. Upon completion, expiration, or termination of this Agreement, MCO will return or destroy all Protected Information that the MCO still maintains received from the STATE or created or received by the MCO for purposes associated with this Agreement. MCO will retain no copies of such Protected Information, provided that if such return or destruction is not feasible, MCO will extend the protections of this Agreement to the Protected Information and refrain from further use or disclosure of such information, except for those purposes that make return or destruction infeasible, for as long as MCO maintains the information.

13.5 Sanctions. In addition to acknowledging and accepting the terms set forth in section 9.12 of this Agreement relating to liability, the parties acknowledge that violation of the laws and protections described above could result in limitations being placed on future access to Protected Information, in investigation and imposition of sanctions by the U.S. Department of Health and Human Services, Office for Civil Rights, and/or in civil and criminal penalties.

13.6 MCO's Own Purposes. The STATE makes no warranty or representations that compliance by the MCO will be adequate or satisfactory for the MCO's own purposes. The MCO is solely responsible for all decisions it makes regarding the safeguarding of PHI or other Protected Information.

13.7 Privacy Act Compliance. The MCO shall comply with the requirements of the Privacy Act, as implemented by 45 CFR § 5b and 42 CFR § 401(B), as applicable. The MCO must comply with the confidentiality requirements of 42 CFR § 482.24 for medical records and for all other health and enrollment information on Enrollees that is contained in the MCO's records or obtained from CMS or the STATE. The MCO must use and disclose

individually identifiable health information in accordance with the privacy requirements in 45 CFR § 160 and 164, subparts A and E, to the extent that the requirements are applicable.

13.8 Procedures and Controls. The MCO agrees to establish and maintain procedures and controls so that no information contained in its records or obtained from the STATE or CMS or from others in carrying out the terms of this Contract shall be used by or disclosed by it, its agents, officers, or employees except as provided in Minnesota Statutes, Chapter 13 and in § 1106 of the Social Security Act and implementing regulations.

13.9 Requests for Data. 42 CFR § 431.301 (pursuant to 1902(a)(7) of Title XIX and 42 U.S.C. 1396a(7)) requires the STATE to ensure that disclosures of data concerning Enrollees and Potential Enrollees be limited to purposes directly connected with the administration of the State Plan, as defined in 42 CFR § 431.302. The STATE has not delegated to the MCO the authority to determine whether such disclosures of data are appropriate for any population covered under this Contract. The MCO must get prior approval from the STATE for disclosures of such data on the MnDHO population.

13.9.1 Data Sharing with Local Agency Welfare and Public Health Offices. The STATE authorizes the MCO to enter into data sharing agreements with Local Agency welfare and public health offices for the purpose of administering the C&TC program and county outreach for C&TC. The STATE shall provide, upon request, a model data sharing agreement and technical assistance with establishing the agreement.

13.9.2 The STATE authorizes the MCO to enter into data sharing or subscriber agreements with the Minnesota Health Information Exchange (MN-HIE).

13.10 Authorized Representatives for Data. STATE's authorized representative for data privacy and security is the Minnesota Department of Human Services Privacy Official. MCO's responsible authority for complying with data privacy and security is the MCO's Privacy and/or Security Official(s).

13.11 Indemnification. Notwithstanding section 9.10, the MCO agrees to indemnify and save and hold the STATE, its agents and employees harmless from all claims arising out of, resulting from, or in any manner attributable to any violation by the MCO of any provision of the laws listed in section 13.5.1 in connection with the performance of the MCO's duties and obligations under this Agreement. This includes, but is not limited to, legal fees and disbursements paid or incurred to enforce the provisions of this Agreement.

Article. 14 Lobbying Disclosure. The MCO certifies that, to the best of its knowledge, understanding, and belief, that:

14.1 No Federal Funds Used. No Federal appropriated funds have been paid or will be paid in what the undersigned believes to be a violation of 31 U.S.C. 1352, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative

agreement, and the extension, continuation, renewal, amendment, the modification of any Federal contract, grant, loan, or cooperative agreement, or in any activity designed to influence legislation or appropriations pending before Congress.

14.2 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.

14.3 Certification. The undersigned will require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and will require that all sub-recipients certify and disclose accordingly. This certification is a material representation of facts upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by 31 U.S.C. 1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Article. 15 Clinical Laboratory Improvement Amendments (C.L.I.A.) Requirements. All laboratory testing sites providing services under this contract must comply with the C.L.I.A. requirements in 42 CFR § Part 493. The MCO shall obtain the valid C.L.I.A. certificate numbers from laboratories used by the MCO, and shall ensure that the certificates remain current. The MCO shall make a written report to the STATE of any laboratories it discovers to be non-C.L.I.A. certified.

Article. 16 Advance Directives Compliance. Pursuant to 42 U.S.C. 1396a(a)(57) and (58) and 42 CFR § 422.128, 42 CFR § 434.28 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:

16.1.1 Information regarding the Enrollee's right to accept or refuse medical or surgical treatment and to execute a living will, durable power of attorney for health care decisions, or other Advance Directive;

16.1.2 Written policies of the MCO respecting the implementation of the right;

16.1.3 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; and

16.1.4 Information that complaints concerning noncompliance with the Advance Directive requirements may be filed with the State survey and certification agency (i.e. Minnesota Department of Health), pursuant to 42 CFR § 422.128(b)(3), as required in 42 CFR § 438.6(i).

16.2 Providers. 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 Comply with State Law. To comply with State law, whether statutory or recognized by the courts of the State, on Advance Directives, including Laws of Minnesota 1998, Chapter 399, § 38.

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 any financial, character, and other inquiries by the STATE. Upon request by the STATE, the MCO must disclose the following information as indicated in the Sections below:

17.1.1 The MCO shall notify the STATE in a timely manner of changes to the MCO's Government Programs staff and management.

17.1.2 The type of organizational structure, a description of the management plan, the general nature of the MCO's business and general nature of the management plan's business.

17.1.3 The MCO's full legal or corporate name and any trade names, aliases, and/or business names currently used.

17.1.4 The jurisdiction of the MCO and date of incorporation, along with any articles of incorporation and by-laws, if applicable, along with state and federal tax returns for the past five (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.

17.1.5 The date the MCO commenced doing business in Minnesota, and, if the MCO is incorporated outside of Minnesota, a copy of the MCO's certificate of authority to do business in Minnesota. Whether the MCO is directly or indirectly controlled to any extent or in any manner by another individual or entity. If so, the MCO must disclose the identity of the controlling entity and a description of the nature and extent of control.

17.1.7 Any agreements or understandings that the MCO has entered into regarding ownership or operation of the MCO.

17.2 Disclosure of Management/Fiscal Agents. The MCO must disclose the following, if applicable:

(A) A description of the terms and conditions of any contract or agreement between the MCO and the management or fiscal agent.

(B) All corporations, partnerships or other entities providing management of fiscal agent services.

(C) The management or fiscal agent's full legal or corporate name and any trade names currently used. The legal name, aliases, and previous names of management personnel, to the extent known.

(D) The jurisdiction of the management or fiscal agent and date of incorporation, along with any articles of incorporation and by-laws, if applicable, along with state and federal tax returns for the current period and the past six periods. Copies of any agreements creating or governing the organization must be submitted if the management or fiscal agent is an organization other than a corporation.

(E) The date the management or fiscal agent commenced doing business in Minnesota, and if they are incorporated outside of Minnesota, a copy of their certificate of authority to do business in Minnesota.

17.3 Disclosure of, Compliance with, and Reporting of Physician Incentive Plans. The MCO may operate a Physician Incentive Plan, as defined in 42 CFR § 422.208(a), only if the requirements of 42 CFR § 422.208 are met.

17.3.1 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 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 Plan s that place physician/physician groups at SFR for the cost of referral services it must conduct Enrollee surveys and provide a summary of the survey results. Additionally, the STATE shall annually conduct the survey of Enrollees who have disenrolled, and make available the survey results to the MCO.

17.3.2 Disclosure to Enrollees. The MCO must provide the following information in accordance with 42 CFR § 422.210 to any Enrollee or Potential Enrollee upon request:

(A) Whether the MCO or its subcontractors use a Physician Incentive Plan that affects the use of referral services.

(B) The type of incentive arrangement(s) used.

(C) Whether stop-loss protection is provided.

Article. 18 Federal Audit Requirements and Debarment Information.

18.1 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.

18.2 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 16C.03, Subd. 2, provides the Minnesota 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;

(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;

(C) Are not presently indicted or otherwise criminally or civilly charged by a governmental entity for: 1) commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (federal, state or local) transaction; 2) violating any federal or state antitrust statutes; or 3) committing embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property;

(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; and

(E) Shall immediately give written notice to the STATE should the MCO come under investigation for allegations of: 1) fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state or local government) transaction; 2) violating any federal or state antitrust statutes; or 3) committing embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property.

Article. 19 Emergency Performance Interruption (EPI).

19.1 Business Continuity Plan (BCP). By April 1st of the Contract Year, the MCO shall have in place a written Business Continuity Plan (BCP) to be enacted in the event of an EPI. The BCP must:

19.1.1 Identify an Emergency Preparedness Response Coordinator (EPRC). Include the appointment and identification of an Emergency Preparedness Response Coordinator (EPRC). The EPRC shall serve as the contact for the STATE with regard to emergency preparedness and response issues and shall provide updates to the STATE as the EPI unfolds. The MCO shall inform the STATE of the name and contact information for its EPRC by April 1st of the Contract Year. If the MCO's EPRC changes at any time during this agreement, the MCO must immediately notify the STATE.

19.1.2 Outline Activation Procedures. Outline the procedures used for the activation of the BCP upon the occurrence of an EPI.

19.1.3 Ensure Priority Services. Ensure that MCO operations continue to produce and deliver Priority Services under this contract. This includes, but is not limited to:

(A) Outlining the roles, command structure, decision making processes and emergency action procedures that will be implemented upon the occurrence of an EPI;

(B) Providing alternative operating plans for Priority Services;

(C) Providing procedures to move Enrollees to Fee for Service if the STATE determines such movement is necessary to properly provide service to the Enrollees; and

(D) Providing procedures to allow Enrollees to go to another clinic if their primary care clinic is not functioning.

19.1.4 Include Reversal Process. Include procedures to reverse the process once the external environment permits the MCO to re-enter normal operations.

19.1.5 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.

19.1.6 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.

19.2 EPI Occurrence. If an EPI occurs, the MCO must:

19.2.1 Implement the BCP. 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:

(A) Require joint management of contract operations between MCO and STATE staff.

(B) Move some or all of the MCO's Enrollees to another MCO.

(C) Bring some or all of the MCO's contractual duties in-house within the STATE.

(D) Immediately terminate the contract for the MCO's failure to provide the BCP services.

19.2.2 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.

19.2.3 Provide Notice to the State. Use best efforts to provide notification to the STATE of any significant closures within the MCO or its network.

19.2.4 Affected Enrollee Access. Allow Enrollees whose Primary Care Provider(s) is significantly affected by the EPI to access other Primary Care Providers or, if found necessary by the STATE, be moved to Fee for Service.

19.2.5 Continuation and Excuse from Services. Continue its duties and obligations under this contract for as long as is practical. If the MCO believes that, despite the

implementation of its BCP, it can no longer provide any or all of the Priority Services, the MCO must provide the STATE prompt written notices of such belief and request the STATE excuse it from those services. The notice and request must include specific details as to: (a) what services the MCO is requesting to be excused from providing; and (b) what circumstances prevent the MCO from providing the services.

19.2.6 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:

(A) Reasonable steps were taken (under the circumstances) to minimize delay or damages caused by foreseeable events;

(B) That all non-excused obligations will be substantially fulfilled; and

(C) 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.

19.2.7 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.

19.2.8 Return to Normal Operations. The MCO may suspend the performance of excused services under this Agreement until any disruption resulting from the EPI has been resolved. However, the MCO shall make every effort to eliminate any obstacles resulting from the EPI so as to minimize to the greatest extent possible its adverse effects. Once the disruptions from the EPI are resolved to the point that the MCO can reasonably resume normal performance on one or more of the excused services, the MCO shall reverse the BCP process, resume normal operations for those services, and provide notice to the STATE of the same.

Article. 20 Modifications. Any material alteration, modification or variation in the terms of this contract shall be reduced to writing as an amendment hereto and signed by the parties.

Article. 21 Survival. Notwithstanding the termination of this Contract for any reason, Article 14 (Indemnification), sections 3.5 and 9.4 (reporting and access to records), , sections 4.17 and 4.18 (payment error), section 7.13 (Financial Performance Incentives) and section 14.5 (Information Privacy and Security) shall survive the termination of this Contract.

Article. 22 Entire Agreement. The parties understand and agree that the entire agreement of the parties is contained herein and that this Contract supersedes all oral agreements and negotiations between the parties relating to this subject matter. All items referred to in this Contract are incorporated or attached and deemed to be part of the Contract. Any amendments to this Contract shall be in writing, signed by all parties, and attached hereto.

Article. 23 Execution 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.

Signature Page Follows.

Remainder of page intentionally left blank.

STATE OF MINNESOTA	UCare Minnesota (MCO)
DEPARTMENT OF HUMAN SERVICES	(Two corporate officers must execute)
By: [signature]	By: Nancy J Feldman
Title: Assistant Commissioner	Title: President & CEO
Date: 12/23/08	Date: 12/19/08

and

	By: Mark Traynor
	Title: Secretary & General Counsel
	Date: 12/22/08

List of Exhibits:

Exhibit I : **MCO Service Area, Contract Year 2009**

Exhibit II : **Rates**

Exhibit III: **Risk Adjustment Weights**

Exhibit IV: **Risk Adjustment Methods**

Exhibit V: **Protocols for Annual Review of Care System Subcontractors and Care Plans**

Exhibit VI: **Details from section 6.1.16 (A)(22)(a)**

Exhibit VII **Sections 6.1.15 and 6.1.16, Pending Federal Approval**