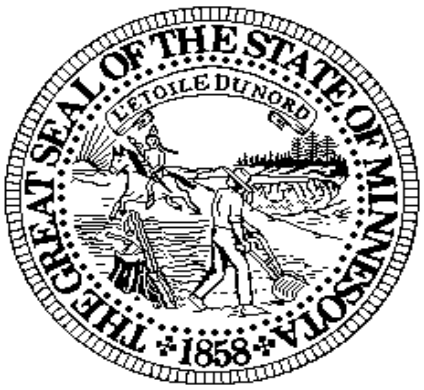
MINNESOTA DEPARTMENT OF HUMAN SERVICES

CONTRACT
FOR
SPECIAL NEEDS BASICCARE PROGRAM SERVICES
FOR PEOPLE WITH DISABILITIES



with

HENNEPIN HEALTH

JANUARY 1, 2020

DATA ELEMENT	ELEMENT NAME	DATA
Program (PMAP/MnCare, MSHO/MSC+, or SNBC)	D_Program	Special Needs BasicCare
Contract name (F&C, Seniors, or SNBC)	D_contract_name	SNBC
MCO formal name	D_entity_formal_name	Hennepin Health
MCO short name	D_entity_short_name	Hennepin Health
Start date	D_start_date	January 1, 2020
End date	D_end_date	December 31, 2020
Contract year	D_contract_year	2020
Previous contract year	D_prev_contract_year	2019
Two years previous	D_prev_contract_2_year	2018
Next contract year	D_next_contract_year	2021
Two years next	D_next_contract_2_year	2022
Contract signer	D_contract_signer	Charles E. Johnson
Contract signer title	D_contract_signer_title	Deputy Commissioner
New contract number	D_contract_number	166518
Previous contract number	D_prev_contract_number	144469
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SNBC

HENNEPIN HEALTH

MINNESOTA DEPARTMENT OF HUMAN SERVICES CONTRACT FOR MINNESOTA SPECIAL NEEDS BASICCARE

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MINNESOTA DEPARTMENT OF HUMAN SERVICES
CONTRACT
FOR SPECIAL NEEDS BASICCARE

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

WHEREAS, the STATE, pursuant to Minnesota Statutes, §256B.69, subd. 28, may contract with MCOs qualified under Minnesota Statutes, §256B.69, subd. 23 to provide Medicaid services and coordination of Medicare services, or integrated Medicare and Medicaid services, to persons with disabilities who are eligible for Medicaid;

WHEREAS, the STATE has authority to enter into contracts for the provision of prepaid medical and remedial services under Medicaid, pursuant to: Title XIX of the Social Security Act; 42 USC §1396 et. seq; 42 CFR, Ch. IV, Subchapter C; Minnesota Statutes, Chapter 256B; and a Medicaid waiver under §1915(a) of the Social Security Act;

WHEREAS, the Special Needs BasicCare (SNBC) service delivery system is designed to: 1) support Enrollees by assuring access to necessary primary, specialty, rehabilitative and acute care medical services; 2) for SNBC Special Needs Plan (SNP) Enrollees, integrate Medicare and Medicaid service delivery including the provision of prescription drugs under both programs for those who are Dually Eligible, and for non-SNP Enrollees, coordinate such services; 3) facilitate seamless transitions to Medicare Part D drug coverage for those who become Dually Eligible while enrolled; 4) facilitate choices among a range of Providers; 5) facilitate, to the extent of an Enrollee's ability, the Enrollee's involvement in his or her own decisions about care; 6) focus on the person being served in the context of his or her living situation and disability diagnosis;

WHEREAS, the MCO may have entered into a contract with the Centers for Medicare & Medicaid Services (CMS) to provide Medicare Parts A, B, and D services for SNBC SNP Enrollees pursuant to the Medicare Modernization Act, the MCO is participating in Medicare Advantage as a Dual SNP approved to serve a subset of Dual Eligibles as defined by the State of Minnesota, and meets or will meet CMS qualifications to participate as a low income benchmark plan for Medicare Part D services;

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

WHEREAS, the STATE and the MCO agree to continue to coordinate and share Medicare and Medicaid information about SNBC Enrollees; and

Through this Renewal Contract, number **166518,** the STATE and the MCO have agreed to renew the 2019 Contract number 144469 for the next Contract Year, January 1, 2020 through December 31, 2020.

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 Minnesota Special Needs BasicCare (SNBC) program. SNBC creates an alternative health care and support services delivery system for people with disabilities, who are eligible for Medicaid or have Dual Eligibility for Medicaid and Medicare. The SNBC program is a public health benefits program intended to provide Enrollees with access to cost-effective health care options.

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

ARTICLE. 2 ABBREVIATIONS, ACRONYMS, AND DEFINITIONS.

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

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

2.2 Abuse means abuse as defined in Minnesota Rules Part 9505.2165, subpart 2. Abuse also includes Enrollee practices that result in unnecessary cost to the Medicaid program. Abuse shall also include substantial failure to provide Medically Necessary items and services that are required to be provided to an Enrollee under this Contract if the failure has adversely affected or has a substantial likelihood of adversely affecting the health of the Enrollee.

2.3 Action means: 1) the denial or limited authorization of a requested service, including decisions based on the type or level of service; requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; 2) the reduction, suspension, or termination of a previously authorized service; 3) the denial, in whole or in part of payment for a service; 4) the failure to provide services in a timely manner; 5) the failure of the MCO to act within the timeframes defined in Article 8 regarding the standard resolution of grievances and appeals; 6) denial of an Enrollee's request to dispute a financial liability, including cost sharing, or 7) 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. Action means the same as "adverse benefit determination" in 42 CFR §438.400(b).

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

2.5 Additional Services means any services beyond those covered under this Contract that the MCO voluntarily provides to Enrollees. See section 6.4.

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

2.7 Adult means an individual twenty-one (21) years of age or older.

2.8 Adult Guardianship means:

2.8.1 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.

2.8.2 Public Guardian: refers to when the Commissioner of the Minnesota Department of Human Services is ordered and appointed by the court to act as public guardian for an adult with a mental

disability who lacks resources to employ a guardian, but needs this level of supervision and protection, and has no other private party willing and able to act as private guardian, in accordance with Minnesota Chapter Law 252A and Public Guardianship Rule #175, Minnesota Rules, parts, 9525.3010 through 9525.3100.

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

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

2.11 American Indian means those persons for whom services may be provided as an Indian pursuant to 25 USC 1603(13), 1603(28), or 1679(a), or 42 CFR §136.12. This means the individual:

2.11.1 Is a member of a Federally recognized Indian tribe;

2.11.2 Resides in an urban center and meets one or more of the four criteria:

- Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
- Is an Eskimo or Aleut or other Alaska Native;
- Is considered by the Secretary of the Interior to be an Indian for any purpose; or
- Is determined to be an Indian under regulations issued by the Secretary;

2.11.3 Is considered by the Secretary of the Interior to be an Indian for any purpose; or

2.11.4 Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

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

2.13 Assessment means determining the: 1) functioning; 2) health status, including high risk health conditions; 3) living environment; 4) social supports; 5) mental and/or substance use disorder problems; 6) developmental disability; and 7) language or comprehension barriers of an Enrollee. This includes, but is not limited to, identifying appropriate services and evaluating the effectiveness of these services.

2.14 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 individuals with disabilities. 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.

2.15 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.

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

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

2.18 Auxiliary Aids and Services means equipment and services to persons with impaired sensory, manual, or speaking skills to ensure that communications with individuals with these impairments are as effective as communications with others in health programs and activities, in accordance with the standards found at 28 CFR §§35.160 through 35.164, consistent with 45 CFR §92.4. At a minimum, auxiliary aids and services includes qualified interpreters and qualified translators; use of translated written materials; large print materials, screen readers or other effective methods of making visually delivered materials available to individuals who are blind or have low vision; and TTY/TTD systems or equally effective telecommunications devices for those who are deaf or hard of hearing.

2.19 BasicCare Rate means the rate for provision and administration of state plan services covered in the MCO's contract (excluding nursing facility services).

2.20 Behavioral Health Home (BHH) means a MHCP-enrolled provider certified by the STATE to provide services in accordance with Minnesota Statutes §256B.0757. BHH is a care coordination model that focuses on the behavioral, and physical health, and social service and support needs of populations with serious mental illness. BHH comprises the following services delivered by an inter-professional team: comprehensive care management; care coordination; health promotion services; comprehensive transitional care; referral to community and social support services; and individual and family support services. BHH services are available to Enrollees who have been determined eligible by the BHH provider in accordance with Minnesota Statute §256B.0757, subd. 2, (b).

2.21 Benefit Period means, under Medicare, the period of consecutive days that begins with the first day on which an Enrollee is furnished Inpatient Hospital 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.

2.22 Beneficiary means a person who has been determined by the STATE or Local Agency to be eligible for the Medical Assistance program.

2.23 Brain Injury (BI) Waiver means the Home and Community-Based Services waiver program, authorized by a federal waiver under §1915(c) of the SSA, 42 USC §1396n, and pursuant to Minnesota Statutes, §§256S, 256B.093 and 256B.49, for people with acquired, traumatic or degenerative brain injury who are at risk of the level of care provided in specialized nursing facilities or neurobehavioral hospitals.

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

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

2.26 Care Management means the overall method of providing ongoing health care in which the MCO manages the provision of primary health care services with additional appropriate services provided to an Enrollee. See section 6.1.4.

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

2.28 Case Management means the assignment of an individual who coordinates Medicare, to the extent feasible, and Medicaid health services for an Enrollee.

2.29 Certified Community Behavioral Health Clinics (CCBHC) means a Minnesota Health Care Programs-enrolled Provider certified by the STATE to provide services in accordance with Minnesota Statutes, §245.735. CCBHCs provide an integrated behavioral and physical health delivery model. Services provided under this model include but are not limited to primary care screening and monitoring; outpatient mental health and substance use disorder services, including screening, assessment and diagnosis (including risk management); crisis mental health services (including 24-hour mobile crisis teams), crisis intervention services and crisis stabilization; patient-centered treatment planning, targeted case management, peer and family support, services for members of the armed forces and veterans; psychiatric rehabilitation services, including adult rehabilitative mental health services (ARMHS) and children's therapeutic services and supports (CTSS). CCBHC services are available to Enrollees who have been determined eligible for services by the CCBHC in accordance with Minnesota Statutes §245.735.

2.30 Child or Children means an individual under twenty-one (21) years of age. [Minnesota Statutes, §256B.055, subd. 9]

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

2.32 Clean Claim means 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. [42 CFR §§447.45 and 447.46; Minnesota Statutes, §62Q.75]

2.33 Clinical Trials means trials that: 1) have been subjected to independent peer-review of the rationale and methodology; 2) are sponsored by an entity with a recognized program in clinical research that conducts its activities according to all appropriate federal and state regulations and generally accepted standard operating procedures governing the conduct of participating investigators; and 3) the results of which will be reported upon completion of the trial regardless of their positive or negative nature.

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

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

2.36 Community Alternative Care (CAC) Waiver means the Home and Community Based Services waiver program, authorized by a federal waiver under Section 1915(c) of the SSA, 42 USC §1396(n)(c), and pursuant to Minnesota Statutes, §256B.49 for people with disabilities who require the level of care provided in a hospital.

2.37 Community Alternatives for Disabled Individuals (CADI) Waiver means the Home and Community-Based Services waiver program, authorized by a federal waiver under Section 1915(c) of the SSA, 42 USC §1396n(c), and pursuant to Minnesota Statutes, §256B.49, for people with disabilities who require the level of care provided in a Nursing Facility.

2.38 Community EMT means a provider certified as a community medical response emergency medical technician under Minnesota Statutes, §144E.275, subd. 7.

2.39 Community Health Services Agency means a "local health agency" or a public or private nonprofit organization that enters into a contract with the Minnesota Commissioner of Health. [Minnesota Statutes, §§145.891 through 145.897]

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

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

2.42 Community Paramedic means a provider certified as a community paramedic under Minnesota Statutes, §144E.001, subd. 5f.

2.43 Community-Based Services Manual (CBSM) is the primary source of information related to home care services, and is found at http://www.dhs.state.mn.us/main/id_000402#. This manual is incorporated by reference, as applicable, as updated from time to time.

2.44 Compliance Officer means a designated individual, who is qualified by knowledge, training, and experience in health care or risk management, to promote, implement, and oversee the managed care plan's compliance program. The Compliance Officer shall also exhibit knowledge of relevant regulations, provide expertise in compliance processes to address Fraud, Abuse, and waste pursuant to this Contract and state and federal law. The Compliance Officer reports directly to the MCO's CEO and the board of directors.

2.45 Comprehensive risk contract means a risk contract between the State and an MCO that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services:

- Outpatient hospital services.
- Rural health clinic services.
- Federally Qualified Health Center (FQHC) services.
- Other laboratory and X-ray services.
- Nursing facility (NF) services.
- Early and periodic screening, diagnostic, and treatment (EPSDT) services.
- Family planning services.
- Physician services.
- Home health services.

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

2.47 Coordination of Benefits has the meaning described in Minnesota Statutes, §62A.046, subd. 6, except that MCOs must coordinate benefits, and must coordinate using the procedures found in Minnesota Rules, Part 9505.0070.

2.48 Cost Avoidance Procedure means the following techniques to ensure benefit coordination and by which the MCO ensures that a Provider obtains payment from the identified Third Party Liability resources before billing the MCO: MCO coverage is secondary to other health coverage for which Enrollees are eligible; coverage by all potential third-party payers must be exhausted before MCO payment for health services will be made. An eligible provider must attempt to collect payment from

potential third-party payers before billing the MCO for Covered Services; private accident and health care coverage must be used according to the rules of the specific carrier.

2.49 Cost-sharing means copayment, coinsurance, or deductible.

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

2.51 Covered Service means a service as defined in the state plan or approved waiver, Minnesota Statutes, §256B.0625 et seq., and Minnesota Rules, Parts 9505.0170 through 9505.0475, and as applicable, Minnesota Statutes, §§256B.49 and 256B.092, and that is provided in accordance with the MCO's Service Delivery Plan and the MCO Enrollee Handbook, as approved by the STATE.

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

2.53 Developmental Disability means a person who has been determined by the Local Agency to have a disability 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, and Minnesota Rules part 9525.0016 subpart 2, item A.

2.54 Developmental Disability Screening (DD Screening) means, a screening performed by the county, that is available to a person with a diagnosis of Developmental Disability which evaluate the level of care needed when the assessment indicates that the person is at risk of placement in an Intermediate Care Facility (ICF/DD), Nursing Facility, or Home and Community-Based Services.

2.55 Developmental Disability (DD) Screening Document means a form designated by the STATE used to record the outcomes of an assessment, screening or case management activities. [Minnesota Statutes, §256B.092, subd. 8(b)]

2.56 Developmental Disabilities (DD) Waiver means the Home and Community-Based Services waiver program, authorized by a federal waiver under §1915(c) of the SSA, 42 USC §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 (ICF/DD) for an Enrollee with a Developmental Disability.

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

2.58 Drug Formulary means a list of drugs that includes therapeutic classes for both generic and brand-name medications. Within the formulary, a drug or dosage form may be designated as "preferred" or "non-preferred." Preferred drugs generally require minimal or no prior authorization; non-preferred drugs require prior authorization and may also require periodic regimen review or specific billing requirements. To disadvantage a drug means to modify these requirements to make

use of a non-preferred drug similar to use of a preferred drug, or to make a preferred drug similar to a non-preferred drug.

2.59 Drug Formulary Committee is a committee comprising physicians, pharmacists, a consumer representative, and others. [Minnesota Statutes §256B.0625, subd. 13c]

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

2.61 Early Intensive Developmental and Behavioral Intervention (EIDBI) means services for children up to the age of twenty-one (21) that are provided to promote the child's optimal independence and participation in family, school, and community life, educate and support families, reduce stress, and improve long-term outcomes and quality of life for individuals and their families. EIDBI targets the functional skills and core deficits of a child in a comprehensive manner with skill development focused on the following domains: social/interpersonal interactions, verbal and non-verbal communication, cognition, learning and play, adaptive/self-help skills, motor skills, behavior and self-regulation.

2.62 Emergency Care. See Medical Emergency at section 2.110.

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

2.64 Emotional Disturbance means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior as defined in Minnesota Statutes, §245.4871.

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

2.66 Enrollee, for this Contract, means a SNBC eligible person whose enrollment in the MCO has been entered into MMIS. The use of the terms "Beneficiary" or "Enrollee" does not preclude the legal representative (including a conservator, guardian or Authorized Representative) from meeting the obligations or exercising the rights under this Contract, to the extent of the legal representative's or Authorized Representative's authority.

2.67 Enrollee Encounter Data means the information relating to the receipt of any item(s) or service(s) by an Enrollee that is subject to the requirements of 42 CFR §§438.242 and 438.818, and as described in section 3.16.1 below.

2.68 EPSDT (or C&TC) means the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program required under 42 CFR §441.50, known in Minnesota as the Child and Teen checkups (C&TC) Program, that provides comprehensive health services for Medical Assistance-eligible Children under age twenty-one (21).

2.69 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. [Minnesota Rules, Parts 4685.0100, subpart 6a and 4685.0700, subpart 4, item F]

2.70 Family Planning Service means a family planning supply (related drug or contraceptive device) or health service, including screening, testing, and counseling for sexually transmitted diseases, when

provided in conjunction with the voluntary planning of the conception and bearing of children and related to an Enrollee's condition of fertility.

2.71 FFS means fee for service or fee-for-service.

2.72 Fraud means the definition set out in Minnesota Rules, Part 9505.2165, subpart 4 and 42 CFR §455.2.

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

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

2.75 Grievance and Appeals System means the overall system that includes Grievances and Appeals handled at the MCO, and access to the State Fair Hearing (also called state appeal) process.

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

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

2.78 Home and Community-Based Waiver Services (HCBS) means services provided under a federal waiver under §1915(c) of the SSA, 42 USC §1396n(c), and pursuant to Minnesota Statutes, §256B.092, subd. 4, §256S, and §256B.49. 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 ICF-DD placements, Nursing Facility placements or neurobehavioral rehabilitative hospitalizations.

2.79 Home Care Services means Medical Assistance covered services that are home health agency services, including skilled nurse visits, home care nursing services, home health aide services, personal care assistance services, qualified professional supervision of personal care services, physical therapy, occupational therapy, speech therapy, respiratory therapy, durable medical equipment, and supplies. For this SNBC Contract, home care nursing services, personal care assistance services and qualified professional supervision of personal care services, are paid under the FFS program; see section 6.7.3 below.

2.80 Home Health Agency means a home care provider agency that is Medicare-certified. [Minnesota Statutes, §256B.0653]

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

2.82 Hospice Services 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 SSA and defined in 42 CFR §418.3.

2.83 IHP Entity means a health care delivery system demonstration Integrated Health Partnership (IHP) entity that has a contract with the STATE to develop alternative and innovative health care delivery methods. [Minnesota Statutes, §256B.0755]

2.84 Improper Payment means any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This includes, but is not limited to: 1) any payment for an ineligible Recipient; 2) any duplicate payment; 3) any payment for services not received; 4) any payment incorrectly denied; and 5) any payment that does not account for credits or applicable discounts. [42 CFR §431.958]

2.85 In Lieu of Services means services or settings used in place of services and settings covered under the State plan. In Lieu of Services must be medically appropriate and cost effective as determined by the STATE. The approved in Lieu of Services are identified in section 6.3 of the Contract. [42 CFR §438.3(e)(2)(iii)]

2.86 Incarcerated means involuntary confinement of an Enrollee in a jail, detention facility, prison or other penal facility for adults under the authority of a governmental entity. Involuntary confinement of juveniles means confinement in a secure juvenile detention facility licensed by the Department of Corrections, or in a secure state or private correctional program licensed by the Department of Corrections.

2.87 Indian Health Care Provider (IHCP) means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in §4 of the Indian Health Care Improvement Act (25 USC §1603). IHCP includes a 638 Facility and provision of Indian Health Service Contract Health Services (IHS CHS). [42 CFR § 438.14]

2.88 Indian Health Service (IHS) means the federal agency charged with administering the health programs for American Indians as defined in section 2.11 above. The STATE shall provide the MCO with information identifying Indian Enrollees pursuant to section 6.12.1 below

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

2.90 Indian Health Services Facility (IHS Facility) means a facility administered by the Indian Health Service that is providing health programs for American Indians as defined in section 2.11 above.

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

2.92 Inpatient Hospitalization means inpatient medical, mental health and substance use disorder services provided in an acute care facility licensed under Minnesota Statutes, §§144.50 through 144.56.

2.93 Institutionalized means Beneficiaries who are coded in MMIS as being in a Nursing Facility or in an ICF/DD, at the time of enrollment or after initial enrollment, and Enrollees who are living in a Nursing Facility or an ICF/DD at capitation.

2.94 Integrated Care System Partnership (ICSP) means relationships between MCOs and providers including primary care providers (which may include health care homes or health homes) and behavioral health providers, which are designed to promote the integration, co-location or improve the coordination of physical and behavioral health, under contracting arrangements that include gain and/or risk sharing, performance-based payments, or other payment reforms tied to financial performance and STATE-approved quality metrics.

2.95 Intermediate Care Facility for Persons with Developmental Disability (ICF/DD) 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 who require 24-hour supervision and active treatment for medical, behavioral, or habilitation needs.

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

2.97 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.

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

2.99 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 Beneficiary eligibility for the Medical Assistance program. Local Agency also means a federally recognized American Indian tribe's social service, human service, and/or health services agency that is responsible for DD, CADI or BI waiver services.

2.100 Long Term Care Consultation (LTCC) means the assessment of Enrollees for the purposes 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. [Minnesota Statutes, §256B.0911]

2.101 Long-term Services and Supports (LTSS) means services and supports provided to Enrollees of all ages who have functional limitations and/or chronic illnesses, that have the primary purpose of supporting the opportunity to achieve person-centered goals, supporting the ability of the Enrollee to live or work in the setting of their choice. Living or work settings may include the Enrollee's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

2.102 Managed Care Organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract, and that is: 1) a Federally Qualified HMO that meets the advance directives requirements of 42 CFR §489.100 through 104; or 2) any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: a) makes the services it provides to its Medicaid Enrollees as accessible (in terms of timeliness, amount,

duration, and scope) as those services are to other Medicaid Beneficiaries within the area served by the entity; and b) meets the solvency standards of 42 CFR §438.116.

2.103 Managing Employee means an individual (including a general manager, business manager, administrator or director), who exercises operational or managerial control over the entity or part thereof, or who directly or indirectly conducts the day-to-day operation of the entity or part thereof. [42 CFR §§1001.2 and 455.101]

2.104 Marketing means any communication from the MCO, or any of its agents or independent contractors, to an Enrollee or Beneficiary that can reasonably be interpreted as intended to influence that individual to enroll, remain enrolled or reenroll in the MCO's product(s), or to disenroll from or not enroll in another MCO's product. Marketing does not include communication to a Medicaid beneficiary from a qualified health plan, as defined in 45 CFR §155.20, about the qualified health plan.

2.105 Marketing Materials for SNBC means materials that are produced in any medium by or on behalf of an MCO and can reasonably be interpreted as intended to market to potential or current Enrollees. Marketing Materials include any informational materials targeted to potential or current Enrollees that: 1) promote the MCO or any SNBC product offered by the MCO; 2) informs potential or current Enrollees that they may enroll or remain enrolled in an SNBC plan offered by the MCO; 3) explain the benefits of enrollment in an MCO or rules that apply to Enrollees; or 4) explain how Medicare services are covered under the SNBC product, including conditions that apply to such coverage. [42 CFR §438.104(a); 438.56(d)(2)(iv)]

2.106 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);

(3) A change that results in a potential need for Enrollees receiving residential services to change their residence if the Provider Network changes;

(4) A change that involves a termination of a sole source Provider where the termination is for cause, or

(5) A significant change, including but not limited to termination or addition of a subcontract, in the arrangement that the MCO uses to provide a major Subcontractor providing a network of Providers, including but not limited to the MCO's dental or behavioral health network, or pharmacy benefit manager Subcontractors, or an ICSP. For SNBC-SNP Enrollees, such changes include both Medicare and Medicaid Providers and pharmacy benefit managers.

For the purposes of this section, termination of a Provider for cause does not include the inability to reach agreement on contract terms.

2.107 MDH means the Minnesota Department of Health.

2.108 Medical Assistance means the federal/state Medicaid program authorized under Title XIX of the federal SSA and Minnesota Statutes, Chapter 256B.

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

2.110 Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) placing the physical or mental health of the Enrollee (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) continuation of severe pain; 3) serious impairment to bodily functions; 4) serious dysfunction of any bodily organ or part; or 5) death. Labor and delivery is a Medical Emergency if it meets this definition. The condition of needing a preventive health service is not a Medical Emergency. [Minnesota Statutes, §62Q.55, subd. 2, and SSA §1867(e)(1)(A)]

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

2.112 Medically Necessary or Medical Necessity means a health service that is: 1) consistent with the Enrollee's diagnosis or condition; 2) recognized as the prevailing standard or current practice by the Provider's peer group; and 3) rendered:

2.112.1 In response to a life threatening condition or pain;

2.112.2 To treat an injury, illness or infection;

2.112.3 To treat a condition that could result in physical or mental disability;

2.112.4 To care for the mother and unborn child through the maternity period;

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

2.112.6 As a preventive health service defined under Minnesota Rules, Part 9505.0355. [Minnesota Rules, Part 9505.0175, subpart 25]

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

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

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

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

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

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

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

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

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

2.122 MHCP means Minnesota Health Care Programs.

2.123 MHCP Provider Manual is located at http://www.dhs.state.mn.us/main/id_000094#. This manual is incorporated by reference, as applicable, as updated from time to time.

2.124 Minnesota Online Mental Health Services Manual is located within the MHCP Provider Manual at https://mn.gov/dhs/partners-and-providers/policies-procedures/adult-mental-health/ and https://mn.gov/dhs/partners-and-providers/policies-procedures/childrens-mental-health/. This manual is incorporated by reference, as applicable, as updated from time to time.

2.125 MinnesotaCare means the program authorized in Minnesota Statutes, Chapter 256L.

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

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

2.128 MMIS means the Medicaid Management Information System.

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

2.130 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 (for example, UPIN, Medicaid Provider Number, Medicare Provider Number, Blue Cross and Blue Shield Numbers) in standard transactions.

2.131 Network Provider means any provider, group of providers, or entity that has a network provider agreement with the MCO or a Subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render Covered Services as a result of this Contract. A Network Provider is not a Subcontractor by virtue of the network provider agreement. [42 CFR §438.2]

2.132 Non-emergency Transportation (NEMT) means the modes of transportation defined in Minnesota Statutes, §256B.0625, subd. 17. NEMT includes Enrollee reimbursement; volunteer transport; unassisted transport, (including transportation by a taxicab or public transit); assisted transport (transport provided to Enrollees who require assistance by an NEMT provider); lift-

equipped/ramp transport; stretcher transport; and protected transport. See section 6.1.30.1 and 6.1.30.2 for MCO coverage of NEMT.

2.133 Notice of Action means a Denial, Termination, or Reduction of Service Notice (DTR) or other Action as defined in section 2.3.

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

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

2.136 Nursing Facility Resident (NFR) means a Beneficiary who is coded as being in a Nursing Facility living arrangement in MMIS at the time of requested enrollment or after initial enrollment; NFR Beneficiaries are those Enrollees who have been residing in the Nursing Facility for thirty (30) consecutive days.

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

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

2.139 Network Provider means any provider, group of providers, or entity that has a network provider agreement with the MCO or a Subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render Covered Services as a result of this Contract. A Network Provider is not a Subcontractor by virtue of the network provider agreement.

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

2.141 Payment Suspension or suspension has the meaning described in 42 CFR §455.23 and Minnesota Statutes §256B.064.

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

2.143 Person with an Ownership or Control Interest means a person or corporation that: 1) has an ownership interest, directly or indirectly, totaling five percent (5%) or more in the MCO or a disclosing entity; 2) has a combination of direct and indirect ownership interests equal to five percent (5%) or more in the MCO or the disclosing entity; 3) owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by the MCO or the disclosing entity, if that interest equals at least five percent (5%) of the value of the property or assets of the MCO or the disclosing entity; or 4) is an officer or director of the MCO or the disclosing entity (if it is organized as a corporation) or is a partner in the MCO or the disclosing entity (if it is organized as a partnership). [42 CFR §455.101]

2.144 Person with Physical Disability means a person who: 1) has been certified as having a disability by the Social Security Administration (SSA) or the State Medical Review Team (SMRT); and 2) does not meet the definition for a person with a developmental disability, or the definition of a person who has Serious and Persistent Mental Illness.

2.145 Physician Incentive Plan means any compensation arrangement between an organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided to Enrollees of the MCO, as defined in 42 CFR §§ 438.3(i) and 422.208(a).

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

2.147 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.

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

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

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

2.151 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, pediatrician or geriatrician, or other licensed practitioner as authorized by the STATE, to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them.

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

2.153 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;

- A process to authorize the services described in paragraphs (A) through (C);
- A process for expedited appeals for the services described in paragraphs (A) through (C); and
- A process to pay Providers who provide the services described in paragraphs (A) through (C).

2.154 Privacy Incident means violation of the Minnesota Government Data Practices Act (MGDPA) and/or the HIPAA Privacy Rule (45 CFR Part 164, subpart E) and the laws listed in section 2.155, including, but not limited to, improper and/or unauthorized use or disclosure of Protected Information, and incidents in which the confidentiality of the information maintained by the parties has been breached.

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

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

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

2.155.3 Confidentiality of Alcohol and Drug Abuse Patient Records (as governed by 42 USC §290dd-2 and 42 CFR §§ 2.1 to 2.67);

2.155.4 Protected health information (PHI) (as defined in and governed by the Health Insurance Portability Accountability Act (HIPAA), 45 CFR §§ 160.103 and 155.260);

2.155.5 Tax Information Security Guidelines for Federal, State and Local Agencies (26 U.S.C. 6103 and Publication 1075);

2.155.6 Computer Matching Requirements (5 U.S.C. 552a) and NIST Special Publication 800-53, Revision 4 (NIST.SP.800-53r4);

2.155.7 Disclosure of Information to Federal, State and Local Agencies ("DIFSLA Handbook" Publication 3373);

2.155.8 Social Security Data Disclosure (section 1106 of the SSA); and

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

2.156 Provider means an individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services. A Subcontractor that does not directly deliver health care services as its primary contractual responsibility is not a Provider. [42 CFR §438.2]

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

2.158 Rate Cell means the pricing data attributed to an Enrollee to determine the monthly prepaid capitation payment that will be paid by the STATE to the MCO for health coverage of that Enrollee. A Rate Cell is determined based on SNBC 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.

2.159 Recovery Community Organization means an organization eligible to provide SUD peer support services. [Minnesota Statutes, §254B.01, subd. 8]

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

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

2.162 Rural Area means any county designated as ''micro,'' ''rural,'' or ''County with Extreme Access Considerations (CEAC)'' in the Medicare Advantage Health Services Delivery (HSD) Reference file for the applicable calendar year.

2.163 SBIRT (Screening, Brief Intervention, and Referral to Treatment) means a structured assessment for alcohol or substance use disorder that is provided to an Enrollee by a primary care clinic, hospital, or other medical setting. [Minnesota Statutes, §254A.03]

2.164 Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system. Security incident shall not include pings and other broadcast attacks on MCO's or its Subcontractors' firewall, port scans, unsuccessful log-on attempts, denials of service, and any

combination of the above; so long as such incidents do not result in unauthorized access, use or disclosure of the STATE's information.

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

2.166 Service Area means the counties of Minnesota in which the MCO agrees to offer coverage under this Contract. See Appendix 1 - MCO Service Areas.

2.167 Service Authorization means an 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 prior to the delivery or payment of the service.

2.168 Service Delivery Plan means the plan submitted by the MCO as part of the response to the Request for Proposals that resulted in this Contract, and approved by the STATE.

2.169 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.

2.170 Special Investigations Unit (SIU) means an internal investigation unit composed of an MCO manager and staff physically located within the State of Minnesota, who are responsible for conducting investigations of potential fraud, waste and abuse, and ensuring compliance with mandatory reporting and other Fraud and Abuse requirements of this Contract, as well as state and federal law.

2.171 SIU Investigator means an individual, or the functional equivalent, who initiates investigations, identifies subjects, and develops cases for future action. This includes referral to law enforcement and regulatory authorities, education, overpayment prevention and recovery, and other administrative actions. The SIU Investigator works with internal resources and external agencies to develop cases and corrective actions as well as respond to requests for data and support. SIU investigators shall have knowledge, training or experience in general claims practices, the analysis of claims for aberrant patterns, and current trends in Fraud, waste and Abuse.

2.172 SIU Manager means an individual, or the functional equivalent, who manages or oversees the functions of the SIU.

2.173 SSA means the Social Security Act.

2.174 Special Needs BasicCare (SNBC) means the Minnesota prepaid managed care program, 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). [Minnesota Statutes, §256B.69, subd. 28]

2.175 SNBC SNP means the Medicare Advantage Special Needs Plan (SNP) specific to the program described in this Contract.

2.176 SNBC SNP Enrollees means the Dual Eligible persons enrolled in the SNBC SNP.

2.177 SNBC Non-SNP Enrollees means the persons not enrolled in the SNBC SNP but eligible for Medical Assistance and enrolled under this Contract.

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

2.178.1 Institutional Spenddown means a type of Spenddown for Enrollees who are long term care facility residents.

2.178.2 Medical Spenddown means a type of spenddown for Enrollees who live in the community who are eligible for Medical Assistance with a medical spenddown. Amd 1 of 2019, rev. 1

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

2.180 State Fair Hearing means a hearing filed according to an Enrollee's written request with the STATE related to: 1) the delivery of health services by or enrollment 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. [Minnesota Statutes, §256.045]

2.181 Step therapy protocol means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition, including self-administered and physician-administered drugs, are medically appropriate for a particular enrollee and are covered under this Contract.

2.182 Step therapy override means that the step therapy protocol is overridden in favor of coverage of the selected prescription drug of the prescribing health care provider because at least one of the conditions described in Minnesota Statutes, §62Q.184, subd. 3, (a), exists.

2.183 Subcontractor means an individual or entity that has a contract with the MCO that relates directly or indirectly to the performance of the MCO's obligations under this Contract. A Network Provider is not a Subcontractor by virtue of the Network Provider agreement with the MCO. A Subcontractor that does not directly deliver healthcare services as its primary contractual responsibility is not a Provider.[42 CFR §438.2]

2.184 Substance Use Disorder (SUD) means, following Minnesota Statutes, §245G.01, a disorder as defined in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). The SUD disorder is classified as mild, moderate, or severe to indicate the level of severity, determined by the number of diagnostic criteria met by an individual who is being assessed for treatment.

2.185 Substance Use Disorder Professional means a person who meets the staff qualification requirements in Minnesota Statutes, § 245G.11, subdivision 4 or 5or 254B.05, subd. 1(b).

2.186 Substance Use Disorder Treatment means, consistent with Minnesota Statutes, §245G.01, subd. 24, treatment of a substance use disorder, including the process of assessment of an Enrollee's needs, development of planned methods, including interventions or services to address needs, provision of services, facilitation of services provided by other service providers, and ongoing reassessment by a qualified professional when indicated. The goal of SUD Treatment is to assist or support the Enrollee's efforts to recover from a substance use disorder.

2.187 Surveillance and Integrity Review Section (SIRS) means a STATE program of surveillance, integrity, review, and control to ensure compliance with MHCP requirements by monitoring the use and delivery of services.

2.188 Tagline means the STATE provided language indicating how to request help interpreting materials.

2.189 Telemedicine Services means the delivery of health care services or consultations while the Enrollee is at an originating site and the Provider is at a distant site. A communication between Providers, or a Provider and an Enrollee, that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitates the assessment, diagnosis, consultation, treatment, education, and care management of an Enrollee's health care.

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

2.191 Tribal Community Member means individuals identified as enrolled members of the tribe and any other individuals identified by the tribe as a member of the tribal community. This definition is referenced in the Tribal Assessments and Service Plans in section 6.1.24.1(6).

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

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

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

- Minimum requirements for opiates, stimulants, and other drugs as identified by the Universal Pharmacy Workgroup.
- Maximum daily morphine equivalent dose limits for opiate analgesics and standardized criteria for doses exceeding the limits.
- Maximum daily doses for medication assisted treatment for addiction, including daily dose limits for Suboxone® and methadone.

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

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

2.197 Withdrawal Management means a licensed program that provides short-term medical services on a 24-hour per day basis for the purpose of stabilizing intoxicated patients, managing their withdrawal, and facilitating access to SUD treatment as indicated by a comprehensive assessment described in section 6.1.50.2(2). [Minnesota Statutes, §245F.02, subd. 26]

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ARTICLE. 3 ELIGIBILITY AND ENROLLMENT; ENROLLEE MATERIALS AND DATA.

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

3.1 ELIGIBILITY.

3.1.1 Service Area.

Only those eligible persons who are enrolled in Medical Assistance residing within the counties of the State of Minnesota identified in Appendix 1 shall be eligible for enrollment in SNBC.

3.1.2 Enrollment and Opt-Out for SNBC.

Any Beneficiary who resides within the Service Area must enroll in the MCO unless he or she has chosen to opt out. A Beneficiary may enroll (or opt out) at any time, effective at the beginning (or end) of the month, during the duration of this Contract, subject to the limitations contained in this Contract. Enrollees in integrated SNPs may also be subject to CMS enrollment requirements.

3.1.3 Eligibility/Presumptive Eligibility Determination.

Eligibility/presumptive eligibility for Medical Assistance will be determined by the Local Agency, and any other entity designated by the STATE to make eligibility/presumptive eligibility determinations. Eligibility for Medicare will be determined by CMS.

3.1.4 Enrollment Exclusions.

The following populations, both SNBC SNP and non-SNP, are excluded from enrollment in the MCO under the SNBC program [Minnesota Statutes, §256B.69, subd. 4; Minnesota Rules, Part 9500.1452]:

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

3.1.4.2 Persons up to eighteen (18) years of age, or sixty-five (65) years of age and over. Enrollees who turn sixty-five (65) will no longer remain enrolled in SNBC.

3.1.4.3 Beneficiaries who are residents of state regional treatment centers or a state-owned long term care facility.

3.1.4.4 Beneficiaries who are eligible while receiving care and services from a non-profit center established to serve victims of torture.

3.1.4.5 Beneficiaries eligible for the emergency Medical Assistance program.

3.1.4.6 Non-citizen Beneficiaries who only receive emergency medical assistance under Minnesota Statutes, §256B.06, subd. 4.

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

3.1.4.8 Persons eligible for the Minnesota Family Planning Program (MFPP) in accordance with Minnesota Statutes, §256B.78.

3.1.4.9 Beneficiaries, who at the time of notification of enrollment in managed care, have a communicable disease whose prognosis is terminal and whose primary physician is not a Network Provider in the MCO, and that physician certifies that disruption of the existing physician-patient relationship is likely to result in the patient becoming noncompliant with medication or other health services.

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

3.1.4.11 Beneficiaries with private health care coverage through a HMO certified under Minnesota Statutes, Chapter 62D, not including Medicare Supplements.

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

3.1.4.13 Enrollees who are absent from Minnesota for more than thirty (30) consecutive days but who are still deemed a resident of Minnesota by the STATE. Covered services for these Enrollees are paid by FFS.

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

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

3.1.4.16 Persons who are eligible for Medicare Part A only, or Medicare Part B only.

3.1.4.17 Persons participating in the Navigator Pilot in Minnesota Statutes, §254B.13, if applicable.

3.1.4.18 Incarcerated persons; see section 6.7.1.7.

3.1.5 SNBC SNP Exclusions

The following populations are excluded from enrollment for the SNBC SNP program only:

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

3.1.5.2 Individuals who have Medicare coverage through United Mine Workers.

3.1.6 Eligibility Determinations for SNBC.

In order to be eligible to enroll in the MCO for SNBC, the individual must:

3.1.6.1 Be age eighteen (18) through age sixty-four (64);

3.1.6.2 Be eligible for Medical Assistance;

3.1.6.3 Be residing within the Service Area (eligibility for SNBC is based on county of residence); and

3.1.6.4 Be either of the following:

- Certified as having a disability through the Social Security Administration (SSA) or the State Medical Review Team (SMRT); or
- A person with Developmental Disability and receiving services from the DD waiver, as determined by the Local Agency.

3.1.7 Additional Eligibility Parameters.

3.1.7.1 Hospice. Enrollees who elect to enroll in the Hospice program while enrolled are not required to disenroll from the MCO's SNBC SNP product.

3.1.7.2 End Stage Renal Disease. SNBC SNP Enrollees who are identified by CMS as having ESRD after enrollment are not required to disenroll from the MCO's SNBC SNP product. Individuals who develop ESRD while enrolled in a health plan (for example, a commercial or group health plan, or a Medicaid plan) offered by the MCO are eligible to elect the Medicare Advantage plan offered by that MCO. In order to be eligible, there must be no break in coverage between enrollment in the MCO, and the start of coverage in the Medicare

Advantage plan offered by the same MCO. An individual who elects the SNBC SNP plan and who is medically determined to first have ESRD after the date on which the enrollment form is signed (or receipt date stamp if no date is on the form), but before the effective date of coverage under the SNBC SNP plan is still eligible to elect the SNBC SNP plan.

3.1.7.3 Spenddown. SNBC SNP and SNBC non-SNP Enrollees who are enrolled into SNBC prior to acquiring a Medical Spenddown are not required to disenroll from SNBC provided the Enrollee agrees to pay the Medical Spenddown to the STATE on a monthly basis.

3.1.7.4 Until further notice, the STATE will not enroll new Enrollees with Medical Spenddowns into SNBC. However, Potential Enrollees residing in a nursing facility and coded with a Medical (rather than Institutional) Spenddown because they have elected Hospice may be enrolled.

3.1.7.5 Enrollees with a Medical Spenddown who are already enrolled in the MCO as of the effective date of this Contract are not required to disenroll from SNBC, subject to the payment of spenddown described in section 3.7.2.1(5).

3.1.7.6 Waiver Status. Potential Enrollees who are receiving services under the CADI, BI, CAC, or DD waiver are eligible to enroll in SNBC. If the Enrollee chooses to continue with services under the CADI, BI, CAC or DD waiver, he or she may continue to receive services through SNBC provided he or she maintains eligibility for Medical Assistance.

3.1.8 Enrollee Exclusion or Disenrollment Conflict

In the event that enrollment, exclusion or disenrollment status of an Enrollee conflicts with this section, the applicable Minnesota Statute or Rule will govern. Enrollees who may be excluded may also be disenrolled.

3.2 Enrollment

3.2.1 Discrimination is against the law.

The MCO will accept all eligible Beneficiaries who select or are assigned to the MCO without regard to medical condition, health status, receipt of health care services, claims experience, medical history, genetic information, disability (including mental or physical impairment, if eligible since disability is required to enroll in SNBC), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, public assistance status, or political beliefs, and shall not use any policy or practice that has the effect of such discrimination.

3.2.2 Order of Enrollment.

The MCO shall accept enrollment of Beneficiaries in the order in which they apply. Beneficiaries who do not opt out nor choose an MCO will be assigned to an MCO by the STATE.

3.2.3 STATE Enrollment Limitation.

The STATE may further 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 SNBC product.

3.2.4 Timing of Enrollment.

Beneficiaries may be enrolled with the MCO at any time during the duration of this Contract, subject to the limitations of this Article.

3.2.5 Annual Health-Plan Selection

The MCO shall accept enrollment of any eligible Beneficiaries during any annual health-plan selection period required by the STATE or CMS.

3.2.6 Period of Enrollment for Medicare-eligible Enrollees.

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

3.2.7 Single MCO Entity Provider.

If the MCO is a single entity Provider in a Rural Area, the MCO must allow Beneficiaries: 1) to choose from at least two Primary Care Providers in the MCO's Network; and 2) to obtain services from any other Provider when the circumstances allow. [42 CFR §438.52(b)(2)]

3.2.8 Enrollee Change of MCO.

SNBC-SNP Enrollees may change to a different MCO as allowed by Medicare regulations. Non-SNP Enrollees may change to a different MCO at any time. Enrollment changes with a new MCO will be effective on the first day of the following month, and subject to the enrollment provisions in this section.

3.2.9 Enrollee Change of Primary Care Provider.

The Enrollee may change to a different Primary Care Provider within the MCO's network or Care System every thirty (30) days upon request to the MCO. This section does not apply to Enrollees who are under restriction pursuant to section 9.17.

3.2.10 Choice of Network Provider.

The MCO must allow an Enrollee to choose his or her Network Provider to the extent possible and appropriate.

3.2.11 Notice to Student Enrollees.

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

3.3 MCO Enrollment Responsibilities Specific to SNBC SNP Enrollees.

The MCO shall:

3.3.1 Use integrated enrollment forms and process as defined under this Contract for enrollment under both Medicare and Medicaid for Dual Eligible Enrollees. The form shall include primary language spoken by the member, including American Sign Language and preferred modes for those who use assistive devices, including email, for communications.

3.3.2 Assure that prospective Enrollees are eligible for Medical Assistance by checking the Medicaid eligibility verification system (EVS) or MN-ITS, before having the Beneficiary complete an enrollment form. Persons who are found to be ineligible for Medical Assistance are ineligible for enrollment in SNBC.

3.3.3 Medicare Enrollment. Prior to submitting or entering an enrollment form to the STATE, or entering enrollment information on MMIS, the MCO must verify (or must contractually arrange

for verification of) Medicare status of the SNBC Dual Eligible 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.

3.3.4 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.

3.3.5 The MCO must have Enrollees sign an enrollment form that incorporates a Statement of Informed Enrollment and Enrollee Rights. This Statement of Informed Enrollment shall include, but is not limited to the following:

- An explanation that the Enrollee is assigning their Medicaid benefits, and for Dual Eligibles enrolled in the SNP (SNBC SNP Enrollees) also their Medicare benefits to the MCO.
- The Enrollees right to disenroll on a monthly basis, and that upon disenrollment, they will return to the fee-for-service system, unless otherwise required to enroll in PMAP or MSC+.
- 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.
- For Beneficiaries or Enrollees who are under Adult Guardianship, the MCO must ensure that the state legal guardian signs the enrollment form.

3.3.6 SNBC enrollments must be received by noon on the day of capitation to ensure Enrollee information is included on the MCO capitation file. SNBC enrollments received after the noon cut-off will be processed for the appropriate Medicare enrollment effective date. In such an event, the MCO will not receive an enrollment record until the next capitation file and the MCO will need to add these Enrollees to their system manually.

3.4 MCO Enrollment Responsibilities Specific to SNBC non-SNP Enrollees.

The MCO shall:

3.4.1 Use an enrollment form approved by the STATE, and processes as defined under this Contract for enrollment under Medicaid. The form shall include primary language spoken by the member, including American Sign Language and preferred modes for those who use assistive devices, including email, for communications.

3.4.2 Assure that prospective Enrollees are eligible for Medical Assistance by checking the Medicaid eligibility verification system (EVS) or MN-ITS, before having the Beneficiary complete an enrollment form. Persons who are found to be ineligible for Medical Assistance are ineligible for enrollment in SNBC.

3.4.3 Submit SSI or SMRT documentation of a Potential Enrollee's certified disability with the completed enrollment form if the person's Medical Assistance basis of eligibility is other than disability eligibility.

3.4.4 The MCO must ensure that appropriate MCO staff has access to the MN-ITS and managed care systems as directed by the STATE.

3.4.5 The MCO must have Enrollees sign an enrollment form that incorporates a Statement of Informed Enrollment and Enrollee Rights. This Statement of Informed Enrollment shall include, but is not limited to the following:

- An explanation that the Enrollee is assigning their Medicaid benefits.

- The Enrollees right to disenroll on a monthly basis, and that upon disenrollment, they will return to the fee-for-service system, unless otherwise required to enroll in PMAP or MSC+.
- 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.
- For Beneficiaries or Enrollees who are under Adult Guardianship, the MCO must make reasonable efforts to ensure that the state legal guardian signs the enrollment form.

3.4.6 Enrollment Application. For non-SNP Enrollees who are or become eligible for Medicare coverage after enrollment in the MCO, the MCO may enroll the Enrollee in the SNBC SNP if the MCO obtains a signature on the MCO's SNP enrollment form.

3.5 STATE AND CMS SNP ENROLLMENT; INTEGRATED ENROLLMENT PROCEDURES; ENROLLMENT TPA SERVICES.

3.5.1 Enrollment in SNBC for Medicaid in MMIS will be performed by the STATE or MCO.

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

3.5.3 MCO agrees to use the real-time data exchange and enrollment processes further described in sections 3.2, 3.3.2, and 3.8, and the timeframes in section 3.13.2.

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

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

3.5.6 The STATE may propose to contract with the MCO for processes performed by the STATE that are required to maintain integrated enrollment, and may charge for these processes, as an alternative to the TPA contract in section 3.5.5. If the STATE determines such a contract is necessary, the STATE will provide one hundred and fifty (150) days' notice to the MCO.

3.6 EFFECTIVE DATE OF COVERAGE.

MCO coverage of Enrollees shall commence as follows:

3.6.1 For SNBC non-SNP Enrollees, when enrollment occurs and has been entered on the STATE's MMIS on or before the Cut-Off Date, medical coverage shall commence at midnight, Minnesota time, on the first day of the month following the month in which the enrollment was entered on the STATE MMIS.

3.6.2 For SNBC non-SNP Enrollees, when enrollment occurs and has been entered on the STATE MMIS after the Cut-Off Date, medical coverage shall commence at midnight, Minnesota time, on the first day of the second month following the month in which the enrollment was entered on the STATE MMIS.

3.6.3 For SNBC SNP Enrollees only, when enrollment has been approved on or before the last day of the month, medical coverage shall commence at midnight, Minnesota time, on the first day of

the month following the month in which enrollment was approved. Enrollments received after capitation must be submitted directly to the STATE.

3.6.4 Inpatient Hospitalization and Enrollment (Change of Payer While Inpatient).

3.6.4.1 Inpatient Hospitalization. Enrollees receiving Inpatient Hospitalization services on the first effective date of enrollment will be enrolled in accordance with 3.6.1 and 3.6.2 above. All charges related to Inpatient Hospitalization for any Enrollee on the effective date of enrollment will not be the responsibility of the new MCO or FFS.

3.6.4.2 Eligible newborns may be enrolled in the MCO effective the first day of the month of birth even if hospitalized. If an eligible newborn is born to a mother enrolled with the MCO under SNBC but the MCO does not have a program covered by a Families and Children Contract in that same Service Area, the newborn will be enrolled in accordance with STATE policies and procedures.

3.6.4.3 Psychiatric Residential Treatment Facility. If an Enrollee's MCO enrollment changes during a PRTF stay, the new MCO will be financially responsible for the stay beginning on the first day of coverage with the new MCO. The new MCO will honor the previous MCO's prior authorization through the end date of the previous MCO's authorization or through the end of the month that the new MCO becomes effective, whichever date is earlier. Fee-for-service to MCO, and MCO to MCO, authorizations will be honored. If an Enrollee becomes Medicaid eligible and enrolled in the MCO while admitted to the PRTF, the certification of need for services is completed by the treatment team at the PRTF.

3.6.5 Maintenance of Enrollment Forms.

Original enrollment forms and any Medicare assignment supplemental forms shall be maintained by either the STATE or MCO, whoever enrolls the Enrollee, and may be imaged in accordance with Minnesota Statutes, §15.17.

3.6.6 Enrollee Eligibility Review Dates.

The STATE will provide a report of eligibility review dates for Enrollees covered under this Contract and enrolled in the MCO. [Minnesota Statutes, §256.962, subd. 8]

3.7 TERMINATION OF ENROLLEE COVERAGE; CHANGE OF MCOS; CHANGE OF PROGRAMS.

3.7.1 Disenrollment from SNBC.

The Enrollee may disenroll from the MCO's SNBC product at any time. Disenrollment will be effective according to the termination of coverage schedules outlined in section 3.7.5. If the Enrollee disenrolls from the MCO's SNBC product, the Enrollee shall return to the Medical Assistance fee-for-service system, or into other available options.

3.7.1.1 Except as provided in this section, the MCO may not orally or in writing or by any action or inaction encourage an Enrollee to disenroll.

3.7.1.2 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.

3.7.2 Termination by STATE.

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

3.7.2.1 Required termination includes:

(1) The Enrollee becomes ineligible for Medical Assistance.

(2) The Enrollee's basis of eligibility changes and no longer meets the enrollment criteria for SNBC;

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

(4) 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 SNBC.

(5) The Enrollee does not pay the Medical Spenddown in full for three months directly to the STATE. The Enrollee will not be allowed to re-enroll in SNBC after termination for non-payment unless all past due Medical Spenddowns are paid in full and the Enrollee no longer has a Medical Spenddown at the time of application.

(6) The SNBC SNP Enrollee elects to change MCOs as described in 42 CFR §422.62 (election of coverage for Medicare Advantage plan).

(7) The Enrollee reaches the age of sixty-five (65).

(8) Incarceration.

(a) For SNBC SNP Enrollees' Medicaid benefits enrollment for a Medical Assistance Incarcerated Enrollee will end at the end of the month in which the Enrollee is Incarcerated. Provision of Covered Services ends when the Enrollee is Incarcerated. [Minnesota Statutes, §256B.055, subd. 14]

(b) For SNBC Non-SNP Enrollees enrollment for a Medical Assistance Incarcerated Enrollee will end at the end of the month in which the Enrollee is Incarcerated. Provision of Covered Services ends when the Enrollee is Incarcerated. [Minnesota Statutes, §256B.055, subd. 14]

(c) Incarcerated individuals admitted to a medical institution must apply for and be determined eligible for Medical Assistance inpatient services, and if eligible will be covered on a fee-for-service basis.

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

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

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

(3) The MCO must notify the STATE prior to terminating a SNBC SNP Enrollee under the circumstance described in (1) and (2) above.

3.7.3 Termination by MCO.

The MCO may not request disenrollment of an Enrollee for any reason, except a SNBC SNP Enrollee as described in section 3.7.2.2.

3.7.4 Optional Termination by Enrollee

For Enrollees currently using an MLTSS Provider that changes status from Network Provider to Non-network provider, and

(1) If the Enrollee would have to change his or her residential or institutional Network Provider because of the change in Network status with the MCO, that results in disruption in the Enrollee's residence or employment,

(2) Then the Enrollee may request disenrollment from the MCO.

(3) This provision does not apply to situations in which an Enrollee is using a DHS-enrolled MLTSS provider that is not contracted with the MCO as a Network Provider, but it does apply if the MCO is changing from an open network provider model to a Network provider model, and the Enrollee's MLTSS Provider is not in the Network. [42 CFR §438.56(d)(2)(iv)] See also section 3.14.

3.7.5 Notification and Termination of Enrollment.

Notification and termination of MCO enrollment shall become effective at the following times:

3.7.5.1 For SNBC-SNP Enrollees, when a disenrollment request has been received by the STATE on or before the last day of the month, MCO enrollment shall cease at midnight, Minnesota time, on the first day of the month following the month in which termination was approved.

3.7.5.2 For SNBC non-SNP Enrollees, when termination has been entered on the STATE MMIS on or before the Cut-Off Date, MCO enrollment shall cease at midnight, Minnesota time, on the first day of the month following the month in which termination was entered on the STATE MMIS.

3.7.5.3 For SNBC non-SNP Enrollees, when termination has been entered on the STATE MMIS after the Cut-Off Date, MCO enrollment shall cease at midnight, Minnesota time, on the first day of the second month following the month in which termination was entered on the STATE MMIS.

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

3.7.5.5 When termination takes place for any reason other than those set forth in this section, including the termination or expiration of this Contract, and the Enrollee is receiving Inpatient Hospitalization services on the effective date of the termination, MCO coverage of inpatient hospital services and associated ancillary services shall cease at midnight, Minnesota time, on the first day following the day of discharge from the hospital.

3.7.6 Reinstatement.

An Enrollee whose termination from the MCO has been entered into MMIS by the monthly Cut-Off Date may be reinstated for the following month with no lapse in coverage if the Enrollee re-establishes Medical Assistance eligibility and such eligibility is entered into MMIS by the last business day of the month.

3.7.7 Re-enrollment.

3.7.7.1 An Enrollee who is identified within ninety (90) days of losing Medical Assistance eligibility for not more than three months, or for any break of time within a three month period and establishes continuous Medical Assistance eligibility with no break in eligibility may be re-enrolled for the month following disenrollment and subsequent months in the same MCO without completing a new enrollment form.

3.7.7.2 If a Non-SNP Enrollee is disenrolled for any reason and subsequently becomes eligible to enroll, upon notification, the STATE shall reenroll the Enrollee to SNBC in the same MCO,

unless the Enrollee requests a change in MCOs. The status of the one hundred (100) 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.

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

3.8 Electronic Data.

3.8.1 The MCO shall be capable of receiving the following data electronically from the STATE: price files, remittance advices, enrollment data, third party liability, and rates files. If there is a disruption of the STATE's electronic capabilities, the MCO has the time period specified in section 3.13.2 to disseminate enrollment information to its Enrollees.

3.8.2 The MCO must perform the following data exchanges electronically with applicable Providers.

- Accept and transmit eligibility transactions;
- Accept claims transactions; and
- Transmit payment and remittance advice. [Minnesota Statutes, §62J.536 and the resulting uniform companion guides]

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

3.8.4 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.

3.8.5 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.

3.9 Communication with STATE; E-Mail Encryption.

The MCO shall communicate with the STATE by contacting the assigned contract manager electronically, by mail, or telephone. If electronic communication is used and security for PHI or other information is needed, the MCO must communicate with the STATE using MN-ITS, or request that the STATE contract manager initiate a secure e-mail exchange.

3.10 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.

3.10.1 When providing services to Enrollees, the MCO must ensure that its staff and Network Providers consider the Enrollee's rights to the following:

- Receive information pursuant to 42 CFR §438.10.
- Be provided with services under this Contract in accordance with 42 CFR §§ 438.206 through 438.210.

- Be treated with respect and with due consideration for the Enrollee's dignity and privacy. [42 CFR §438.100(b)(2)(ii)]
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand. [42 CFR §438.100(b)(2)(iii)]
- Participate in decisions regarding his or her health care, including the right to refuse treatment. [42 CFR §438.100(b)(2)(iv)]
- 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. [42 CFR §438.100(b)(2)(v)]
- Be free from any form of aversion or deprivation procedures as described in Minnesota Rules, parts 9525.2700 through 9525.2810.
- Request and receive a copy of his or her medical records and request to amend or correct the record. [45 CFR §§ 160 and 164, subparts A and E]
- Have freedom to exercise his or her rights The exercise of these rights must not adversely affect the way the Enrollee is treated. [42 CFR §438.100(c)]
- The MCO shall not specify confidential services, as defined by the STATE, in Notices sent to the Enrollee, including but not limited to EOBs, and which must not be sent to the Enrollee if the only service furnished was confidential. [42 CFR §433.116(f)(2)].

3.11 COMMUNICATION WITH POTENTIAL ENROLLEES AND ENROLLEES.

3.11.1 For SNBC SNP Enrollees.

The SNBC 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 SNBC SNP Enrollees, clarifying language is included.

3.11.2 Communications Compliance with Title VI of the Civil Rights Act and Section 1557 of the Affordable Care Act.

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

3.11.2.1 The MCO shall comply with the recommendations of the revised Policy Guidelines published on August 4, 2003, by the Office for Civil Rights of the Department of Health and Human Services, titled "*Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*" (hereinafter "Guidance") and take reasonable steps to ensure meaningful access to the MCO's programs and services by LEP persons, pursuant to that document. The MCO shall apply, and require its Providers and Subcontractors to apply, the four factors described in the Guidance to the various kinds of contacts they have with the public to assess language needs, and decide what reasonable steps, if any, they should take to ensure meaningful access for LEP persons.

The MCO shall document its application of the factors described in the Guidance to the services and programs it provides.

3.11.2.2 The MCO shall provide to the STATE a copy of its Limited English Proficiency (LEP) plan for its current service area annually. The MCO shall use the LEP plan template provided by the STATE as the minimum requirements of the plan, but may add additional measures.

3.11.2.3 Section 1557 of the Affordable Care Act prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in health care programs and activities receiving federal financial assistance.

- The MCO will provide auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner, to ensure an equal opportunity to participate in Minnesota Health Care Programs
- The MCO will also provide translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to programs and services that are offered by the MCO.

3.11.3 Communications Compliance with the Americans with Disabilities Act.

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

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

3.11.3.2 The MCO shall have information available in alternative formats and through the provision of auxiliary aids and services for the MCO's health programs and activities, in an appropriate manner that takes into consideration the Beneficiary or Enrollee's special needs, including those who have visual impairment or limited reading proficiency, and at no cost to the Beneficiary or Enrollee.

3.11.4 Requirements for Potential Enrollee or Enrollee Communication.

The MCO shall submit to the STATE for review and approval written information intended for Potential Enrollees or Enrollees.

3.11.4.1 Information requiring approval is listed in the *Materials Guide* posted on the DHS managed care web site. The list of materials identifies information that is submitted for purposes of file and use, information only, STATE review and approval, or information not to be submitted. The STATE will notify the MCO of any changes or updates to the *Materials Guide*.

3.11.4.2 The MCO will use the STATE-approved discrimination and complaint notice which includes the accessibility (auxiliary aids and services) language, and include this information with written communications from the MCO to Enrollees. The auxiliary aids and language assistance services language must be in a fourteen (14) point font size in the notice. These communications can either incorporate the notice information into the written communication or include it with the communication as a separate document. Any waiver from this requirement must be prior approved by the STATE. [42 CFR §438.10(d)(2), and (3); DHS Civil Rights Notice #CB-5]

3.11.4.3 Written material for SNBC SNP Enrollees will include both Medicare and Medicaid information.

3.11.4.4 The MCO shall determine and translate vital documents by qualified translators as defined in 45 CFR §92.4, and provide them to households speaking a prevalent non-English language, whenever the MCO determines that five percent (5%) or one thousand (1,000)

persons, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered in the MCO's Service Area speak a non-English language. If a Potential Enrollee or Enrollee speaks any non-English language, regardless of whether it meets the threshold, the MCO must provide that the Potential Enrollee or Enrollee receives information in his or her primary language, free of charge, by providing oral interpretation or through other means determined by the MCO. [42 CFR 438.10(d)(1)]

3.11.5 Language and Format.

3.11.5.1 All material sent by the MCO targeting Potential Enrollees or Enrollees under this Contract shall include the STATE's sixteen (16) tagline language block.

3.11.5.2 For significant smaller materials, such as tri-fold brochures or postcards the MCO must use the STATE's three (3) tagline language block that reflects the STATE's two top languages spoken by Enrollees with limited English proficiency. The MCO may request a change from this requirement, which must be approved by the STATE.

3.11.6 Readability Test.

All written materials, including Marketing, new Enrollee information, member handbooks, Grievance, Appeal and State Fair Hearing information and other written information, that target Potential Enrollees or Enrollees under this Contract and are disseminated to Potential Enrollees or Enrollees by the MCO in English must be understandable to a person who reads at the seventh grade level, using the Flesch scale analysis readability score as determined under Minnesota Statutes, §72C.09. The results of the Flesch score must be submitted at the time all documents specified in this section are submitted to the STATE for approval. All materials sent to Potential Enrollees or Enrollees must be in at least a 12-point type size, with the exception of the MCO member identification card, which may have non-essential items in a smaller type size.

3.11.7 Compliance with State Marketing 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.

3.11.8 American Indians.

All Marketing or enrollment materials that refer to access to covered benefits or the MCO's network shall explain the right of American Indians to access out-of-network services at Indian Health Care Providers. [42 CFR §438.14]

3.11.9 Notice to the MCO 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.

3.12 Marketing and Marketing Materials

3.12.1 Marketing Materials Development.

The MCO shall participate with the STATE in the development of general Marketing Materials, member materials and enrollment materials.

3.12.2 Prior Approval of Marketing Materials.

For both SNBC SNP and SNBC Non-SNP:

3.12.2.1 The MCO shall present to the STATE for approval, in a final format, all Marketing Materials that the MCO or its Subcontractors plan to use during the contract period prior to the MCO's use of such Marketing Materials.

When the MCO submits the material for review, the MCO shall include information on the purpose, the intended audience and the timeline for use of the material being reviewed. 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 Beneficiaries, the STATE shall consult with tribal governments within a reasonable period of time before approval. Approval by the STATE shall not be unreasonably withheld or delayed. [42 CFR §§438.104(b)(1)(i); 438.700(c)]

3.12.2.2 CMS and STATE Review Process for SNBC SNP Enrollee Materials.

All Enrollee education and Marketing Materials for the SNBC SNP product, 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, if required by CMS. The MCO must submit all materials for review. The STATE and CMS shall review all Medicare related materials, including Medicare and Part D materials.

(1) Upon receiving STATE approval of SNBC 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.

(2) The STATE shall review all Medicaid only materials.

3.12.2.3 STATE Review Process for SNBC Non-SNP.

The MCO shall present to the STATE for approval, in a final format, all Marketing Materials for non-SNP Enrollees that the MCO or its Subcontractors plan to use during the contract period, including but not limited to posters, brochures, Internet web sites, any materials which contain statements regarding the benefit package, and Provider network-related materials, prior to the MCO's use of such Marketing Materials. The STATE shall review Medicaid only materials. For SNBC, if Care Management or Case Management is delegated to an organization with disability expertise, Marketing and enrollment materials for this product must include specific information on how to contact these organizations when appropriate.

3.12.3 Marketing Standards and Restrictions.

3.12.3.1 Inducements to Enroll. The MCO, its agents and Marketing representatives, may not offer or grant any reward, favor or compensation as an inducement to a Potential Enrollee or Enrollee to enroll in the MCO. Additional health care benefits or services are not included in this restriction. The MCO shall not seek to influence a Potential Enrollee's or Enrollee's enrollment with the MCO in conjunction with the sale of any other insurance. Mailings shall not contain false or misleading information. [42 CFR §1003.1000; 42 CFR §§438.104, 438.700]

3.12.3.2 Direct Marketing for SNBC SNP Enrollees. The MCO may do direct Marketing of its SNBC SNP product to SNBC-eligible individuals and current MCO Enrollees who will become eligible for Medicare, within the limits imposed by 42 CFR §438.104. If the MCO directly markets to eligible individuals within a given Service Area, it must market to both institutional and community eligible individuals and to potential Enrollees with all types of disabilities, including physical disabilities, Mental Illness, and Developmental Disabilities. The MCO may not use Subcontractors, including its Care Systems, to market SNBC to SNBC-eligible individuals not currently enrolled in the MCO.

3.12.3.3 Direct Marketing for SNBC Non-SNP Enrollees. Direct Marketing for SNBC Non-SNP Enrollees is not allowed, except for mailing and publications set forth in section 3.12.3.4. Except through mailings and publications, the MCO, which includes any of its Subcontractors,

agents, independent contractors, employees and Providers, is restricted from Marketing and promotion to Beneficiaries who are not enrolled in the MCO. This restriction includes but is not limited to: telephone Marketing, face-to-face Marketing, promotion, cold-calling, or direct mail Marketing. The MCO shall not make any written or oral assertions or statements that a Beneficiary or Enrollee must enroll in the MCO in order to obtain or maintain covered benefits, or that the MCO is endorsed by CMS, the STATE, or federal government. [42 CFR §438.104]

3.12.3.4 Mailings to SNBC Potential Enrollees. The STATE is prohibited from providing the names of potential SNBC Enrollees to MCOs for marketing purposes. The STATE shall send no more than two mailings provided by the MCO per Contract Year to each eligible Beneficiary who resides in the Service Area, at MCO expense. The MCO notices shall be mailed within thirty (30) days of receipt of these materials from the MCO. Mailings by the STATE will include all Potential Enrollees in the MCO's Service Area. The MCO's notices must not contain false or misleading information. [Minnesota Statutes, §256B.69, subd. 28, (f); 42 CFR §438.104(b)(1)(ii)]

3.12.3.5 Other Publications/Indirect Marketing. The MCO, acting indirectly through the publications and other material made available by the Local Agency or the STATE, or through mass media advertising (including the Internet), may inform Potential Enrollees who reside in the Service Area of the availability of medical coverage through the MCO, the location and hours of service and other plan characteristics, subject to all restrictions in this section.

3.12.3.6 The MCO may distribute brochures and display posters at physician offices and clinics, informing patients that the clinic or physician is part of the MCO's Provider network provided that all MCOs contracted with the Provider have an equal opportunity to be represented. Indirect marketing provisions apply to all Providers. The MCO may provide health education materials for Enrollees in Providers' offices. All materials must be Prior Approved by the STATE and/or CMS as required in section 3.12.2.

3.12.4 SNBC SNP Marketing Consistent with CMS Medicare Requirements.

In its Marketing, the MCO must establish and maintain a system for confirming that SNBC SNP Enrollees have in fact enrolled in the MCO and understand the rules applicable under the plan, and have made an Informed Choice to enroll. 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. The MCO may provide health education materials for Enrollees in Providers' offices. 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 SNBC SNP Potential Enrollee or Enrollee to enroll or remain enrolled in the MCO. This restriction does not prohibit the MCO from explaining any legitimate benefits a Potential Enrollee might obtain as an Enrollee of the MCO, or from offering incentives to Enrollees for taking part in preventive services, medical management incentive programs, or activities designed to improve the health of MCO Enrollees. The MCO shall not seek to influence a Potential Enrollee's enrollment with the MCO in conjunction with the sale of any private insurance.

(2) Engage in any discriminatory activities.

(3) Offer or grant any reward, favor or compensation to a person, county or organization 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.

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

(5) Make any written or oral assertions or statements that a Potential Enrollee or Enrollee must enroll in the MCO in order to obtain or maintain Medical Assistance and Medicare covered 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 SNBC Enrollees. In addition, the MCO must comply with Medicaid regulations in 42 CFR §438.104 that do not allow direct or indirect telephone or other cold-call marketing activities to potential SNBC Enrollees.

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

3.13 Enrollee Materials

3.13.1 STATE Approval of Information for Enrollees.

The STATE must approve all information for Enrollees that will be provided to Enrollees prior to use of the materials. The MCO must submit its Enrollee materials in their final version before approval from the STATE can be given. Approvals by the STATE for these materials shall not be unreasonably withheld.

3.13.1.1 For SNBC-SNP Materials. The MCO agrees that the integrated Medicare, Part D and Medicaid EOC documents made available to each MCO Enrollee; and all Marketing Materials, plans, procedures, mailings, enrollment forms and revisions that are designed for Beneficiaries shall be used only after receiving approval.

3.13.1.2 For SNBC Non-SNP Materials. The STATE must approve all enrollment materials including the Medicaid Enrollee Handbook sent to Enrollees prior to their use. The STATE agrees to inform the MCO of its approval or denial within thirty (30) days of receipt of these documents from the MCO.

3.13.2 Information for Enrollees to be Made Available.

Pursuant to Minnesota Statutes, §256B.6925, subd. 2, and 42 CFR §438.10:

3.13.2.1 The MCO shall make available to all new Enrollees the following information within fifteen (15) calendar days of availability of readable enrollment data from the STATE.

3.13.2.2 If an Enrollee becomes ineligible and is disenrolled from the MCO, but eligibility is reestablished within the following three months and the Enrollee's eligibility is reestablished in the same program and he/she is re-enrolled in the same MCO, the MCO will not be required to send a new member packet, including the Handbook and a provider directory, but must send the Enrollee another MCO member identification card.

3.13.2.3 The MCO must give each Enrollee notice of any change that the STATE defines as significant, as specified in the STATE's approval in section 3.12.2, at least thirty (30) days before the intended effective date of the change.

3.13.3 Handbook

3.13.3.1 For SNBC, a Handbook must be provided that has been prior approved by the STATE:

(1) For SNBC SNP Enrollees, the MCO will cooperate with the D-SNP Integrated Member Materials workgroup to adjust the CMS Medicare model Handbook to incorporate STATE requirements. The MCO will use the model developed by the D-SNP Materials workgroup to develop its own Handbook, which is then submitted to the STATE and includes

information as below in section 3.13.3.2(1) through (38). For SNBC SNP the complete Handbook must be made available annually to Enrollees as required by CMS.

(2) For non-SNP Enrollees, the STATE will provide annually to the MCO a model Handbook as the base document. Prior to distribution to the MCO, the model Handbook will be prior approved by MDH to ensure that MDH's requirements are included. The MCO will not have to subsequently submit the Handbook to MDH after receiving approval from the STATE. After the MCO has incorporated its specific information, the completed Handbook will be submitted to the STATE for prior approval. For SNBC non-SNP the complete Handbook must be made available annually to Enrollees no later than January 1.

3.13.3.2 The Handbook must include the following [42 CFR §438.10(g)]:

(1) Definitions consistent with 42 CFR §438.10(c)(4)(i), as listed in the model Handbook;

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

(3) A description of the MCO's medical and remedial care program, including specific information on Covered Services, including amount, duration and scope of benefits available, limitations and non-covered services;

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

(5) A description of the MCO's policies related to access to Case Management or Care Management services from the MCO;

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

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

(8) A description of cost sharing, if applicable;

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

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

(11) A statement informing Enrollees that the MCO shall provide language and accessibility assistance to Enrollees that ensures meaningful access to its programs and services, and how to obtain auxiliary aids and services, including information in alternative formats or languages;

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

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

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

(15) A description of how transportation is provided;

(16) A description of how the Enrollee may access and 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; 6) procedures for Urgent Care, and Out of Network care; 7) how Enrollees may access Home and Community-Based Services through the county, and 8) how to obtain accessibility information required under section 6.11.

(17) 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.

(18) 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;

(19) What constitutes an emergency medical condition and emergency services;

(20) Any restrictions on the Enrollee's freedom of choice among network providers;

(21) The process of selecting and changing the Enrollee's Primary Care Provider, if the MCO requires the Enrollee to select a Primary Care Provider;

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

(23) The number of the 24-hour telephone nurse line where an RN can be reached for assistance related to urgent medical needs or emergency care;

(24) A description of all Grievance, Appeal and State Fair Hearing rights and procedures available to Enrollees, including the MCO's Grievance and Appeal System procedures that must be exhausted before filing for a State Fair Hearing, and the availability of an expert medical opinion from an external organization pursuant to section 8.8.7, and the availability of a second opinion at the STATE's expense during a State Fair Hearing. This includes, but is not limited to:

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

(26) The right to file Grievances and Appeals.

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

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

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

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

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

(32) The Enrollee may be required to pay the cost of services furnished while the Appeal is pending, consistent with state policy, if the final decision is not wholly favorable to the Enrollee.

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

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

(35) How to exercise an Advance Directive;

(36) Information on how to report suspected Fraud or Abuse;

(37) A description of the Enrollee's right to request information about Physician Incentive Plans from the MCO, including whether the MCO uses a Physician Incentive Plan that affects the use of referral services, the type of incentive arrangements, whether stop-loss protection is provided, and a summary of survey results pursuant to section 11.8 below; and

(38) 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(c)(2)(ii).

3.13.4 Handbook Revisions.

The MCO must revise its Medicaid Handbook and its SNP EOC for all substantial changes including but not limited to 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 Handbook or EOC must be approved in writing by the STATE in accordance with section 3.12.2 and must be issued to Enrollees prior to implementation of the change.

3.13.5 Handbook Delivery.

Handbook information required to be provided by the MCO will be considered to be provided if the MCO [42 CFR §438.10(g)(3)]:

3.13.5.1 Mails a paper copy of the information to the Enrollee's mailing address;

3.13.5.2 Provides the information by e-mail after obtaining the Enrollee's agreement to receive the information by e-mail;

3.13.5.3 Posts the information on the MCO web site and advises each Enrollee in paper or electronic form, as permitted by the Enrollee under section 3.13.10 below, that the information is available on the MCO web site including the applicable Internet address; provided that Enrollees with disabilities who cannot access this information on the web site are provided auxiliary aids and services upon request at no cost; or

3.13.5.4 Provides the information by any other method that can reasonably be expected to result in the Enrollee receiving that information.

3.13.6 Provider Directory.

The MCO must make available:

3.13.6.1 For SNBC SNP Enrollees, an integrated Medicare and Medicaid Provider directory, and for SNBC-Non-SNP Enrollees, a Medicaid Provider Directory that lists the Network Providers within the MCO's network, including primary care Providers, Care Systems, physicians including specialists and subspecialists, hospitals, pharmacies, behavioral health providers, LTSS providers, and Nursing Facilities. The Directory must include Network Provider names, group affiliation, locations, and telephone numbers, web sites as appropriate, and other requirements as specified in the State document entitled "*Provider Directory Guidelines*" posted on the STATE's managed care web site. [42 CFR §438.10(h)(1)] The MCO must include a statement on how an Enrollee can request a listing of home care agencies.

3.13.6.2 The Directory shall indicate the Network Provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the Provider or a skilled medical interpreter at the Provider's office, and whether the provider has completed cultural competence training. For hospitals, the MCO should list only the languages spoken by on-site interpreter staff.

3.13.6.3 The directory shall include:

(1) Whether the Network Provider's office/facility has accommodations for Enrollees with physical disabilities, including offices, exam room(s) and equipment.

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

(3) Information that written materials is available about how to obtain accessible accommodation information required under section 6.11, SNBC Compliance with Service Accessibility Requirements.

(4) Information about how to access mental health, substance use disorder, Home Care, dental, and Medical Emergency and Urgent Care services.

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

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

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

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

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

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

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

3.13.6.4 A misrepresentation of Providers on the MCO's Provider Directory may be determined by the STATE to be an intentional misrepresentation in order to induce Beneficiaries to select the MCO.

3.13.6.5 The MCO must identify whether the Network Provider is accepting new patients.

3.13.6.6 The Provider directory shall include a phone number where an Enrollee may call to verify or receive current information and shall be updated:

- If in paper format, at least monthly, and
- If in electronic format, no later than thirty (30) calendar days after the MCO receives updated Network Provider information.

3.13.6.7 The Provider directory document must be posted on the MCO's web site. The document must meet all of the Provider Directory Guidelines and may not differ from the

State-approved paper copy. The MCO web site must include the Provider Directory as a machine readable file, in a format specified by CMS. [42 CFR §438.10(h)(4)]

3.13.7 Formulary.

3.13.7.1 The MCO must make available, in electronic or paper format, the following information about its formulary, consistent with 42 CFR §438.10(i):

3.13.7.2 Which medications are covered (both generic and name brand);

3.13.7.3 What tier each medication is on;

3.13.7.4 The formulary document must be posted on the MCO's web site. The document must meet all of the List of Covered Drugs Guidelines and may not differ from the State-approved paper copy. The MCO web site must include the formulary as a machine readable file, in a format specified by CMS. [42 CFR §438.10(i)]

3.13.8 Identification Card.

The MCO must provide Enrollee (member) identification cards that conform to the requirements in Minnesota Statutes, §62J.60, subd. 3, approved by the STATE prior to distribution.

- For SNBC SNP Enrollees, an integrated Medicare and Medicaid identification card, and
- For SNBC-Non-SNP Enrollees, an identification card that conforms to the requirements in Minnesota Statutes, §62J.60 subd. 3.

3.13.8.1 Identification cards must be approved by the STATE prior to distribution. The card must identify the Beneficiary as an MCO Enrollee and contain an MCO telephone number to call regarding coverage, procedures and Grievances and Appeals. The identification card shall demonstrate that the Enrollee is a Beneficiary of MHCP by printing the Enrollee's STATE PMI number on the card or by other reasonable means.

3.13.8.2 The card may include data elements required by CMS for Medicare eligible Enrollees.

3.13.8.3 The MCO and/or its Pharmacy Benefit Manager Subcontractor must assign a unique BIN/PCN combination that will only be used for MHCP enrollees, including Medical Assistance, MinnesotaCare, and dual eligible integrated programs. The same BIN/PCN combination can be used for all MHCP programs. The MCO and/or PBM must not use the same BIN/PCN combination for its commercial or standalone Medicare Part D enrollees. The MCO must provide the unique BIN/PCN combination numbers to the STATE. The revised identification card containing the unique BIN/PCN combination must be made available to the MCO's Enrollees.

3.13.9 Web site.

The MCO must have a dedicated, readily accessible web site for its MHCP programs which is accessible to Potential Enrollees and Enrollees, Local Agency staff, and other outreach partners, that links to the Enrollee/Member Handbooks or EOcs, Provider Directories, Formularies and any other information necessary for a Potential Enrollee or Enrollee to obtain or access covered services. These documents must be readily accessible and provided in an electronic form which can be electronically retained and printed. The web site must be easily accessible from the MCO's main landing page and the documents listed above must be prominently placed on the MHCP programs web site. The MCO web site 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 STATE will provide this information on its public web site; the MCO is required to send any changes or updates in the web site link of the MCO web site to the STATE before the web site link changes.

3.13.10 Provision of Required Materials in Electronic Formats.

The STATE or the MCO must provide in electronic format enrollment materials including the Provider Directory, Handbook, and Formulary, or materials otherwise required to be available in writing under 42 CFR §438.10(c).

3.13.10.1 Any materials provided by the MCO in electronic format must meet the requirements of 42 CFR §438.10(c)(6). For SNBC SNP Enrollees, the MCO may follow CMS guidance regarding the provision of materials in alternative formats.

- The format is readily accessible;
- The information is placed in a location on the MCO's web site that is prominent and readily accessible;
- The information is provided in an electronic form which can be electronically retained and printed;
- The information is consistent with the content and language requirements of this section; and
- The Enrollee is informed that the information is available in paper form without charge upon request, and the MCO shall mail the information to the Enrollee or the Enrollee's address within five business days from the request.

3.13.10.2 The materials must also comply with the accessibility standards of Sections 504 and 508 of the Rehabilitation Act of 1973, as amended. See 36 CFR Part 1194, and the Final Rule in FR Vol. 82, No. 11, published January 18, 2017. For SNBC SNP, the MCO may follow CMS guidance regarding the provision of materials in alternative formats.

3.13.10.3 If the materials contain individually identifiable Enrollee data, the materials must be sent to a secure electronic mailbox and made available at a password-protected secure electronic Web site or on a data storage device;

3.13.10.4 The MCO shall provide the Enrollee with an MCO customer service number on the Enrollee's identification card that may be called to request a paper version of the materials provided in an electronic format; and

3.13.10.5 The materials provided in an electronic format must meet all other requirements of the Contract regarding content, accessibility, and any required time frames for distribution.

3.13.11 Materials for New Service Areas

When the MCO is new to a Service Area, the MCO must supply the STATE, or in certain circumstances the Local Agency, with the final, printed and approved Provider Directory pursuant to the STATE's specifications, in quantities sufficient to meet the STATE's need. The MCO must provide its Provider Directory in electronic format pursuant to section 3.13.10 above. The MCO must update the Provider Directory to be consistent with section 3.13.6.6 above. The Provider Directory and all revisions to the Provider Directory must be submitted to the STATE along with a cover letter detailing all changes. The Provider Directory must be approved in writing by the STATE before copies are provided to the STATE. Such approval by the STATE shall not be unreasonably withheld. The MCO shall distribute the Provider Directories to the Local Agencies and the STATE in a timely manner. The STATE shall respond to inquiries by the Local Agencies in a timely manner and shall communicate to the MCO any issues or problems regarding distribution of the Provider Directories.

3.13.12 Tribal Training and Orientation.

The MCO shall provide training and orientation materials to tribal governments upon request, and shall make available training and orientation for any interested tribal governments.

3.13.13 Additional Information Available to Enrollees.

The MCO shall furnish the following information to Potential Enrollees and Enrollees upon request:

3.13.13.1 The licensure, certification and accreditation status of the MCO, or the health care facilities in its network;

3.13.13.2 Information regarding the education, licensure, and board certification and recertification of the Providers in the MCO's network. For purposes of this section, Providers means Providers with whom the Beneficiary or Enrollee has or may have an appointment for services under this Contract; and

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

3.13.14 SNBC Enrollee Orientation and Customer Service for SNBC.

3.13.14.1 MCO will provide welcome calls to all new SNBC Enrollees that will include basic information on how to access services.

3.13.14.2 MCO will maintain key county contact telephone numbers for customer service and other personnel to use in assisting Enrollees who require a referral to the county for additional community services.

3.13.15 SNBC Enrollee and Potential Enrollee Education.

3.13.15.1 The STATE will not 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. This does not prohibit the MCO or its Subcontractors from providing information to Potential Enrollees eligible for SNBC for the purposes of educating Potential Enrollees about Provider choices available through the MCO, subject to restrictions in the Marketing Standards and Restrictions section 3.12.3 and section 3.12.4 as applicable.

3.13.15.2 The STATE will inform Beneficiaries who reside in the Service Area of the options available in health care coverage. The STATE will describe through presentations, electronic or written materials the various MCOs available to Beneficiaries in a particular geographic area and will assist in completing the enrollment process by securing an electronic or written signature of Beneficiaries or their Authorized Representatives on the enrollment form. For Beneficiaries who are assigned to an MCO, a signature will not be obtained.

3.13.16 Consumer Education

The MCO must supply all Local Agencies within its Service Area with its Provider Directory that provides information about the MCO's Medicare and Medicaid Provider network and that includes a description of the essential components of the MCO, to be used by the STATE and Local Agencies to educate consumers. The MCO must provide its Provider Directory in electronic format to all Local Agencies within its Service Area.

3.14 Significant Events Requiring Notice.

The MCO must notify the STATE as soon as possible of significant events affecting the level of service either by the MCO or its Medicare and Medicaid Providers or Subcontractors. Such events include, but are not limited to:

3.14.1 Material Modification of Provider Network

3.14.1.1 Notice to STATE. The MCO must notify the STATE of a possible Material Modification in its Provider Network within ten (10) business days from the date the MCO has been notified that a Material Modification is likely to occur. A Material Modification shall be reported in writing to the STATE no less than one hundred and twenty (120) days prior to the effective date or within two (2) business days of becoming aware of it, whichever occurs first. An MCO may terminate a Provider Contract without one hundred twenty (120) days' notice to the STATE in 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.

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

- 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 MCO's remaining choices; or that the Enrollee has been reassigned from a terminated sole source Provider; or
- One of the major Subcontractors providing a network of Providers, including but not limited to the behavioral health network, pharmacy benefit manager, or dental network will no longer be available in the MCO's network and that access to these services may require that the Enrollee choose a different provider for these services.
- The notice shall also inform the Enrollee that 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.

3.14.2 Enrollee Notification of Terminated Provider.

The MCO (or if applicable its Subcontractor) shall make a good faith effort to provide written notice of the termination of a Network Provider, within fifteen calendar (15) days after the MCO's (or if applicable its Subcontractor's) receipt or issuance of the Network Provider termination notice, to an Enrollee who receives his or her Primary Care from or was seen on a regular basis by that Network Provider. [Minnesota Statutes, §256B.6925, subd. 2, (4)]

The STATE may extend the timeframe for Enrollee notification in instances when the MCO has more than sixty (60) days advance notice of a terminated Network Provider. A sample Enrollee notice must be prior approved by the STATE. The MCO must provide the following information to the STATE:

- Date the Network Provider will no longer be available to Enrollees;
- Number of Enrollees affected in each Minnesota Health Care Program;
- Impact on the MCO's Provider network; and
- MCO's transition of care plan for the affected Enrollees.

3.14.3 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) and his or her physician specialists. Examples of methods of Provider access include but are not limited to: 1) Enrollee has open access to all Primary Care Providers (clinics); 2) Enrollee may self-refer to a physician specialist; 3)

Enrollee must choose one Primary Care Provider (clinic); and 4) Enrollee must receive a referral to a physician specialist from his or her Primary Care Provider (clinic). For the purposes of this section, a substantive change in the method of Provider access shall not include the addition or deletion of Service Authorization requirements for services.

3.14.4 Service Delivery Plan.

Any substantive changes in the Service Delivery Plan shall be provided by the MCO to the STATE thirty (30) days prior to any changes made by the MCO. The STATE must approve all changes to the MCO's Service Delivery Plan.

3.14.5 Reporting of Issues.

The MCO shall make a good faith effort to promptly report to the STATE any significant delays, errors, deficiencies in service delivery, delays in claims payment to Providers, or failure to implement the correct member materials, including approved templates.

3.14.6 Significant Changes in Handbook.

The MCO must give each Enrollee notice of any change that the STATE defines as significant in the information in the Handbook, at least thirty (30) days before the intended effective date of the change. [42 CFR §438.10(g)(4)] Enrollee Notification of Cost-Sharing Limit.

The MCO shall provide to each Enrollee a notice that the Enrollee has reached the cost-sharing limit described in section 4.11.

3.15 HEALTH RISK ASSESSMENT ENTRY FOR SNBC.

3.15.1 The MCO will be responsible for timely entering specified fields from the annual health risk assessment into MMIS for all Enrollees, according to section 6.1.5.2.

3.15.2 The MCO may enter the information or may contract with a Local Agency or Case Management delegate to enter screening documents and shall submit screening documents consistent with the timeframes established by the STATE. The MCO shall submit to the STATE's security liaison a signed data privacy statement for all MCO employees and Subcontractors who will be responsible for entering specified fields from screening documents into MMIS. The STATE shall offer training to MCOs and its Subcontractors on this process. The MCO shall download and install the required internet access software "Blue Zone" onto workstations for staff who will be responsible for entering Screening Documents.

3.16 REPORTING ENCOUNTERS AND OTHER DATA.

3.16.1 Encounter Data Reporting.

3.16.1.1 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 SSA, 42 USC §1396b(m)(2)(A)(xi).

3.16.1.2 The MCO agrees to furnish information from its records to the STATE or the STATE's agents that are required in State or federal law or which the STATE may reasonably require to administer this Contract. The MCO shall provide to 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 [42 CFR §§438.2; 438.242; 438.604; 438.818]:

(1) Individual Enrollee-specific, claim-level encounter data for services provided by the MCO to Enrollees detailing all of the following: 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; and Home Care Services for which the MCO is financially responsible.

(2) The MCO shall submit electronic encounter data that includes all paid lines and all MCO-denied lines associated with the claim. Claims and lines for which Medicare or another Third Party has paid in part or in full are considered paid and shall be submitted as such. Third Party paid claims include immunizations which are paid for by the Minnesota Vaccines for Children Program (MNVFC).

(3) All denied claims, except those claims that are denied because the enrollee was not enrolled in the MCO must be submitted to the STATE.

(4) Claim-level data must be reported to the STATE using the following claim formats:

- The X12 837 standard format for physician, professional services, and for physician-dispensed pharmaceuticals (837P), inpatient and outpatient hospital services (837I), Nursing Facility services, and dental services (837D) that are the responsibility of the MCO; and
- The NCPDP Batch 1.2/ D.0 pharmacy. The MCO may submit the NCPDP Batch 1.2/ D.0 for non-durable medical supplies which have an NDC code.
- The MCO shall comply with the applicable provisions of Subtitle F (Administrative Simplification) of the Health Insurance Portability and Accountability Act of 1996 and any regulations promulgated pursuant to its authority, including the 5010 transaction standards. The MCO shall cooperate with the STATE as necessary to ensure compliance.
- The MCO must comply with state and federal requirements, including the federal Implementation Guides, and the STATE's *837 Encounter Companion Guide for Professional, Institutional and Dental Claims*, and the *Pharmacy Encounter Claims Guide* posted on the STATE's managed care web site.

(5) The MCO must submit charge data using HIPAA standard transaction formats. Charge data shall be the lesser of the usual and customary charge (or appropriate amount from a Relative Value Scale for missing or unavailable charges) or submitted charge.

(6) The MCO shall submit on the encounter claim for 837P, 837I, 837D, and NCPDP Batch 1.2/D.0 the Provider allowed and paid amounts. For the purposes of this section "paid amount" is defined as the amount paid to the Provider excluding Third Party Liability, Provider withhold and Provider incentives, and Medical Assistance cost-sharing. For the purposes of this section "allowed amount" is defined as the Provider contracted rate prior to any exclusions or add-ons. In accordance with Minnesota Statutes, §256B.69, subd. 9c, (a), the data reported herein is defined as non-public in Minnesota Statutes, §13.02.

(a) If the MCO uses a Subcontractor to administer a benefit, for example a dental administrator or Pharmacy Benefit Manager, the "paid amount" is defined as the amount paid to the Provider excluding Third Party Liability, Provider withhold and Provider incentives, and Medical Assistance cost-sharing by the Subcontractor.

(b) Paid amounts for services rendered under subcapitated risk-based arrangements must be estimated using usual and customary payment or an appropriate amount from a Relative Value Scale or the DHS FFS fee schedule, and must not include administrative costs or other incentives.

(7) The MCO will submit Medicaid drug information on pharmacy (NCPDP Batch 1.2/D.0), professional (837P) and institutional (837I) encounter claims in accordance with STATE data

element specifications related to the collection of drug rebates. These specifications will be outlined in the *Encounter Companion Guides* for the NCPDP Batch 1.2/D.0 Pharmacy, 837 Professional and 837 Institutional encounter claims. The MCO and its Subcontractor, if applicable, must comply with these specifications and submit encounter data every two weeks and no later than thirty (30) days for original claims and forty-five (45) days for adjusted claims, after the MCO (or its Subcontractor) adjudicates both outpatient pharmacy and physician-administered drug claims. This process enables the STATE to comply with 1927(b) 1903m(2)(A) and 1927(j)(1) of the SSA as amended by Section 2501 (c) of the Patient Protection and Affordable Care Act.

(8) The MCO shall submit individual-enrollee specific, claim-level data on all post-payment recoveries for pharmacy claims from liable third parties on a quarterly basis, in a format determined by the STATE.

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

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

3.16.1.3 The MCO shall notify the STATE ninety (90) days prior to any change in the submitter process, including but not limited to the use of a new submitter.

3.16.1.4 The MCO shall submit original submission encounter claims no later than thirty (30) days after the date the MCO adjudicates the claim. The MCO shall make submissions for each transaction format at least bi-weekly. If the MCO is unable to make a submission during a certain month, the MCO shall contact the STATE to notify it of the reason for the delay and the estimated date when the STATE can expect the submission. The MCO's submission of claim adjustments must be done by voiding the original claim and submitting a corrected claim, within forty-five (45) days of the date adjusted at the MCO. See also section 9.9.6 below regarding claims voided or reversed because of program integrity concerns.

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

3.16.1.6 The STATE will provide a remittance advice, on a schedule specified by the STATE, for all submitted encounter claims, including void claims. The remittance advice will be provided in the X12 835 standard transaction format.

3.16.2 Encounter Data Quality

3.16.2.1 The STATE shall monitor and evaluate encounter data lines and shall require correction of encounter data found deficient according to specifications published on the STATE's managed care web site. Encounter data not corrected shall be assessed a penalty as specified in section 5.8 below. [42 CFR § 438.242(d)]

(1) Within twenty-one (21) days after the end of each calendar quarter, the STATE shall provide to the MCO an error reference report (ERR) of erroneous encounter lines and/or headers processed during the quarter.

(2) The MCO shall, within the calendar quarter in which the ERR is provided, respond by appropriately voiding the erroneous encounter lines and/or headers and submitting corrected encounter data claims, as described in the technical specifications posted on the STATE's managed care web site.

(3) The MCO shall include on each corrected encounter data claim a "tracking ICN" as defined in the technical specifications posted on the STATE's managed care web site.

(4) The STATE will post on its managed care web site technical specifications including but not limited to definitions for encounter lines and headers; definitions for edits and errors; management of duplicate encounter lines or headers, submissions of multiple errors on one encounter claim, and voids that are within the same quarter; and a list of designated edits which may change at the discretion of the STATE. The STATE shall provide a minimum of ninety (90) days' notice before implementing a new edit that will require correction.

(5) Encounter headers/lines identified by the STATE as errors subject to this section may not be voided as a method to avoid penalties. Encounter claims that should not have been submitted to the STATE and should not reside in STATE data as MCO accepted claims must be explicitly identified as such. Voided claims are subject to a validation process by the STATE.

(6) The MCO may contest encounter lines or claims the STATE has identified as erroneous by sending the encounter ICN and a detailed description of the contested encounter lines or claims by e-mail to the STATE's Encounter Data Quality contact. The STATE will remove the encounter line from the penalty assessment pending resolution of the issue. Contested errors will not be adjusted retroactively, but can be removed from the penalty going forward (as defined in the technical specifications posted on the STATE's managed care web site).

(7) The notice and opportunity to cure requirements in section 5.4 will not apply to encounter data quality errors and penalties assessed under section 5.8.

The MCO shall collect and report to the STATE individual Enrollee specific, claim level encounter data that identifies the Enrollee's treating Provider NPI or UMPI (the Provider that actually provided the service), when the Provider is part of a group practice that bills on the 837P format or 837D format. The treating Provider is not required when the billing provider is an individual and is the same as the individual that provided the service. Procedure codes on 837P and 837D format claim lines, for which registered individual treating Provider data submissions are required, are listed on the DHS web portal page as HCPCS codes.

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

3.16.2.3 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.

3.16.3 Coding Requirements.

3.16.3.1 The MCO must use the most current version of the following coding sources:

(1) Diagnosis and inpatient hospital procedure codes obtained from the International Classification of Diseases, Clinical Modification ICD-10-CM/PCS coding requirements on claim and encounter data submissions;

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

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

(4) National Drug Codes; and

(5) Current local home care codes including units of service.

3.16.3.2 Neither the MCO nor its Subcontractors may redefine or substitute these required codes.

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

3.16.4 Encounter Data Quality Assurance Protocol.

The MCO shall participate in a quality assurance protocol that verifies timeliness, completeness, accuracy and consistency of encounter data that is submitted to the STATE. The STATE has developed quality assurance protocols for the program, in consultation with the MCOs which will be evaluated by an independent third party auditor for the capacity to ensure complete and accurate data and to evaluate the STATE's implementation of the protocols.

3.16.5 Encounter Data for the Supplemental Recovery Program.

The STATE will be using encounter data to manage the Supplemental Recovery Program described in Minnesota Statutes, §256B.69, subd. 34.

3.16.6 Provider-Preventable Conditions.

Pursuant to 42 CFR §438.3(g), the MCO must comply with 42 CFR §447.26 and Minnesota Statutes, §144.7065 (provider-preventable conditions) in the encounter data, as determined by the STATE. The STATE shall provide a quarterly report of the MCO's incidents back to the MCO. In the event that an encounter is reported with any amount other than zero in the payment fields, the MCO shall review and appropriately recoup the payment from the provider, consistent with Minnesota Statutes, §§ 256.969, subd. 3b, (c) and 256B.0625, Subd. 3.

3.17 FQHCS AND RHCS SERVICES.

The STATE and MCO shall instruct Federally Qualified Health Centers that, for dates of service beginning July 1, 2019, the FQHCs will bill Medicaid services provided under this Contract directly to the STATE. See section 6.7.

3.17.1 RHCs Services. Rural Health Centers will continue to bill the MCO, and the MCO shall follow the procedure as follows:

3.17.1.1 The MCO shall adjudicate Medicaid claims as a zero pay for services provided to the MCO's Enrollees at a FQHC or RHC.

3.17.1.2 The MCO will forward these adjudicated claims to the STATE within seven (7) calendar days of adjudication and will submit the claims in a weekly file submission.

- Claims in which Medicare is primary and the claim is paid in full are not to be included in the weekly file submission.
- Claims for which another payer (TPL) is primary, the claim is paid in full and $0.00 is assigned to patient responsibility are to be excluded from the weekly file submission

3.17.1.3 The STATE will adjudicate the Medicaid claims for the RHC and provide the MCO with a Remittance Advice for the processed claims. The MCO will be required to submit a separate encounter claim for these transactions. The STATE will provide technical specifications for this process and will post the document on the managed care webpage. The MCO and STATE will continue to collaborate through a workgroup to monitor the implementation progress of this section and address concerns about the process.

3.17.1.4 The MCO will submit a quarterly data report of RHC copayments for service dates on or after January 1, 2015. The MCO shall provide the data report in a format specified by the STATE within thirty (30) days of the end of each quarter.

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

3.18 Health Care Homes in Integrated Programs.

Pursuant to Minnesota Statutes, Ch. 256B.0751, subd. 4, the development of Health Care Homes does not preclude alternative models and payment mechanisms for persons who are enrolled in integrated Medicare and Medicaid programs under Minnesota Statutes, §256B.69.

3.19 Special Needs Plan Duties.

3.19.1 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.

3.19.1.1 The MCO shall inform the STATE regarding significant changes in its Medicare Program or the administration of Medicare Programs, in order to facilitate operating SNBC in as fully integrated a manner as possible. Significant changes include, for this section, a change in the SNP service area. MCOs must send a copy of the proposed service area to the STATE within ten (10) days of the time a Notice of Intent to Apply is submitted to CMS.

3.19.1.2 The MCO will notify the STATE of changes, including but not limited to terminations of SNPs, 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, Part D issues that may materially affect the SNP, or a decision to conduct a Federal investigative audit that may lead to the termination of the SNP, within thirty (30) days of such actions for any SNP that may enroll Dual Eligibles. The MCO also agrees to inform the STATE of any requests to CMS for service area changes in its SNP(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.

3.19.1.3 Additional Benefits and Premiums. The MCO 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.

3.19.1.4 Corrective Action Requests. 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.

3.19.2 Integration of Medicare and Medicaid Benefits.

The MCO will cooperate with the STATE to promote the continued integration of Medicare and Medicaid benefits for 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.

3.19.3 Proposed Plan Benefit Packages (PBPs) and Bids.

The MCO/SNP will provide a copy of its CMS submitted bid to the STATE's actuarial firm within thirty (30) days of final submission to CMS for the purpose of assuring that the STATE does not duplicate payments on any provided services. The MCO will provide a copy of the MCO's approved CMS bid to the STATE's actuarial firm, if the approved bid differs significantly from the submitted bid. The STATE will not directly review this information. The MCO must identify information as "Trade Secret" prior to or at the time of its submission for the STATE to consider classifying it as non-public, as described in section 9.7.

3.19.4 SNP Participation Requirements; Medicare Savings.

3.19.4.1 The MCO agrees to participate in Medicare Advantage as a Dual Eligible SNP approved to serve the State's Dual Eligible subset as specified under the SNBC program and to meet CMS requirements as a low income benchmark plan for Part D benefits.

3.19.4.2 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 Dual Eligible Enrollees of the SNP and agrees to consult with the STATE about any such benefits offered prior to the submission of its bids to CMS. If there are significant changes after CMS approval, the MCO agrees to notify the STATE of changes in such benefits following the approval of the bid.

3.20 INTEGRATED CARE SYSTEM PARTNERSHIPS.

3.20.1 The MCO shall develop and maintain coordination of care and other arrangements with providers as outlined in section 7.8, Integrated Care System Partnerships.

3.20.2 The MCO will participate in a clinical workgroup for continuing development of ICSP quality metrics, and reporting for ICSP models.

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ARTICLE. 4 PAYMENT.

4.1 PAYMENT OF CAPITATION.

4.1.1 Payment.

Except as noted below in section 4.1.2, by the 14th day of each month, the STATE agrees to pay the MCO the following rates as specified in the Payment Appendices attached hereto, per month, per Enrollee enrolled with the MCO as full compensation for Medical Assistance goods and services provided hereunder in that month, under this Comprehensive Risk Contract. For the Capitation Payment for those Enrollees who have been reinstated, the STATE agrees to pay the MCO on the next available warrant.

4.1.2 Exceptions to Payment Schedules.

Section 4.1 does not apply to Capitation Payments for services provided in the month of May and June, for which payment shall be made no earlier than the first day of each July. [Minnesota Statutes, §256B.69, subd. 28, (b)]

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

4.1.2.3 Any excess of total payments to the MCO that exceed $99,999,999.99 in a single warrant period. The STATE may 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.

4.1.2.4 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.

4.1.3 Schedule for Return of Withheld Funds.

As required by Minnesota Statutes, §256B.69, subd. 5a:

(1) The Non-Performance-Based total 37.5% (3.0 / 8.0 x 100) of the withheld funds shall be returned with no consideration of performance, no sooner than July 1st and no later than July 31st of the subsequent Contract Year as required by Minnesota Statutes, §256B.69, subd. 5a.

(2) The Performance-Based Totals will also be returned as required by Minnesota Statutes, §256B.69, subd. 5a, no sooner than July 1st and no later than July 31st of the subsequent Contract Year. See also section 4.12.1.

4.2 SNBC STOP-LOSS.

The STATE agrees to make payment to the MCO for seventy-five percent (75%) of allowable medical expenses in excess of one million dollars ($1,000,000) for Contract Year 2018 for Outlier Enrollees under this Contract, as described in this section. The MCO shall retain responsibility for Care Management and prompt payment to providers for services provided to all potential Outlier Enrollees.

4.2.1 Definitions. For the purposes of this section:

(1) Outlier Enrollees means persons for whom the MCO has incurred at least $2.0 million ($2,000,000) in allowable medical expenses for dates of service in calendar year 2017 and at least $2.0 million ($2,000,000) in allowable medical expenses for dates of services in calendar year 2018.

(2) Allowable medical expenses includes only reasonable payments by the MCO to providers for Covered Services and Substitute Health Services received by the Outlier Enrollee, as determined by the STATE. Allowable medical expenses will not include Provider-Preventable Conditions identified in section 9.1, expenditures resulting from egregious lapses in prudent Care Management, services exceeding standards set in section 6.6, services excluded from the Contract, including those listed in section 6.7, amounts covered under a reinsurance policy held by the MCO, or Third Party Liability.

4.2.2 The MCO shall identify potential Outlier Enrollees to the STATE by March 31, 2018 and shall engage in conference calls as requested by STATE to monitor successful submission of encounter claims and provision of any additional necessary information regarding each Outlier Enrollee case. The MCO shall provide information needed to review allowable medical expenses as requested on a quarterly basis, in a form and format determined by the STATE.

4.2.3 The STATE shall determine the allowable medical expenses by reviewing encounter claims and conducting a detailed case review of the Care Management and medical expenses incurred for the Outlier Enrollee during the relevant contract years. The MCO shall notify the STATE upon submission of all relevant encounter claims and requested information for the Outlier Enrollee so that a final calculation may be made.

4.2.4 The STATE shall calculate allowable medical expenses for dates of service in Contract Year 2018. Seventy-five percent of medical expenses shall be calculated after one million dollars ($1,000,000) shall be subtracted from the total allowable medical expenses to arrive at the payment amount owed to the MCO. The STATE shall make payment for allowable medical expenses to the MCO within ninety (90) days of completing its review.

4.3 Medicaid Capitation Payment.

The STATE will pay to the MCO a Medicaid Capitation Payment for each Enrollee in accordance with Article 4 for the month in which coverage becomes effective and thereafter until termination of Enrollee coverage pursuant to section 3.6 becomes effective. The MCO shall receive for each Enrollee the rate of the county of residence.

4.3.1 Medicare-Eligible SNBC Non-SNP Enrollees.

For SNBC Enrollees with only Part A or Part B as shown in MMIS, the STATE will pay the Medicaid capitation until the Enrollee is disenrolled from SNBC. If the Enrollee has permanently lost both Medicare Parts A and B, the Enrollee remains enrolled in SNBC as a Medicaid Enrollee.

4.3.2 Assignment of Rate Cells.

Assignment of Rate Cells shall be made based on information on the STATE MMIS at the time of capitation. The STATE will periodically review information in MMIS related to the assignment of Rate Cells to verify that appropriate rates are being paid.

4.4 SNBC Payment Rates.

Monthly rates paid to the MCO shall be paid by the STATE according to the Payment Appendix of this Contract.

4.4.1 Basic Care Rates for SNBC.

For the Contract Year, payments for SNBC Enrollees shall be:

4.4.1.1 Monthly payments paid by the STATE to the MCO shall be at 100% of the statewide Base Rate in the Payment Appendix, multiplied by the MCO's (Plan) risk factor normalized by the overall average rate cell-specific risk scores for all MCOs. The dollar value of the risk adjustment rate is shown in the Payment Appendix.

4.4.1.2 Rates, as reduced by eight percent (8.0%) withhold, plus (if applicable) the NF add-on is the total capitation payment to the MCO.

4.4.2 Add-on Rates for SNBC.

4.4.2.1 A nursing facility add-on (NF Add-on) will be included in the capitation rate for non-institutionalized rate cells. The NF Add-on is not subject to the withhold and is not risk adjusted.

4.5 Disability Risk Adjusted Payment System.

The STATE agrees to apply risk adjustment of capitation rates using the Chronic Disability Payment System (CDPS; see http://cdps.ucsd.edu/) and the Medicaid Rx risk adjustment model (collectively, "CDPS+Rx") with Minnesota-specific custom weights to calculate risk scores. Custom weights are developed separately for Dual Eligible Enrollees and for Medical Assistance only (non-Dual Eligible) Enrollees.

4.5.1 Risk Adjustment Overview

Appendix 2 contains the capitation rates used to calculate the Calendar Year risk adjusted payments to the MCO. The risk adjustment weights are found in Appendix 3.

The STATE or its actuarial vendor will use, for Contract Year SNBC risk scores, a prospective risk adjustment model. The average risk score across all MCOs will be normalized to 1.0 for each rate cell.

4.5.2 Development of Weights.

The risk adjustment method utilizes two sets of weights, one for Medical Assistance only (non-Dual Eligible) Enrollees, and one for Dual Eligible Enrollees. These two models include disease categories and risk factor weights customized separately for non-Dual Eligible and Dual Eligible experience. The weights were developed using constrained linear regression and were based upon the Fiscal Years (FYs) 2016 and 2017 experience of individuals enrolled in the SNBC program. Risk factor weights were constrained to be non-negative. The model includes: 1) demographic information; 2) diagnoses from health care claims for services provided to individuals during FY 2016; 3) costs from health care claims for services provided to individuals during FY 2017; and 4) developmental disability (DD) waiver status.

4.5.3 Base Rates.

Based on FY 2018 health plan experience, the STATE calculated base rates based on the following factors: Dual and non-Dual status, institutional (NF, ICF, ICF/DD) and community status, and rate region (Metro, Non-metro North, or Non-metro South as designated in Appendix 3-B). The STATE agrees not to rebase the base rates for risk adjustment during the term of this Contract. Base rates are provided in Appendix 2.

4.5.4 Methodology

4.5.4.1 The MCO will receive an SNBC risk score for each rate cell subject to risk adjustment, based on average risk scores across all the MCO's Enrollees in that rate cell and enrolled in the MCO during the exposure month in 4.5.5.1 and 4.5.5.2.

4.5.4.2 New Enrollees. Each MCO Enrollee with no FFS claim experience or managed care encounters in the assessment period will be assigned a risk score equal to the average risk score for the MCO's Enrollees in the same rate cell.

4.5.4.3 Enrollees with Claims Experience. Enrollees with at least one FFS claim or managed care encounter during the assessment period will be assigned one risk score. Minnesota-specific weights will be used to determine an Enrollee's risk score.

4.5.4.4 Individual risk scores for MCO Enrollees will be aggregated by rate cell into MCO aggregate risk scores (normalized to 1.0 for each rate cell). These risk scores will be applied to the appropriate capitation rate for the Contract Year.

4.5.4.5 MCO aggregate risk scores for the Institutional rate cells will be set no lower than 0.900 and no higher than 1.100 for each rate cell.

4.5.4.6 Managed care costs that are not included in encounter claims will be reviewed for any material effect on weights and adjustments will be made if deemed material.

4.5.4.7 The STATE shall provide MCO with the MCO-specific data, including member level diagnosis, demographic information, and prescription drug utilization that was used to calculate the MCO-specific risk score.

4.5.5 Risk Adjustment Calculation Timeline.

For Contract Year 2020, the MCO's aggregate risk score will be calculated two times.

4.5.5.1 For Capitation Payments for January through June 2020, the MCO will receive aggregate risk scores calculated by the STATE, using:

- Encounter claims and FFS claims for dates of service of July 2018 through June 2019 (the assessment period) that were received by October 23, 2019, and
- The MCO's enrollment as of October 2019 (the exposure month), for each population subject to risk adjustment.

4.5.5.2 For Capitation Payments for July through December 2020, the MCO will receive aggregate risk scores calculated by the STATE, using:

- Encounter claims and FFS claims for dates of service of January 2019 through December 2019 (the assessment period) that were received by April 22, 2020 and
- The MCO's enrollment as of April 2020 (the exposure month), for each population subject to risk adjustment.

4.5.6 Risk Adjustment Appeals.

The MCO may appeal the STATE's calculation of the MCO's risk scores upon notification that risk scores will change. Any appeal of risk factors must be filed with the STATE within six weeks of notification of the new risk scores. 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. The risk score appeal must contain a succinct explanation of why the MCO finds the scores incorrect, with supporting data sufficient to allow the STATE to evaluate the appeal in a timely fashion.

4.5.7 If the MCO appeals under this section, the STATE shall continue to pay the MCO using the MCO's risk scores 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.

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

4.6 Premium Tax; HMO Surcharge.

The MCO may 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 these taxes, the MCO's base rate will be adjusted to reflect that change. [Minnesota Statutes, §297I, and §256.9657, subd. 3, as applicable]

4.7 Contingent Reduction in Health Care Access Tax.

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

4.8 Health Insurance Providers Fee.

If the MCO is identified by the Internal Revenue Service as being subject to the annual health insurer fee ("Annual Fee") required under Section 9010 of the ACA, the STATE will make a payment in order to satisfy the requirement for actuarial soundness set forth in 42 CFR §438.4, (c) for amounts paid by the STATE under this Contract.

4.8.1 MCO Duties.

4.8.1.1 The MCO shall provide the STATE with a copy of its final Form 8963 and Schedule A at the controlled entity level, as submitted to the IRS, within ten (10) business days of the filing. The MCO shall also provide any corrected Form 8963 filings submitted to the IRS within ten (10) business days of the amended filing.

4.8.1.2 The MCO shall also submit to the STATE:

(1) A schedule that reconciles direct premium (Form 8963, Schedule A, item (f)) for the MCO to Line 8 of the Minnesota Supplement Report #1.

(2) The dollar amount of revenue for Covered Services that the MCO determined should be excluded from Form 8963, Schedule A, item (f), including but not limited to long-term care, nursing home care, home health care, and community-based care.

(3) If applicable, MCO shall provide information needed to calculate the effect of taxes upon the final fee. This may include taxes paid that affect the final total to be reimbursed to the MCO.

4.8.1.3 The MCO shall provide the STATE with the preliminary calculation of the MCO's Allocated Annual Fee (the amount of its Annual Fee allocable to this Contract at the controlled entity level), as determined by the IRS, within ten (10) business days of receiving this information from the IRS.

4.8.1.4 The MCO shall provide the STATE with the final calculation of the MCO's Allocated Annual Fee as determined by the IRS, no later than ten (10) business days of receiving this information from the IRS, with a data certification pursuant to section 9.10.

4.8.1.5 Upon request, the MCO shall provide any other documentation required by the STATE to validate the MCO's Allocated Annual Fee or apportionment among Enrollee populations.

4.8.2 STATE Duties.

4.8.2.1 The STATE shall calculate an adjustment for non-deductibility of the Annual Fee for federal and state income taxes, if any; and premium and surcharge taxes. The result will be the MCO's "Adjusted Fee."

4.8.2.2 The STATE's payment to the MCO for the Adjusted Fee shall be made when the STATE determines the MCO has satisfactorily completed its duties in section 4.8.1.

4.8.2.3 The STATE reserves the right to update the calculation and method of payment for the MCO's Adjusted Fee based upon CMS requirements, including the exclusion of appropriate Medicaid payments for long-term care, nursing home care, home health care, and community-based care, or changes to regulations governing the Annual Fee.

4.9 Compliance Related to Payments.

4.9.1 Actuarially Sound Payments.

All payments for which the STATE receives Federal Financial Participation under this Contract, including risk adjusted payments and any risk sharing methodologies, must be actuarially sound. The STATE's contracted actuary must meet the independence requirements under the professional code for fellows in the Society of Actuaries and must not have provided actuarial services to a MCO during the period in which the actuarial services are being provided to the STATE. The certification and attestation of actuarial soundness provided by the actuary must be auditable. [42 CFR §438.6 and 438.4; Minnesota Statutes, §256B.69, subd. 9d]

4.9.2 Financial Audit.

As outlined in Minnesota Statutes, §256B.69, subd. 9e and 3.972, subd. 2, the Office of the Legislative Auditor (OLA) shall audit the MCO to determine if the MCO used the public money in compliance with federal and state laws, rules, and in accordance with provisions of this Contract. The MCO shall submit data to and fully cooperate with the auditor, and provide the STATE and the OLA with all data, documents, and other information, regardless of classification, that the OLA requests to conduct the audit.

4.9.3 STATE Request for Data.

The MCO shall comply with requests for data from the STATE or its actuary for rate-setting purposes. The MCO shall make the data available within thirty (30) days from the date of the request and in accordance with the STATE's specifications, including providing a data certification in accordance with section 11.6 under this Contract. [Minnesota Rules, Part 9500.1460, subpart 16]

4.9.4 Renegotiation of Prepaid Capitation Rates.

The prepaid capitation rates shall be subject to renegotiation not more than annually unless required by state or federal law, regulation or directive, or necessary due to changes in eligibility and/or benefits.

4.9.5 No Recoupment of Prior Years' Losses.

The capitation rate shall not include payment for recoupment of losses incurred by the MCO from prior years or under previous contracts.

4.9.6 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 Article 4 of this Contract.

4.9.7 CMS Approval of Contract.

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

4.9.7.1 The STATE shall adjust MCO payments to bring previous payments in line with rates agreed upon by the STATE and CMS. When possible, a recovery for an overpayment or payment due because of an underpayment shall be offset against or added to future payment made according to section 4.1 of this Contract.

4.9.7.2 For the remainder of the Contract term, the Contract shall be amended, with rates agreed upon by the STATE and CMS, pursuant to Article. 16 of this Contract.

4.9.8 Payment of Clean Claims.

The MCO shall promptly pay all Clean Claims, whether provided within or outside the Service Area of this Contract consistent with 42 USC §1395(h)(C)(2)); 42 USC §1395u(c)(2); and 42 USC §1396 (a)(37); 42 CFR §§ 447.45 and 447.46; and Minnesota Statutes, §§ 256B.69, subd. 6, clause (b), 16A.124 and 62Q.75. In the event the MCO is unable to pay clean claims promptly, the MCO shall notify the STATE of any significant problem, as required in section 3.14.1. The MCO must comply with the interest payment requirement of Minnesota Statutes, §62Q.75, subd. 2, (c).

Claims related to providers under investigation for fraud, waste, or abuse, or claims withheld under Federal regulations are not subject to these requirements.

4.10 Enrollee Cost-Sharing.

4.10.1 Collection of Cost-Sharing.

The MCO may delegate to the Providers of these services the responsibility to collect cost-sharing. The MCO may not reduce or waive the cost-sharing as an inducement to Enrollees to enroll or continue membership in the MCO. [42 CFR §§1001.951, 1003.110, and 1003.1000]

4.11 Medical Assistance Enrollee Cost-Sharing for SNBC.

Except as noted in section 4.11.1, SNBC Enrollees must pay cost-sharing for the services in section 4.11.2 below.

4.11.1 Exceptions from Cost-Sharing.

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

- Children under age 21;
- Pregnant women;
- Enrollees expected to reside for thirty (30) days or more in an institution;
- Enrollees receiving Hospice Care;
- American Indians as defined in section 2.11 who receive or have ever received a service(s) from an Indian Health Care Provider, or through IHS CHS referral from an IHS facility;
- Emergency Services;
- Family Planning;
- Preventive services including:

- Services with a rating of A or B from the United States Preventive Services Task Force, which includes tobacco use counseling and interventions (smoking cessation) services;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- Preventive services and screenings provided to women as described in 45 CFR §147.130.

- Services paid for by Medicare for which Medical Assistance pays the coinsurance and deductible;
- Copayments that exceed one per day per Provider for non-preventive visits, and non-emergency visits to a hospital-based emergency department; and
- Substance use disorder treatment services pursuant to Minnesota Statutes, §254B.03, subd. 2.

4.11.2 Medicaid Cost-Sharing Amounts

- See also section 4.11.6.
- Except for anti-psychotic drugs for which no copayment is required, Enrollees shall pay copayments of three dollars ($3.00) per prescription for brand name drugs and one dollar ($1.00) per prescription for generic drugs, with a combined maximum of twelve dollars ($12.00) per month.
- Except for mental health services which are exempt from this copayment, Enrollees shall pay copayments of three dollars ($3) per non-preventive visit. For purposes of this paragraph, a "visit" means an episode of service which is required because of an Enrollee's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;
- Enrollees shall have a copayment for non-emergency use of the emergency department of three dollars and fifty cents ($3.50) per visit.
- The MCO agrees to waive the monthly family deductible The STATE will provide the amount no later than December 1 of the previous calendar year. The MCO must track the amounts for reporting.

4.11.3 Cost-Sharing and Family Income.

For SNBC Medicaid-only Enrollees, Enrollees' total monthly cost-sharing must not exceed five percent (5%) of family income.

(1) For purposes of this paragraph, family income is the total earned and unearned income of the Enrollee and the Enrollee's spouse, if the spouse is enrolled in Medical Assistance and also subject to the five percent (5%) limit on cost-sharing as authorized by Minnesota Statutes, §256B.0631, subd. 1, (a)(6).

(2) The MCO must provide to the Enrollee a notice, within five (5) days of adjudicating the claim that causes the total cost-sharing to exceed five percent (5%), for each month the Enrollee meets the five percent (5%) limit on cost-sharing.

4.11.4 Inability to Pay Cost-Sharing.

The MCO must ensure that no Provider denies Covered Services to an Enrollee because of the Enrollee's inability to pay the cost-sharing. The MCO must ensure that Enrollees can obtain services from other Providers. [42 CFR §447.52]

4.11.5 Cost-Sharing and Residents of Nursing Facility.

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

4.11.6 MCO Waiver of SNBC Medicaid Cost-Sharing.

The MCO has chosen to waive Medicaid cost-sharing for community Enrollees for the term of this Contract. The MCO shall have a uniform policy to assure that the same amounts of cost-sharing for the same types of services are waived for all SNBC community Enrollees. Cost-sharing for the following services will be waived for both SNBC SNP and SNBC non-SNP community Enrollees:

- Nonpreventive visits;
- Non-emergency use of the emergency department;
- Family deductible; and
- Medicaid Prescription drugs (those prescription drugs covered by Medicaid rather than Medicare, for SNBC SNP Medicare Enrollees and prescription drugs for those eligible for Medicaid only).

4.11.7 Notification to Enrollees of Cost-Sharing.

The MCO shall explain the cost-sharing policy in the MCO's Evidence of Coverage, Handbook, and other materials for Enrollees. Unless CMS has approved waiver of payment of cost-sharing by the MCO as an additional benefit in the MCO's Medicare bid process, the MCO shall not offer waiver of cost-sharing as an inducement to enroll nor describe it in any of the MCO's Marketing Materials.

4.11.8 Payment for Medicaid Covered Medicare Cost-Sharing.

The MCO is responsible for payment of Medicaid-covered Medicare cost-sharing where applicable. Medicaid-covered Medicare cost-sharing is included in the rates. The MCO may limit its payment to the provider (for Medicare Part B cost-sharing) to the amount included in the rates paid to the MCO as defined in Minnesota Statutes, §256B.0625, subd. 57.

4.12 MEDICAID MANAGED CARE WITHHOLD.

The STATE shall withhold eight percent (8%) from the basic care SNBC rates. SNBC Medicaid Nursing Facility payments are excluded from the withhold provision. [Minnesota Statutes, §256B.39, subd. 5a]

4.12.1 Return of Withhold Based on Performance.

The Performance-Based withheld funds (shown in section 4.12.5.2(1)), shall be returned only if, in the judgment of the STATE, performance targets in section 4.12.2 are achieved.

4.12.2 Withhold Return Scoring for the 2020 Contract Year.

4.12.2.1 The Performance-Based withheld funds will be returned to the MCO for the Contract Year based on the following performance targets and assigned points:

(1) Repeat Deficiencies on the MDH QA Examination for MHCP, fifteen (15) points.

(2) Compliance with section 6.11 (SNBC Compliance with Service Accessibility Requirements), fifteen (15) points. Compliance means that the MCO will create a process for obtaining updated access information from its provider offices, and the MCO demonstrates that access information continues to be made available to Enrollees and prospective Enrollees as required, and that the MCO provides copies of this information to the STATE.

(3) Maintaining a local or regional stakeholders group as required in section 7.5, fifteen (15) points. The MCO will submit documentation with elements required by the STATE that demonstrates the MCO responds to significant concerns raised by stakeholder group participants.

(4) Annual Dental Visit, age 18-64, fifteen (15) points.

4.12.2.2 The percentage of the MCO's withheld funds to be returned shall be calculated by summing all earned points, dividing the sum by sixty (60), and converting to a percentage. This percentage is referred to as the Withhold Score.

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

4.12.2.4 All measures in section 4.12.2, except for the Repeat Deficiencies on the MDH QA Examination, will be calculated from: 1) encounter data submitted no later than May 31st of the year subsequent to the Contract Year by the MCO to the STATE, pursuant to section 3.16.1; 2) additional data sources approved by the STATE and in the STATE's possession; or 3) as otherwise stated below.

4.12.3 Withhold Data from the STATE

The STATE shall provide data and rates to the MCO on the dental visit withhold measure in 4.12.2.1(4).

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

(a) January preview, 2016 for the previous calendar year;

(b) June final, for the previous calendar year;

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

(d) October preview, for the first nine months of the Contract Year.

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

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

4.12.4 Administrative and Access/Clinical Performance Targets for SNBC.

Detailed descriptions of each withhold measure are provided in the most recent version of the STATE document titled "*2020 Managed Care Withhold Technical Specifications*." These specifications are posted on the DHS Partners and Providers, Managed Care Organizations web site at www.dhs.state.mn.us/dhs16_139763.

4.12.4.1 Repeat Deficiencies on the MDH QA Examination. No partial whole number of points will be assigned if the MCO fails to completely meet this performance target.

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

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

4.12.4.2 Compliance with Service Accessibility Requirements. The MCO will make available to Potential Enrollees and Enrollees the access survey information collected as required in section 6.11. By December 15th of the Contract Year the MCO shall demonstrate compliance with 6.11 below by submitting a detailed survey plan for transportation access to DHS. The MCO shall further demonstrate compliance with 6.11 below by December 15th of 2020 by presenting the results of the survey for transportation, and presenting on 6.11.1 and 6.11.2 at the DHS-led Stakeholder Meeting for Seniors and People with Disabilities in Managed Care. No partial whole number of points will be assigned if the MCO fails to completely meet this performance target.

4.12.4.3 MCO Stakeholder Group for SNBC. The MCO will maintain a local or regional stakeholder group as required in section 7.5. In order to qualify for the withhold, the stakeholder group will meet at least twice per Contract Year. The MCO will submit to the STATE twice per Contract Year, on or before December 15th, documentation in the form of stakeholder meeting agendas, meeting minutes and all other elements required by the STATE that demonstrate the MCO response to significant concerns raised by stakeholder group participants. No partial whole number of points will be assigned if the MCO fails to completely meet this performance target.

4.12.4.4 Annual Dental Visit, age 18-64. The Annual Dental Visit rate must be equal to or greater than ten percent (10%) of the difference between the eighty percent (80%) target and the rate of the year preceding the Contract Year. Partial scoring of a portion of the withhold target points will be awarded commensurate with the achieved increase less than the targeted amount. The percentage of increase will be calculated to the second decimal. The number of points will be awarded on the percentage increase achieved. If the MCO's measurement rate is equal to or greater than the 80% target rate, all assigned points will be awarded.

4.12.5 Return of Withheld Funds for SNBC.

4.12.5.1 For this Contract the total amount of the withheld funds available to be returned (the Withheld Total) shall be calculated as the difference between:

(1) The total Contract Year basic care portion minus NF add-on of the SNBC Plan Reimbursement Amounts to the MCO (as of May 31 of the year subsequent to the Contract Year), divided by 0.92 (92%) and

(2) The total Contract Year basic care portion of the SNBC Plan Reimbursement Amount to the MCO (as of May 31st of the year subsequent to the Contract Year.)

4.12.5.2 The amount of the withheld funds to be returned to the MCO shall be calculated as follows:

(1) The Withheld Total shall be multiplied by 0.625 (5.0 / 8.0) or 62.5% to determine the Performance-Based Total.

(2) The Performance-Based Total shall be multiplied by the Withhold Score, subject to the Loss Limit in 4.12.5.2(3).

(3) The difference between 4.12.5.2(1) and 4.12.5.2(2), the Loss Limit or amount of the unreturned funds that are kept by the STATE shall not exceed five percent (5%) of the Performance-Based Total.

(4) The Withheld Total shall be multiplied by 0.375 (3.0 / 8.0) or 37.5% to determine the Non-Performance-Based Total.

(5) The resulting amount from adding the Performance-Based Total and Non-Performance-Based Total will be returned to the MCO according to section 4.1.3.

4.13 PAYMENT ERRORS.

4.13.1 Report to the STATE of Overpayment of Capitation Payment

The MCO shall report to the STATE within sixty (60) calendar days when the MCO has identified capitation payments or other payments in excess of amounts specified in the Contract. [42 CFR §438.608(c)(3); Minnesota Statutes, §256B.064, subd. 1c]

4.13.2 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.

4.13.3 Payment Error in Excess of $500,000.

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

4.13.3.1 Independent Audit.

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

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

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

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

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

4.13.3.2 Two Year Limit to Assert Claim.

(1) The STATE shall not assert any claim for, seek the reimbursement of, or make any adjustment for any alleged overpayment made by the STATE to the MCO under section 4.1 of this Contract more than two (2) years after the date such payment was actually received by the MCO from the STATE.

(2) The MCO shall not assert any claim for, seek the payment of, or make any adjustment for any alleged underpayment made by the STATE to the MCO under Article 4 of this Contract more than two (2) years after the date such payment was actually received by the MCO from the STATE. The MCO must have filed a timely appeal of risk factors under section 4.13 in order to assert any claims regarding risk adjusted payments.

(3) Payment Offset. When possible these payments shall be offset against or added to future payment made according to Article 4.

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

4.13.4 Payment Error Not in Excess of $500,000.

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

4.13.4.1 One Year Limit to Assert Claim.

(1) The STATE shall not assert any claim for, seek the reimbursement of, or make any adjustment for any alleged overpayment made by the STATE to the MCO under section 4.1 more than one (1) 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 4.13.4.1(3), does not apply to duplicate payments made because of multiple PMIs for the same Enrollee, payments for full months for an Enrollee while Incarcerated, and payments for full months after the death of the Enrollee.

(2) The MCO shall not assert any claim for, seek the payment of, or make any adjustment for any alleged underpayment made by the STATE to the MCO more than one (1) year after the date such payment was actually received by the MCO from the STATE. The MCO must have filed a timely appeal of risk factors under section 4.13 in order to assert any claims regarding risk adjusted payments.

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

4.14 PAYMENT FOR SKILLED NURSING FACILITY/NURSING FACILITY BENEFIT.

4.14.1 100-Day SNF/NF Benefit Period, SNBC-SNP.

The MCO is responsible for services covered under the Medicare Advantage SNF benefit regardless of whether NF liability is indicated on the STATE's Medical Assistance file.

(1) For any Beneficiary who enrolls in the MCO's SNBC product while in a community setting the MCO shall have financial responsibility for Nursing Facility services for one hundred (100) days. The 100 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 MCO enrollment. Both Medical Assistance and Medicare covered days shall be counted toward the 100-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 100 days shall be counted cumulatively. After the 100-day benefit period is expended, the STATE shall assume responsibility for Medical Assistance Nursing Facility Days. The 100-day benefit period may be applied to an individual more than once if the requirements of the 180-day Separation Period are met as specified in section 4.14.7.

(2) The MCO may accrue the following types of days toward the cumulative 100-day benefit period:

(a) Medicare SNF days. Medicare SNF days incurred during the 100-day period may count towards the 100-day benefit period.

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

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

(3) The MCO may not accrue the following types of days toward the cumulative 100-day benefit period for SNBC:

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

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

(c) Institutional SNF or NF days that accrue during a Hospice election period do not count toward the 100-day SNF/NF benefit period. (Institutional room and board for these days is paid by the STATE on a fee-for-service basis.)

(d) Medicare SNF days for the Enrollee incurred prior to the begin date of the 100-day NF benefit do not count toward the 100-day benefit.

(e) Medicare SNF days paid for in full by Original Medicare and other insurance (for example, a Medicare supplement), and for which the MCO paid nothing.

(4) The MCO agrees to waive the Medicare requirement under 42 CFR §409.30 of a three (3) day hospital stay prior to SNF admission for SNBC-SNP Enrollees.

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

(6) The MCO remains liable for the 100-day SNF/NF benefit across Contract Years.

4.14.2 Responsibility for Tracking 100-Day Benefit.

The MCO shall be responsible for tracking accrual of days toward the 100-day SNF/NF benefit period for SNBC Enrollees to whom the benefit applies. During the 100-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 100 days of SNF/NF services, using DHS 4461A. The STATE will verify the information documented by the MCO.

4.14.3 Responsibility for Payment of Medicare SNF Days.

After the one hundred (100) day benefit period for SNBC-SNP is expended, the MCO shall retain responsibility for Medicare SNF days according to Medicare SNF benefit policy.

4.14.4 100-Day SNF/NF Benefit Period. Non-SNP

(1) For any Beneficiary who enrolls in the MCO's SNBC product while in a community setting the MCO shall have financial responsibility for Nursing Facility services for one hundred (100) days. The 100 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 MCO enrollment. Both Medical Assistance and Medicare covered days shall be counted toward the 100-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 100 days shall be counted cumulatively. The MCO shall be responsible for paying any coinsurance for Medicare covered days during the 100 day

benefit period. After the 100-day benefit period is expended, the STATE shall assume responsibility for Medical Assistance Nursing Facility Days. The 100-day benefit period may be applied to an individual more than once if the requirements of the 180-day Separation Period are met.

(2) The MCO may accrue the following types of days toward the cumulative 100-day benefit period:

(a) Medicare SNF days.

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

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

(3) The MCO may not accrue the following types of days toward the cumulative one hundred (100) day benefit period for SNBC:

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

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

(c) Institutional SNF or NF days that accrue during a Hospice election period do not count toward the 100-day SNF/NF benefit period. (Institutional room and board for these days is paid by the STATE on a fee-for-service basis.)

(d) Medicare SNF days for the Enrollee incurred prior to the begin date of the 100-day NF benefit do not count toward the 100-day benefit.

(e) Medicare SNF days paid for in full by Original Medicare and other insurance (for example, a Medicare supplement), and for which the MCO paid nothing.

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

(5) The MCO will remain liable for the 100-day SNF/NF benefit across contract years.

4.14.5 Responsibility for Tracking 100-Day Benefit: Non-SNP.

The MCO shall be responsible for tracking accrual of days toward the 100-day SNF/NF benefit period for SNBC Enrollees to whom the benefit applies. During the 100-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 100 days of SNF/NF services and the STATE will verify the information documented by the MCO. Acceptable documentation shall include a claims record that contains the number of days paid to the Nursing Facility by the MCO. Acceptable documentation shall include a claims record that contains the number of days paid to the Nursing Facility by the MCO. Acceptable documentation shall include but is not limited to the following:

- Provider claims submitted to the MCO for Nursing Facility services;

- Documentation of Medicare covered services, including coinsurance claims for Medicare covered days;
- Internal patient account summaries;
- Service Authorizations if used by the MCO;
- Claim denials for any days billed after the MCO'S 100-day benefit period has ended; or
- Other documentation as agreed upon by the STATE, the MCO and the Nursing Facility.

4.14.6 Responsibility for Payment of Medical Assistance NF Days, SNBC-SNP and Non-SNP.

After the 100-day benefit period is expended for SNBC, the STATE shall assume responsibility for Medical Assistance Nursing Facility Days.

4.14.7 180-Day Separation Period for SNBC-SNP and Non-SNP.

Continuous Separation Period.

(1) If the MCO has already been liable for 100 days of SNF/NF services, then the one hundred eighty (180) day Separation Period is defined as one hundred eighty (180) consecutive Institutional or community days after the MCO has already been liable for 100 days of SNF/NF services. In either case, after this separation period has expired, the MCO shall be liable for a new, distinct 100-day SNF/NF benefit period for any Enrollee who is still community on the last day of the separation period. If an Enrollee becomes institutionalized prior to the end of the separation period, no new SNF/NF Benefit Period is applied.

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

(3) If an Enrollee is hospitalized and/or placed in a Nursing Facility during the 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 180-day Separation Period. If the Enrollee spends more than thirty (30) consecutive days in a hospital and/or Nursing Facility, the counting of the 180-day Separation Period shall begin over again if and when the Enrollee returns to the community.

(4) The STATE shall have the responsibility for tracking the 180-day Separation Period. The MCO shall cooperate with the STATE in verifying the 180-day Separation Period. On a monthly basis, the STATE shall identify SNBC Enrollees with Community payment categories for who the 100 day NF benefit is not in effect. Of these, if the Enrollee is not within a one hundred and eighty (180) day Separation Period, the STATE shall begin a new 100-day NF Benefit Period on the first day of the next available month.

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

4.14.8 Non-Medicare Certified Nursing Facilities.

Enrollees may be admitted for Medicaid-covered services to nursing facilities that do not participate in or accept assignment from Medicare. The STATE will audit such facilities and, if an admission would otherwise have been a Medicare-qualifying stay, the STATE will notify the MCO by e-mail. The MCO will assure that no payment is made to the facility for the first twenty (20) days of such an admission. [Minnesota Statutes, § §256R.05, subd. 2]

4.15 Long Term Care Ineligibility Periods.

The STATE will notify the MCO when an Enrollee has a Long Term Care ineligibility period. As long as the Enrollee remains enrolled in SNBC, the MCO shall be required to reassume financial responsibility for all services covered under SNBC after the LTC ineligibility period has passed. During the LTC ineligibility period payment for Nursing Facility services will be the responsibility of the Enrollee.

4.16 End Stage Renal Disease (ESRD) Payments.

For Enrollees identified by CMS as having ESRD, the MCO will continue to receive the Medicaid capitation rate as appropriate for these Enrollees.

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

4.17.1 The MCO shall pay a care coordination fee to Providers for qualified Enrollees of a certified Health Care Home within the MCO Provider network unless the MCO is using an alternative comprehensive payment arrangement or the Enrollee is attributed to an Integrated Health Partnership (IHP), that is receiving a population-based payment, identified in section 4.18.2(2). The fee schedule for Health Care Homes must be stratified according to the stratification criteria developed by the STATE, pursuant to Minnesota Statutes, §256B.0751 et seq. For Dual Eligible Enrollees, payment will be made for those Enrollees. In addition:

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

(2) If a clinic or clinician is a certified Health Care Home and the MCO has a comprehensive alternative payment arrangement, that includes care coordination and is tied to measures related to patient health, patient experience and cost effectiveness with that clinic or clinician, then upon documentation in accordance with section 11.5.1(11)(b) below, the STATE will exempt the MCO from an additional Health Care Home care coordination fee for that Provider. The MCO is not required to pay both a Health Care Home care coordination fee and a fee based on a more comprehensive payment arrangement.

(3) The MCO is not required to pay both a Health Care Home care coordination fee and a fee based on a more comprehensive payment arrangement.

(4) The MCO is not required to pay a Health Care Home coordination fee if the enrollee is attributed to an IHP that is receiving a population-based payment.

4.18 Integrated Health Partnerships Demonstration for SNBC.

4.18.1 The MCO and the STATE will participate in a quarterly population-based payment and shared savings and losses payment methodology through the Integrated Health Partnerships (IHP) Demonstration with the STATE's contracted IHP Entities in the MCO's provider network, in accordance with Minnesota Statutes, §256B.0755.

4.18.2 The STATE will provide the MCO with the following information:

(1) A list of the STATE's contracted IHP Entities no later than thirty (30) days after the IHP contracts take effect.

(2) Data identifying the MCO's Enrollees that are attributed to a particular IHP Entity at that time for the purposes of the quarterly population-based payments as well as for the shared savings and shared losses payment. The attribution data will include the Enrollee's PMI number, Enrollee name, attribution by IHP Entity, and an indication of whether the IHP is

receiving a population-based payment from the state agency. Attribution data identifying the attributed population will be provided to the MCO:

(a) Thirty (30) days prior to the end of each quarter, and

(b) After the calculation of the interim payment in the second quarter of the year after each performance period and the final payment which occurs no later than fifteen (15) months after the end of each performance period based on dates of service from January 1 through December 31 for each performance period.

(3) (3) For the shared savings and losses payment, the STATE will provide:

(a) Information on the total cost of care for the MCO's attributed Enrollees, including an estimate of the IHP settlement(s) no later than ten (10) days after the end of the Contract Year; and

(b) Subsequently, the STATE will calculate an interim payment and a final payment for the performance periods. The base period total cost of care (TCOC) adjusted for trend and change in risk score from the base period and the performance period risk score, will determine the interim and final adjusted targets respectively. The respective targets will then be compared to the respective interim and final IHP actual observed performance period TCOC to calculate the interim and final payments and ensure that the IHP has met a two percent (2%) minimum performance threshold.

(4) The STATE will notify the MCO in writing of the shared savings for the interim and final payments to be paid to the IHP Entity or Entities; such information shall be held by the MCO as confidential and requests for release of such information and related data shall be referred to the STATE. The MCO shall issue payment to the IHP Entity as identified by the STATE within thirty (30) days from the date of the notification from the STATE.

(5) The STATE will notify the MCO in writing of the quarterly population-based payment amounts to be paid to the IHP Entity or Entities. The STATE will notify the MCO during the settlement process identified under (3) above of any payments due to DHS from the MCO for pre-paid savings included in the population-based payment, for any IHP receiving a shared savings payment.

4.18.3 The STATE will use encounter data and financial data provided by the MCO under sections 3.16.1 and 11.5.1(16), in determining TCOC and quarterly population-based payment. The MCO must ensure the timeliness, accuracy and completeness of the data submitted and shall comply with any actions taken to correct identified issues regarding the data submissions.

4.18.4 If the MCO fails to make the interim or final payments within the time period established by the STATE, the STATE will take appropriate action in accordance with sections 5.4 and 5.5 of the Contract.

4.18.5 The STATE will provide the MCO with reporting twice per year that reflects the costs of the MCO's Enrollees included in an IHP Entity's attributed population relative to the IHP Entity's financial target. This may include, but is not limited to, per member per month costs by service category and risk information.

4.19 PROVIDER INCENTIVE PAYMENTS.

The STATE may make payments for certain Provider incentive programs pursuant to section 7.12.

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ARTICLE. 5 TERM, TERMINATION AND BREACH.

5.1 TERM.

The term of this Contract shall be the Contract Year from January 1, 2020 (Effective Date) through December 31, 2020 (Termination Date). Coverage will begin at 12:00 a.m. on January 1st and end at 11:59:59 p.m. (Central Standard Time) on the Termination Date unless this Contract is: 1) terminated earlier pursuant to section 5.2; or 2) extended through: (a) an amendment pursuant to section 16.1, or (b) automatic renewal pursuant to section 5.1.1; or 3) replaced by a Renewal Contract pursuant to section 5.1.2.

5.1.1 Automatic Renewal.

This Contract will renew for an additional one year term unless the MCO or the STATE provides notice of termination or non-renewal in accordance with this Article. 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 to offer to enter into negotiations for a renewal of this Contract on an annual basis, upon no less than one hundred and twenty (120) days' written notice to the MCO. The MCO has the right to decline the offer to renew this Contract. If the MCO declines this offer to negotiate, this Contract will automatically renew in accordance with section 5.1.1 unless the MCO or the STATE provides notice of termination or non-renewal. If the Parties negotiate and execute a Renewal Contract with the intent that it take effect upon the termination of this Contract on its original or modified Termination Date, this Contract will so terminate and the Renewal Contract will replace it upon the Renewal Contract's effective date

5.1.3 Notice Regarding 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.

5.1.4 Notice to Other Managed Care Organizations of MCO Termination or Service Area Reduction.

If this Contract is terminated by the STATE or MCO, or the Service Area is reduced by the STATE, the STATE will notify any other managed care organization under contract with the STATE for the provision of services covered by this Contract within five (5) business days of the termination or Service Area reduction. This paragraph does not apply to procurement decisions.

5.2 CONTRACT NON-RENEWAL AND TERMINATION.

5.2.1 Notice of Non-Renewal.

5.2.1.1 By the MCO.

(1) 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.

(2) Less Than 150 Days Prior to the End of the Contract. If the MCO provides the STATE written notice prior to the end of the contract term but less than one hundred and fifty (150) days prior to, the Contract will end at 11:59:59 p.m. on the last day of the month which falls one hundred and fifty (150) days from the date the notice is given, unless the parties agree in writing to a different date.

5.2.1.2 By the STATE. The STATE may elect not to enter into negotiations for a renewal of this Contract by providing at least one hundred and twenty (120) days' written notice of non-renewal to the MCO. If the STATE provides the MCO 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 at any time without cause, upon at least one hundred and twenty (120) days' written notice to the MCO, unless CMS terminates its agreement with the SNP, in which case notice to the MCO shall be ninety (90) calendar days.

5.2.3 Termination for Cause.

5.2.3.1 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.

5.2.3.2 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 5.7 prior to termination.

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

(a) Fraudulent action by the MCO;

(b) Criminal action by the MCO;

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

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

(e) Loss of Medicare contractual agreement with CMS

5.2.3.3 Legislative Appropriation. Continuation of this Contract is contingent upon continued legislative appropriation of funds for the purposes of this Contract. If these funds are not appropriated, the STATE will immediately notify the MCO in writing and the Contract will terminate as of 11:59 p.m. on June 30th of the Contract Year.

5.2.4 Contract Termination Procedures.

If the Contract is terminated:

5.2.4.1 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 benefits, at least sixty (60) days in advance of the termination, or immediately as determined by the STATE, if termination is for a material breach listed in section 5.2.3.2(2). Such notice must be approved by the STATE and CMS.

5.2.4.2 The MCO shall assist in the transfer of records and data required to facilitate the transition of care of Enrollees from Network Providers to other Providers, upon request and at no cost to the Enrollee, the STATE, or receiving managed care organization.

5.2.4.3 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.

5.2.4.4 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. See also section 9.6.

5.2.4.5 Written notice can be given by electronic mail, courier service, delivered in person, or sent via U.S. Postal Services certified mail return receipt requested. The required notice periods set forth in Article 5 of this Contract shall be calendar days measured from the date of receipt.

5.2.4.6 Termination under this Article shall be effective on the last day of the calendar month in which the notice becomes effective. Payment shall continue and services shall continue to be provided during that calendar month.

5.3 BREACHES AND DEFICIENCIES.

The STATE and the MCO agree that if the MCO does not perform any of the duties in this Contract, the STATE may, instead of terminating this Contract, enforce one of the remedies or sanctions listed in section 5.5 or section 5.6 at the STATE's option. [42 CFR §§438.700 and 438.702]

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. For the purposes of this Article, the term "breach" shall refer to either deficiency or breach. Concurrent breaches of the same administrative functions may be construed as more than a single breach. Nothing in this article shall be construed as relieving the MCO from performing any contractual duties.

5.3.1 Quality of Services.

If the STATE or CMS finds that the quality of care or services offered by the MCO is materially deficient, the STATE has the right to terminate this Contract pursuant to section 5.2 or to enforce remedies pursuant to section 5.5. [42 CFR §438.708]

5.3.2 Failure to Provide Services.

The MCO shall be subject to one of the remedies listed in section 5.5 or section 5.6 if: a) the MCO fails substantially to provide Medically Necessary items and services that are required to be provided to an Enrollee covered under this Contract; and b) the failure has adversely affected or has a substantial likelihood of adversely affecting the Enrollee. [SSA §1903(m)(3)(B); 42 CFR §438.700(b)(1)]

5.3.3 Misrepresentation

The MCO shall be subject to one of the remedies listed in section 5.5 or 5.6 if the MCO misrepresents or falsifies information that the MCO furnishes to an Enrollee, a Potential Enrollee, providers, the STATE, or CMS. [42 CFR §438.700(b)(4) and (5)]

5.3.4 Discrimination.

The MCO shall be subject to one of the remedies listed in section 5.5 or section 5.6 if the MCO acts to discriminate among Enrollees on the basis of their health status or need for health care services. This includes any practice that would reasonably be expected to discourage enrollment by Beneficiaries whose medical condition or history indicates probable need for substantial future medical services. [42 CFR §438.700(b)(3)]

5.3.5 Physician Incentive Plans.

The MCO shall be subject to one of the remedies listed in section 5.5 or section 5.6 if the MCO fails to comply with the requirements for physician incentive plans described in section 11.8. [42 CFR §438.700(b)(6)]

5.3.6 Considerations in Determination of Remedy.

In determining the remedy or sanction, the STATE may consider as mitigating or enhancing factors, as appropriate, any of the following:

5.3.6.1 The nature and magnitude of the violation, as it relates to this Contract;

5.3.6.2 The number of Potential Enrollees or Enrollees, if any, affected by the breach;

5.3.6.3 The effect, if any, of the breach on Potential Enrollees' or Enrollees' due process rights under this Contract, or Potential Enrollees' or Enrollees' health or access to health services;

5.3.6.4 If only one Potential Enrollee or Enrollee is affected, the effect of the breach on that Potential Enrollee's or Enrollee's health;

5.3.6.5 Whether the breach is an isolated incident or there are repeated breaches of the Contract;

5.3.6.6 Whether and to what extent the MCO has attempted to correct previous breaches; and

5.3.6.7 The economic benefits, if any, derived by the MCO by virtue of the breach.

5.4 NOTICE; OPPORTUNITY TO CURE.

The STATE shall give the MCO reasonable written notice of a breach by the MCO prior to imposing a remedy or sanction under this section. The MCO shall have sixty (60) days to cure the breach from the date it receives the notice of breach or deficiency, unless a longer period is mutually agreed upon to cure the breach if the breach can be cured. In urgent situations, as determined by the STATE, the STATE may establish a shorter time period to cure the breach. The STATE has determined the deficiencies in section 5.5.4 below cannot be cured.

5.5 REMEDIES OR SANCTIONS FOR BREACH.

If the STATE determines that the MCO failed to cure the breach within the time period specified in section 5.4, the STATE may enforce one or more of the following remedies or sanctions which shall be consistent with the factors specified at section 5.3.6. The STATE may impose sanctions until such time as a breach is corrected, or until notification of the correction by the MCO is actually received. The MCO reserves all of its legal and equitable remedies to contest the imposition of a remedy or sanction under this Contract.

5.5.1 Withhold capitation payments or a portion thereof until such time as the breach is corrected to the satisfaction of the STATE.

5.5.2 Monetary payments from the MCO to the STATE in the following amounts, offset against payments due the MCO by the STATE or as a direct payment to the STATE, at the STATE's discretion, until such time as the breach is corrected to the satisfaction of the STATE.

5.5.3 Sanctions in General. The STATE may impose sanctions at the STATE's discretion, in an amount of:

(1) Up to five thousand dollars ($5,000) per day; and/or

(2) The direct and indirect costs to the STATE of an incident or incidents caused by the MCO or its Subcontractor(s), not to exceed two hundred and fifty thousand dollars ($250,000) and/or

(3) For failure to report actions required to be reported to the National Practitioner Data Bank (https://www.npdb.hrsa.gov/), a civil monetary penalty as described in section 9.9.6.6(3). [42 USC §1320a-7e(B)(6)(a)]

5.5.4 Sanctions for Due Process Noncompliance. The STATE may impose a sanction of up to $15,000 for each determination of a deficiency by MDH, during the triennial Quality Assurance Exam or if a deficiency persists at the time of the MDH Mid-cycle Review, for violations of Enrollee rights or due process. For the purposes of this section, violation of due process includes but is not limited to:

(1) Failure to provide an Enrollee under this Contract with timely notice of resolution of a Grievance and/or timely written notice of the resolution of a Standard or Expedited Appeal.

(2) Failure to provide an Enrollee under this Contract with a timely DTR (Notice of Action) for denial of a Standard or Expedited Service Authorization.

5.5.5 Sanctions for Noncompliance with the Restricted Recipient Program (RRP). The MCO will administer and comply with the RRP's rules and policies. The MCO will exercise due diligence to assure that temporary changes in provider designation are only made in appropriate circumstances.

(1) The STATE may impose a sanction of up to $5,000 per Enrollee per occurrence (date of service) for inappropriate payments to non-designated providers and failure to enter appropriate designations into the MMIS system. Prior to imposing the sanction, the STATE will notify the MCO of the payments to non-designated providers.

(2) The MCO will have ten (10) business days to explain the reasoning for the payments. If after reviewing the MCO's explanations, the STATE confirms the payments are inappropriate, the MCO will be held in breach with an opportunity to cure.

(3) If the cure does not rectify noncompliance, including action to prevent repeated breaches, then the $5,000 per Enrollee per occurrence will be imposed.

5.5.6 Suspension of all new enrollment including default enrollment after the date CMS or the STATE notifies the MCO of a determination of a violation of §§1903(m) or 1932 of the SSA, until such time as the breach is corrected to the satisfaction of the STATE. [42 CFR §438.702(a)(4)]

5.5.7 If the MCO does not comply with the Marketing requirements specified in section 3.12.3 of this Contract, the STATE may require the MCO to cease all SNBC Marketing activities until such time as the MCO has complied with section 3.11 of this Contract as defined by the STATE.

5.5.8 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. [42 CFR §438.730]

5.5.9 If the STATE imposes a civil monetary penalty on the MCO for charging premiums or charges in excess of the amounts permitted under section 4.11.2, the STATE will deduct the amount of the overcharge from the civil monetary penalty and require the MCO to ensure its return to the affected Enrollee. [42 CFR §438.704 (c)]

5.5.10 The maximum civil money penalty the State may impose is limited by the general rule and specific limits under 42 CFR §438.704.

5.6 Temporary Management.

In addition to the remedies listed in section 5.5, the STATE shall impose temporary management of the MCO if the STATE finds that the MCO has repeatedly failed to meet the substantive requirements of §§ 1903(m) or 1932 of the SSA. If the STATE enforces a remedy for breach under this section, the STATE shall provide the MCO written notice of the remedy to be imposed.

When imposing this sanction the STATE shall:

5.6.1 Allow Enrollees the right to terminate enrollment without cause and notify the affected Enrollees of their right to disenroll;

5.6.2 Not delay the imposition of temporary management to provide a hearing; and

5.6.3 Maintain temporary management of the MCO until the STATE determines that the MCO can ensure that the sanctioned behavior will not recur. [42 CFR §438.706(b)]

5.7 Mediation Panel.

The MCO may request the recommendation of a three (3) person mediation panel within five (5) business days of receiving notice of a remedy or sanction, or a notice of termination under section 5.2.2 or 5.2.3 from the STATE. The mediation panel shall meet, accept both written and oral argument as requested, and make its recommendation within fifteen (15) days of receiving the request for recommendation unless the parties mutually agree to a longer time period. The Commissioner shall resolve all disputes after taking into account the recommendations of the mediation panel and within three (3) business days after receiving the recommendation of the mediation panel.

- For non-CBP MCOs, the panel shall be composed of one designee of the Minnesota Council of Health Plans, one designee of the Commissioner of Human Services, and one designee of the Commissioner of Health.
- For CBP MCOs, the three-person mediation panel shall be composed of one designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one person selected jointly by the designee of the commissioner of human services and the designee of the Association of Minnesota Counties. The State shall not require that contractual disputes between county-based purchasing entities and the State be mediated by a panel that includes a representative of the Minnesota Council of Health Plans. [Minnesota Statutes, §256B.69, subd. 3a(d) and (f)]
- After the hearing, the STATE must give the MCO written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of termination. [42 CFR §438.710(b)(2)(ii)]

5.8 Penalties for Encounter Data Errors.

The STATE must ensure that enrollee encounter data is validated for accuracy and completeness under 42 CFR §438.242. In pursuit of this goal, the STATE will impose penalties upon the MCO for failure to timely correct encounter data errors as required under section 3.16.2.1. The notice and opportunity to

cure requirements in section 5.4 are not applicable to encounter data quality errors and penalties assessed under section 5.8.

5.8.1 Penalty Timeframes and Amounts.

5.8.1.1 A first penalty of $1.00 (one dollar) will be assessed if an encounter data line or header with an identified error is not corrected by the end of the first calendar quarter following the calendar quarter in which the line was originally processed.

5.8.1.2 A second penalty of $1.00 (one dollar) will be assessed if the same encounter line error is not corrected by the end of the second calendar quarter following the calendar quarter in which the line was originally processed.

5.8.1.3 A third penalty of $1.00 (one dollar) will be assessed if the same encounter line error is not corrected by the end of the third calendar quarter following the calendar quarter in which the line was originally processed.

5.8.1.4 A fourth penalty of $1.00 (one dollar) will be assessed if the same encounter line error is not corrected by the end of the fourth calendar quarter following the calendar quarter in which the line was originally processed.

5.8.2 Penalty Limit.

The sum of penalties related to encounter data errors under this section shall not exceed one tenth of one percent (0.1%) of Capitation Payment for the Contract Year. The STATE will reconcile the amount of penalties for the Contract Year against the total Capitation Payments for the Contract Year at the end of the first, second, third and fourth quarters following the end of the Contract Year. If necessary, the STATE will refund to the MCO any amount in excess of one tenth of one percent (0.1%) of Capitation Payment.

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ARTICLE. 6 BENEFIT DESIGN AND ADMINISTRATION.

All terms of Article 6 apply unless otherwise stated. Medicare services provided by the MCO shall comply with the requirements of this Article.

6.1 SNBC COVERED SERVICES.

The MCO shall provide, or arrange to have provided, to all SNBC Enrollees comprehensive preventive, diagnostic, therapeutic and rehabilitative and long term care services as defined in Minnesota Statutes, Chapters 245G, 256 and 256B and corresponding Minnesota Rules, Parts 9505.0170 to 9505.0475; and Home Care Services as defined in Minnesota Statutes, §§ 256B.0651 through 256B.0656, excluding personal care assistant services, home care nursing services and personal care Qualified Professional supervision services as authorized by Minnesota Statutes, §256B.69, subd. 28.

Except for sections 6.1.41 (Prescription Drugs and Over-the-Counter Drugs) and 6.1.53 (Transplants) or as otherwise specified in the Contract, these services shall be provided to the extent that the above law and rules were in effect on the Effective Date of this Contract. Services in sections 6.1.41 and 6.1.53 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 SNBC SNP Enrollees, Medicare benefits as provided pursuant to 42 USC §1395, and Specialized Medicare Advantage (MA) plans for Special Needs Enrollees, known as Special Needs Plans (SNPs), established by the Medicare Modernization Act of 2003, pursuant to the MCOs MA/SNP contract with CMS.

All covered benefits, except for services mandated by state or federal law, are subject to determination by the MCO of Medical Necessity as defined in section 2.112. For purposes of this paragraph, mandated services do not include the benefits described in Minnesota Statutes, Chapter 245G, 256, and 256B.

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

6.1.1 Acupuncture Services.

Acupuncture services are covered when provided by a licensed acupuncturist or by another Minnesota licensed practitioner for whom acupuncture is within the practitioner's scope of practice and who has specific acupuncture training or credentialing. [Minnesota Statutes, §256B.0625, subd. 8f]

6.1.2 Advanced Practice Nurse Services.

Advanced Practice Nurse Services provided by nurse practitioners, nurse anesthetists, nurse midwives and clinical nurse specialists are covered. [Minnesota Statutes, §256B.0625, subds. 11 and 28]

6.1.3 Cancer Clinical Trials.

Routine care that is provided through the administration or performance of items or services that are: 1) required as part of the protocol treatment in a high-quality cancer Clinical Trial; 2) usual, customary and appropriate to the Enrollee's condition; and 3) would be typically provided to that Enrollee when cared for outside of a Clinical Trial, including those items or services needed for the prevention, diagnosis or treatment of adverse effects and complications of the protocol treatment are covered. [Minnesota Statutes, §62Q.526]

6.1.4 SNBC Care Management Systems.

The MCO shall be responsible for the Care Management of all Enrollees. This system is designed to ensure access to (and for SNBC SNP Enrollees, to integrate the delivery of Medicare and Medicaid) preventive, primary, acute, post-acute, rehabilitative, behavioral health, specialty and pharmacy services. The MCO's Care Management system must be designed to coordinate the

provision of services to its Enrollees and must promote and assure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, the provision of culturally appropriate care, and fiscal and professional accountability. The MCO shall also coordinate the services it furnishes to its Enrollees with the services an Enrollee receives from any other MCO. [42 CFR §438.208]

At a minimum, the MCO's Care Management system must incorporate the following elements:

6.1.4.1 The MCO shall ensure that the Care Management system has the capacity to coordinate the provision of all Medicaid acute and basic care services, including services which the MCO subcontracts to a Care System, and for SNBC-SNP Enrollees to integrate the delivery of Medicare and Medicaid services;

6.1.4.2 Protocols to facilitate annual physician visits for Enrollees for primary and preventive care;

6.1.4.3 Procedures for the provision of an individual needs assessment, diagnostic assessment, the development of an individual treatment plan as necessary based on the needs assessment, the establishment of treatment objectives, the monitoring of outcomes, and a process to ensure that treatment plans are revised as necessary. These procedures must be designed to accommodate the specific cultural and linguistic needs and disability conditions of the MCO's Enrollees.

6.1.4.4 Services which include procedures for promoting rehabilitation of Enrollees following acute events, and for ensuring smooth transitions and coordination of information among acute, sub-acute, rehabilitation, home care and other settings;

6.1.4.5 Strategies that ensure that all Enrollees and/or authorized family members, representatives, or guardians are involved in treatment planning, and consent to the medical treatment;

6.1.4.6 Procedures and criteria for making referrals to specialists and sub-specialists;

6.1.4.7 Procedures for coordinating care for American Indian Enrollees;

6.1.4.8 Procedures for coordinating with Individual Education Plan (IEP), an Individual Family Service Plan (IFSP) or Individual Community Support Plan (ICSP) including services and supports;

6.1.4.9 Procedures for coordinating with care coordination and services provided by children's mental health collaboratives and family services collaboratives, and adult county mental health initiatives;

6.1.4.10 Procedures for coordinating with county social services and Case Management systems, and;

6.1.4.11 Transitional care for Children between the ages of eighteen (18) and twenty-one (21) who require ongoing services as they transition to adult programs covered under this Contract.

6.1.5 SNBC Case Management System.

The MCO must make available a Case Management system that meets the special needs of SNBC Enrollees. This system will include:

6.1.5.1 Partnership with Enrollee. The MCO shall ensure that any Case Management services provided through the SNBC program will work in partnership with the Enrollee and/or authorized family members or alternative decision makers, and Primary Care physicians in consultation with any specialists caring for the Enrollee, to develop and provide services and to assure consent to the medical treatment or service.

6.1.5.2 Health Risk Assessment. MCO shall conduct a health risk assessment of each member's health needs within the first sixty (60) calendar days of enrollment and annually thereafter.

(1) In the event of a large transfer of enrollees into the MCO with the same initial enrollment date and if the MCO determines that meeting the timelines indicated in this section cannot be met, the MCO may submit a transition plan to DHS, for review and approval, indicating the timeline in which they expect to be able to conduct this initial assessment required for new enrollees.

(2) The health risk assessment may be conducted through mailed surveys, email, phone and/or face-to-face contacts. If the MCO does not conduct all initial health risk assessments face-to-face, the MCO shall establish written criteria, policy and procedures, identification processes, schedules and timelines for follow up face-to-face visits for all Enrollees, based on Enrollee's needs and health conditions and service status as indicated in 6.1.5.6 below.

(3) The risk assessment shall include questions designed to identify health risks and chronic conditions, including but not limited to: 1) activities of daily living, 2) risk of hospitalizations, 3) need for primary and preventive care, 4) behavioral health needs, 5) rehabilitative services, and 6) protocols for follow up to assure that physician visits, additional assessments or Case Management interventions are provided when indicated.

(4) Use of the health risk assessment component of the STATE's MnCHOICES tool by the MCO will meet the requirements of this section and will become mandatory when MnCHOICES is implemented.

(5) The MCO or its designee shall enter the ADL information collected through the initial health risk assessment or the refusal of the health risk assessment into MMIS according to section 3.15 until such time MnCHOICES is implemented and this information is processed automatically.

6.1.5.3 Use of STATE-Approved Assessment System for Health Risk Assessment. By a date determined by the STATE and with at least ninety (90) days' notice, and provided required training and testing have been provided, the MCO is required to utilize the STATE-approved assessment system (MNCHOICES) for the health risk assessment.

6.1.5.4 Nurse Line. The MCO will maintain telephone access to registered nurse consultation for members on a 24-hour, seven-day-per-week basis. RNs staffing the nurse line must be familiar with communication devices and methods common among people with disabilities and trained in working with chronic and disabling conditions.

6.1.5.5 Transition to Senior Product. The MCO will have written protocols for identifying, contacting, and educating members who are within ninety (90) days of age 65 to facilitate the transition from SNBC to the Minnesota Senior Care Plus (MSC+) or the Minnesota Senior Health Options (MSHO) program.

6.1.5.6 Case Management Protocols. The MCO will have written protocols for access to Case Management services for members requiring assistance in accessing services, including members who require intensive Case Management due to serious health conditions. The protocol will provide for a range of Case Management services from telephone consultation to face-to-face visits or intensive ongoing intervention based on defined criteria.

(1) At least annually, the MCO must offer all Enrollees who are not on a waiver a face-to-face visit to assess their needs. MCO case managers and navigators used by the MCO will

have experience working with people with disabilities, primary care, nursing, behavioral health, social services and/or community based services.

(2) To help avoid possible conflicts of interest, the MCO shall not use a Case Management system in which the entity providing Case Management has a financial interest in housing and may be in a position to directly influence an Enrollee's housing or employment, except when the MCO can demonstrate such entity is the only willing and qualified entity available in the geographic area.

(3) MCOs will train all case managers/navigators in the use and referral parameters for home care and behavioral health services covered by the MCO and relevant linkages to FFS. Case Management will be provided and/or supervised by qualified professionals. For the purpose of this section, a qualified professional means a social worker, licensed social worker, registered nurse, physician assistant, nurse practitioner, public health nurse or a physician.

(4) When the MCO receives request or identifies a need for intensive case management by a county, health care provider, family member or Enrollee the MCO must respond to that request within one (1) business day.

(5) The MCO must have clinical consultation services available to identity the health care needs of the Enrollee and develop a care plan that appropriately addresses the individual's health care needs.

6.1.5.7 Notification of Contact Persons.

(1) For new Enrollees, if the name of a case manager or navigation assistant is not provided upon initial enrollment, the MCO must provide each Enrollee with a phone number of a contact person knowledgeable about the SNBC program, that a member can call for assistance in transitioning to managed care, including assistance in accessing medications and services that require prior authorization.

(2) When a case manager or navigation assistant is assigned to an Enrollee, the MCO or its Subcontractor must provide the name and telephone number of the individual within ten (10) days of assignment or change in assignment.

(3) The MCO will have a process in place which assists Providers, county staff, family members or others who are calling the MCO requesting the identification of a member's current case manager or navigation assistant and contact information. This process must be efficient and not require the callers to make multiple phone calls to find the requested information.

6.1.5.8 Management of Disability Related Conditions. The MCO will have fast track intervention strategies and Care Management protocols for management of disability related conditions common among Enrollees with disabilities (for example, skin breakdown and urinary tract infection).

6.1.5.9 Self Management Materials and Education. The MCO will develop or obtain and distribute self management materials and education programs to enrollees with disability related conditions common among persons with disabilities.

6.1.5.10 Communication and Coordination with Counties and Providers.

(1) The MCO will establish and maintain written communication protocols for communications with county social service agencies, community agencies, behavioral health homes, nursing homes, residential and home care providers involved in providing care under fee-for-service to SNBC Enrollees. Such protocols will include HIPAA compliant electronic communication vehicles.

(2) The MCO telephone intake system for taking referrals for advanced level of case management will not require the county, health care provider, family member or Enrollee to complete a written document.

(3) If referral is being made to an entity where the information is not already available, prior to referral of the Enrollee to the county for waiver services, the MCO must submit to the county a summary of the Enrollee's strengths and needs, and services the MCO has authorized to meet the Enrollee's identified needs.

(4) The MCO will communicate with lead agencies on the authorization of Medical Assistance home care services using the State form #5841, "Managed Care Organization/Lead Agency Communication Form- Recommendation for State Plan Home Care Services."

(5) Communications include the transfer of an Enrollee from one MCO to another MCO or Local Agency in the event an Enrollee is disenrolled from the MCO, using the Lead Agency HCBS Case Management Transfer Form, DHS-6037 as provided by the STATE.

(6) When an MCO refers an Enrollee to the county for evaluation for HCBS services, the MCO will provide a copy of the health risk assessment conducted under 6.1.26. The MCO agrees to work with the care coordination workgroup to develop communication process in consultation with the counties. The STATE will provide the process to the stakeholder groups.

6.1.5.11 Coordination with the Local Agency. Referrals and/or coordination with county social service staff will be required when the Enrollee is in need of the following services:

(1) Pre-petition screening,

(2) Preadmission screening for HCBS,

(3) County Case Management for HCBS,

(4) Child protection,

(5) Court ordered treatment,

(6) Case Management and service providers for people with developmental disabilities,

(7) Relocation service coordination;

(8) Adult protection,

(9) Assessment of medical barriers to employment,

(10) STATE medical review team or social security disability determination,

(11) Working with Local Agency social service staff or county attorney staff for Enrollees who are the victims or perpetrators in criminal cases.

6.1.5.12 The MCO shall coordinate with Local Agency human service agencies for assessment and evaluation related to judicial proceedings. If the MCO determines that an assessment is required in order for the Enrollee to receive these services, the MCO is responsible for payment of the assessments, unless the requested assessment has been paid for by a MCO within the previous one hundred and eighty (180) days.

6.1.5.13 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.

6.1.5.14 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 USC §300ff-21 to 300ff-29 and Public Law 101-381, Section 2.

6.1.5.15 Advance Directive Planning. The MCO shall inform members of resources available for advance directive planning based on individual Enrollee needs and cultural considerations.

6.1.5.16 Hospital In-reach Community-based Service Coordination (IRSC).

(1) The MCO will cover in-reach community-based service coordination that is performed through a hospital emergency department for an Enrollee who has frequented a hospital emergency department for services three or more times in the previous four consecutive months.

(2) IRSC will also include a Child or young adult up to age twenty-one (21) with SED who has frequented a hospital emergency room two or more times in the previous consecutive three months or been admitted to an inpatient psychiatric unit two or more times in the previous consecutive four months, or is being discharged to a shelter.

(3) The in-reach service coordination will include performing an assessment to address an Enrollee's mental health, substance use, social, economic, and housing needs, or any other activities targeted at reducing the incidence of emergency room and other non-medically necessary health care utilization and to provide navigation and coordination for accessing the continuum of services to address the Enrollee's needs. For a Child with SED, this also includes arranging for these community-based services prior to discharge. In-reach community based service coordination shall seek to connect frequent users with existing covered services including but not limited to, targeted case management, waiver case management, or care coordination in a health care home, and as relevant, children's therapeutic services and supports, crisis services, and respite care.

6.1.5.17 Officer-involved, community-based care coordination pursuant to Minnesota Statutes, §256B.0625, subd. 56a, is not covered under this Contract. The MCO must cooperate with case managers for Enrollees who are receiving officer-involved, community-based care coordination.

6.1.6 Child and Teen Checkups.

The MCO agrees to provide, or arrange to provide, Child and Teen Checkup (C&TC) screenings to each Enrollee under age twenty-one (21). [42 USC §1396d(r)]

6.1.6.1 Specific C&TC components are 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. [42 CFR §441.56 through 441.62]

6.1.6.2 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 according to the age-related periodicity schedule, as above. A C&TC visit is not considered complete unless it includes a HIPAA-compliant referral code which must be included on the encounter claim.

6.1.6.3 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 deficits due to physical or Mental Illness conditions discovered by the screening services, which are mandatory or optional Medical Assistance-covered services under 42 USC §1396d(a) and 42 USC §1396d(r)(5). Diagnostic services

include up to three maternal depression screenings that occur during a pediatric visit for a child under age one. The STATE recommends the initial maternal screening within the first month after delivery, with a subsequent screen suggested at the four month visit.

6.1.6.4 The STATE agrees:

(1) 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.

(2) To work with the MCO on policy issues and process improvements regarding C&TC during the Contract Year.

6.1.7 Chiropractic Services.

Chiropractic services are covered up to the service limits described in Minnesota Statutes §256B.0625, subd. 8e. The MCO may require Service Authorization for chiropractic visits exceeding twenty-four (24) visits in a year. Minnesota Statutes §256B.0625, subd. 8e; Minnesota Rules, Part 9505.0245]

6.1.8 Circumcisions.

Only circumcisions that are Medically Necessary are covered. [Minnesota Statutes, §256B.0625, subd. 3f.]

6.1.9 Clinic Services.

Clinic services are covered. [Minnesota Statutes, §256B.0625, subd. 4.]

6.1.10 Community Health Worker Services.

CHW services are covered. [Minnesota Statutes, §256B.0625, subd. 49.]

6.1.11 Community Medical Response Emergency Medical Technician Services.

Community EMT services are covered. Community EMT services include post-discharge visits, after discharge from a hospital or skilled nursing facility, when ordered by a treating physician; and safety evaluation visits when ordered by a primary care provider in accordance with an Enrollee's care plan. [Minnesota Statutes, §256B.0625, subd. 60a.]

6.1.12 Community Paramedic Services.

Community paramedic services include health assessments, chronic disease monitoring and education, medication compliance, immunizations and vaccinations, laboratory specimen collection, hospital discharge follow-up care, and minor medical procedures approved by the ambulance medical director. Services provided by certified community paramedics must be a part of a care plan ordered by a Primary Care Provider in consultation with the ambulance medical director. The care plan must ensure that the services provided by the certified community paramedics are coordinated with other community health providers and local public health agencies, and are not duplicate services, including home health and waiver services. Certified community paramedics providing services to Enrollees receiving care coordination must be in consultation with the providers of the care coordination. [Minnesota Statutes, §256B.0625, subd. 60]

6.1.13 Dental Services.

Pursuant to Minnesota Statutes, §256B.0625, subd. 9, dental services include the following:

6.1.13.1 Medical Assistance covers dental services for children and pregnant women that are medically necessary. The following guidelines also apply:

(1) Posterior fillings are paid at the amalgam rate;

(2) Application of sealants once every five years per permanent molar for children only; and

(3) Application of fluoride varnish once every six months, and

(4) Orthodontia is eligible for coverage for children only, and in limited circumstances.

6.1.13.2 Services for adults who are not pregnant are limited to the following:

(1) Comprehensive exams, limited to once every five years;

(2) Periodic exams, limited to one per year;

(3) Limited exams;

(4) Bitewing x-rays, limited to one per year;

(5) Periapical x-rays;

(6) Panoramic x-rays, limited to one every five years, except 1) when medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma; or 2) once every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;

(7) Prophylaxis, limited to one per year;

(8) Application of fluoride varnish, limited to one per year;

(9) Posterior fillings, all at the amalgam rate;

(10) Anterior fillings;

(11) Endodontics, limited to root canals on the anterior and premolars only;

(12) Removable prostheses, each dental arch limited to one every six years;

(13) Replacement of removable prostheses if misplaced, stolen or damaged due to circumstances beyond the Enrollee's control;

(14) Replacement of a partial prosthesis if the existing prosthesis cannot be modified or altered to meet the Enrollee's dental needs;

(15) Reline, rebase or repair of removable prostheses (dentures and partials);

(16) Oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;

(17) Palliative treatment and sedative fillings for relief of pain;

(18) Full-mouth debridement, limited to one every five years.

6.1.13.3 In addition to the services specified in section 6.1.13.2 above, the following services for adults are covered, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:

(1) Periodontics, limited to periodontal scaling and root planing once every two years;

(2) General anesthesia; and

(3) Full-mouth survey once every five years.

6.1.13.4 In addition to the services specified in 6.1.13, the following services for adults are covered:

(1) House calls or extended care facility calls for on-site delivery of covered services;

(2) Behavioral management when additional staff time is required to accommodate behavioral challenges and sedation is not used;

(3) Oral or IV sedation, if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center; and

(4) Prophylaxis, in accordance with an appropriate individualized treatment plan, but no more than four times per year.

(5) The MCO may not require Service Authorization for the services in (1) through (3) above. [Minnesota Statutes, §256B.0625, subd. 9, (f)]

6.1.13.5 Services provided by advanced dental therapists and dental therapists when provided within the scope of practice identified in Minnesota Statutes, §§150A.105 and 150A.106 are covered.

6.1.14 Treatment of End Stage Renal Disease (ESRD).

ESRD services are covered.

6.1.15 Early Intensive Developmental and Behavioral Intervention (EIDBI) Services.

The EIDBI benefit provides early intensive intervention to Enrollees under twenty-one (21) years of age with an autism spectrum disorder (ASD) or a related condition. This benefit must provide coverage for a comprehensive, multidisciplinary evaluation, ongoing progress monitoring, and medically necessary early intensive treatment of ASD or a related condition. [Minnesota Statutes, §256B.0949]

6.1.15.1 EIDBI Definitions.

(1) ASD or a related condition means either autism spectrum disorder (ASD) as defined in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or a condition that is found to be closely related to ASD, as identified under the current version of the DSM, and meets all of the following criteria:

(a) Is severe and chronic;

(b) Results in impairment of adaptive behavior and function similar to that of a person with ASD;

(c) Requires treatment or services similar to those required for a person with ASD; and

(d) Results in substantial functional limitations in three core developmental deficits of ASD: social interaction; nonverbal or social communication; and restrictive, repetitive behaviors or hyper-reactivity or hypo-reactivity to sensory input; and may include deficits or a high level of support in one or more of the following domains: Self-regulation; Self-care; Behavioral challenges; Expressive communication; Receptive communication; Cognitive functioning; or Safety.

(2) Qualified EIDBI Provider means a provider as described in Minnesota Statutes, §256B.0949, subd. 15.

(3) Qualified Supervising Provider means a provider as described in Minnesota Statutes, §256B.0949, subd. 15, (a).

6.1.15.2 EIDBI interventions are individualized, intensive treatments based in behavioral and developmental sciences consistent with best practices on effectiveness. Interventions must address the Enrollee's medically necessary treatment goals and must be targeted to develop, enhance, or maintain the individual developmental skills of a Child with ASD or a related condition to improve functional communication, social or interpersonal interaction, behavioral challenges and self-regulation, cognition, learning and play, self-care and safety. Intervention must be provided by a qualified EIDBI provider and supervised by a Qualified Supervising Provider (QSP).

6.1.15.3 EIDBI services are provided by qualified providers to both children and their families.

6.1.15.4 The MCO and its Providers must use the same procedure codes, modifiers and units of service, for EIDBI Services as published by the STATE on its public web site.

6.1.15.5 EIDBI Services must be provided by qualified EIDBI providers and include:

(1) Comprehensive Multi-Disciplinary Evaluation (CMDE) means a comprehensive evaluation of an Enrollee to determine medical necessity of EIDBI services. The CMDE must include:

(a) An assessment of the Enrollee's developmental skills, functional behavior, needs and capacities based on direct observation of the person which must be administered by a qualified CMDE provider who is a physician, advanced practice registered nurse or licensed mental health professional identified by the STATE; and

(b) Medical information from the Enrollee's physician or advanced practice nurse and may also include input from family members, child care providers or other caregivers, as well as any medical or assessment information from other licensed professionals such as rehabilitation or habilitation therapists, licensed school personnel, or other mental health professionals;

(2) Individual Treatment Plan (ITP) means the person-centered, individualized written plan of care that integrates and coordinates person and family information from the CMDE for a person who meets medical necessity for the EIDBI benefit. ITP development and ITP progress monitoring is development of the initial, annual, and progress monitoring of an ITP. ITP development and ITP progress monitoring documents, provides oversight and ongoing evaluation of a person's treatment and progress on targeted goals and objectives and integrates and coordinates the person's and the person's legal representative's information from the CMDE and ITP progress monitoring.

(3) EIDBI Observation and Direction is the clinical direction and oversight of EIDBI services by the QSP, Level I treatment provider, or Level II treatment provider, including developmental and behavioral techniques, progress measurement, data collection, function or behaviors, and generalization of acquired skills for the direct benefit of the Enrollee. EIDBI intervention observation and direction informs any modification of the methods to support the outcomes in the ITP. EIDBI intervention observation and direction provides a real-time response to EIDBI interventions to maximize the benefit to the Enrollee.

(4) Family/Caregiver Training and Counseling is specialized training and education provided to a family/caregiver to assist with the child's needs and development.

(5) Coordinated Care Conference is a voluntary face-to-face meeting, with the Enrollee and family to review the CMDE or ITP progress monitoring and to integrate and coordinate services across providers and service-delivery systems to develop the ITP.

6.1.16 Family Planning Services.

Family planning services are covered.

6.1.16.1 The MCO must comply with the sterilization consent procedures required by the federal government, and must ensure open access to Family Planning Services. [42 CFR §431.51 and Minnesota Statutes, §62Q.14] The MCO may not restrict the choice of an Enrollee as to where the Enrollee receives the following services [42 CFR §441.20 and Minnesota Statutes, §62Q.14]:

- Voluntary planning of the conception and bearing of children, provided that this clause does not refer to abortion services;
- Diagnosis of infertility, including counseling and services related to the diagnosis (for example Provider visit(s) and test(s) necessary to make a diagnosis of infertility and to inform the Enrollee of the results);

- Testing and treatment of a sexually-transmitted disease; and
- Testing for AIDS and other HIV-related conditions.

6.1.16.2 The MCO may require family planning agencies and other Providers to refer Enrollees back to the MCO under the following circumstances for other services, diagnosis, treatment and follow-up:

- Abnormal pap smear/colposcopy;
- Infertility treatment;
- Medical care other than Family Planning Services;
- Genetic testing; and
- HIV treatment.

6.1.17 Gender Confirmation Surgery.

Gender confirmation surgery is covered.

6.1.18 Health Homes.

6.1.18.1 Behavioral Health Home (BHH). Behavioral Health Home services consistent with Minnesota Statutes, §256B.0757 are covered. BHH services are a set of services designed to integrate Primary Care, behavioral health, and social/community services for children with emotional disturbance (including severe emotional disturbance) and adults with serious mental illness (including serious and persistent mental illness).

(1) Eligibility for BHH services. Eligibility for BHH services is determined by a Mental Health Professional employed or under contract with a STATE-certified BHH. [Minnesota Statutes, §256B.0757, subd. 2, (b)]

(2) STATE's Duties. The STATE has established an initial and recertification process to require that providers comply with all system, clinical infrastructure, billing and service delivery requirements established in the BHH certification criteria. Minnesota Statutes, §256.0757, subds. (4) and (8).

(3) MCO Duties. The MCO shall take the following actions to avoid duplication of care coordination activities for Enrollees receiving BHH services.

(a) The MCO must provide the STATE with a designated MCO contact for BHH-related matters to facilitate the sharing of member information and coordination of services for Enrollees receiving BHH services.

(b) The MCO must coordinate with BHHs within the MCO's Service Area as specified in the BHH-MCO "*Roles and Responsibilities*" template document developed by the STATE, with input from managed care organizations, and posted on the DHS web site. The MCO and a BHH are permitted to make additions to the Roles and Responsibilities document by mutual agreement. For example, the MCO may wish to add MCO-specific information about care management programs and resources available that BHHs may leverage to fulfill their requirements. If the MCO and a BHH choose to make additions to the Roles and Responsibilities document, the MCO must provide a copy of the modified document to the STATE within sixty (60) days' of the change. At a minimum, the Roles and Responsibilities document must demonstrate that the BHH provider performs the required BHH services, and that the MCO performs the requirements of sections 6.1.4 and 6.1.5.

(4) Payment.

(a) The BHH care engagement rate established by the STATE is paid a maximum of six months per Enrollee's lifetime. The MCO shall work with the STATE who is responsible for ensuring that the care engagement payment, together with FFS and other managed care organization payments, does not exceed six payments per Enrollee lifetime. The STATE will provide the MCO with a report of an Enrollee's prior use of the BHH care engagement rate. If a report indicates the lifetime limit was exceeded for an Enrollee, the MCO will be required to recoup any care engagement payments it made that exceeds the lifetime limit and process such recoupment within sixty (60) days' of receiving the report.

(b) The MCO shall pay a certified BHH provider the ongoing standard care BHH rate established by the STATE for each month after the completion of the six month BHH care engagement rate.

(c) The MCO may not use an alternative comprehensive payment arrangement for BHH services.

(5) The following services are considered to be duplicative of BHH services:

(a) Adult Mental Health Targeted Case Management/Children's Mental Health Targeted Case Management;

(b) Assertive Community Treatment/Assertive Community Treatment for Youth; or

(c) Health Care Home care coordination services; and

(d) Vulnerable Adult Developmental Disability Targeted Case Management.

(6) The MCO shall pay any BHH provider certified by the STATE within the MCO's Service Area that provides BHH services to the MCO's Enrollee

6.1.18.2 Certified Health Care Home. Enrollees with complex or chronic health conditions may access services through a Health Care Home that meets the certification criteria listed in Minnesota Rules, parts 4764.0010 through 4764.0070.

(1) Health Care Home services include pediatric care coordination for children with high-cost medical or high-cost psychiatric conditions who are at risk of recurrent hospitalization or emergency room use for acute, chronic, or psychiatric illness and who are not receiving care coordination services through another service.

(2) Care coordination services must be provided in accordance with Minnesota Statutes, §256B.0751, subd. 9.

6.1.18.3 Certified Community Behavioral Health Clinics (CCBHC). CCBHC services are covered. CCBHCs provide a set of services designed to integrate primary care, behavioral health, and substance use disorder services (SUDs), social/community services for children with emotional disturbance (including SED) and services for adults with SMI (including SPMI). [Minnesota Statutes, Statutes §245.735 and Public Law Number 113-93, §223]

(1) Authorization for CCBHC services is determined by a Mental Health Professional who is employed or under contract with a STATE-certified CCBHC, using a form and format determined by the STATE. Assessment shall be in accordance with Minnesota Statutes, §245.735 and Public Law Number 113-93, section 223.

(2) The STATE has established an initial and recertification process to ensure that Providers comply with all system, clinical infrastructure, and billing and service delivery requirements established in the CCBHC certification criteria. [Minnesota Statutes, §245.735 and PL 113-93, §223]

(3) Expanded Covered Services, per the MHCP Provider Manual.

(a) The MCO shall cover the following services as expanded services for Enrollees who would not be eligible to receive the services other than under the CCBHC program, at the rates identified for each service below.

(b) Clinical care consultation expanded to cover adults at the same rate that is applicable to children;

(c) Family psychoeducation expanded to cover adults at same rate that is applicable to children;

(d) Mental health certified peer supports expanded beyond ARMHS and CTSS to cover other individuals receiving CCBHC services;

(e) Certified Peer Recovery Specialist expanded to cover eligible Enrollees at the same rate that is applicable to Level I mental health peer supports;

(f) The MCO shall cover functional assessment and treatment plan development for all Enrollees receiving CCBHC services, beyond the scope of ARMHS and CTSS.

(g) The MCO shall cover CCBHC initial evaluations as required by CCBHC criteria, paid at the same rate that is applicable to brief diagnostic assessments.

(h) Ambulatory withdrawal management by a CCBHC is not covered under this Contract.

(4) CCBHC Payment.

(a) Effective for dates of services beginning September 1, 2019 or upon federal approval and notice by the STATE, in addition to billed claims from CCBHCs, the MCO shall be responsible for a supplemental CCBHC payment as directed by the STATE. The MCO will submit encounter claims to the STATE following the technical specifications in section 3.16.1.

(b) The STATE or its agent will calculate the amount due to the CCBHC under the prospective payment system required in Minnesota Statutes, §256B.0625, subd. 5m, as added by Minnesota Laws 2019, SS1, Ch. 9, Art. 6, sec. 52.

(c) The STATE will provide a monthly report of additional payments or recoveries based upon the encounter claims submitted applicable to each CCBHC.

(d) The MCO shall provide the additional payment to the CCBHC, or complete the recovery, within thirty (30) days of the date the report is available to the MCO in its MNITS mailbox. In the event that the MCO disagrees with the supplemental CCHBC payment, the MCO shall pay the CCBHC the supplemental amount, then resolve the payment according to section 4.13.

6.1.19 Hospice Services.

Hospice services include services provided by a Medicare certified hospice agency or, when a Medicare certified hospice agency is not available, services that are equivalent to those provided in a Medicare-certified hospice agency. For purposes of this section, “equivalent” means that the Enrollee will be provided with a hospice election process that is similar to the hospice election process used by a Medicare-certified hospice agency; and will be provided with the same choice and amount of services that would be available through a Medicare certified hospice agency.

An Enrollee under age twenty-one (21) who elects to receive hospice services does not waive coverage for services that are related to the treatment of the condition for which a diagnosis of terminal illness has been made. [Minnesota Statutes, §256B.0625, subd. 22]

6.1.20 Housing Stabilization Services

As of July 1, 2020, housing stabilization services will be covered.

6.1.21 Inpatient Hospital Services.

Inpatient Hospital Services are covered. Coverage for Inpatient Hospitalization services shall not exceed the actual semi-private room rate, unless a private room is determined to be Medically Necessary by the MCO. [Minnesota Statutes, §256B.0625, subd. 1]

6.1.22 Interpreter Services.

The MCO shall provide sign and spoken language qualified interpreter services that assist Enrollees in obtaining services covered under this Contract, to the extent that interpreter services are available to the MCO or its Subcontractor when services are delivered. The intent of the limitation, above, is that the MCO should not delay the delivery of a necessary health care service, even if through all diligent efforts, no interpreter is available. This does not relieve the MCO from using all diligent efforts to make interpreter services available. [45 CFR §92.4]

6.1.22.1 Coverage for face-to-face oral language interpreter services shall be provided only if the oral language interpreter used by the MCO is listed in the registry or roster established under Minnesota Statutes, §144.058.

6.1.22.2 Interpreter services shall be provided at no cost to the Enrollee.

6.1.22.3 The MCO is not required to provide an interpreter for activities of daily living in residential and institutional facilities. The MCO is not responsible to provide interpreter services for services provided through fee-for-service. The MCO is responsible to provide an interpreter for medical services provided by the MCO outside of the residential facility and the *per diem* institutional facilities under this Contract.

6.1.23 Laboratory, Diagnostic and Radiological Services.

Laboratory, diagnostic and radiological services are covered. [Minnesota Statutes, §256B.0625, subd. 10]

6.1.24 Long Term Services and Supports (LTSS)

6.1.24.1 Specific Home Care Services for SNBC.

(1) Home health agency services require qualifying documentation of a face-to-face encounter. This includes: an encounter with a physician, advanced practice nurse, or physician assistant, that must be related to the primary reason the Enrollee requires home health services and must occur within the ninety (90) days before or the thirty (30) days after the start of services. The encounter may occur through telemedicine. For home health services requiring authorization, including prior authorization, home health agencies must retain the qualifying documentation of a face-to-face encounter as part of the Enrollee's health service record, and submit the qualifying documentation to the MCO upon request. [Minnesota Statutes, §256B.0653, subd 7]

(2) Home health services may be provided to the Enrollee at the Enrollee's residence or in the community where normal life activities take the Enrollee, other than a hospital or long-term facility, or as specified in Minnesota Statutes, §256B.0625, subd. 6a and subd. 7.

(3) Home care policy is in the Community-Based Services Manual (CBSM).

(4) For Enrollees who are ventilator-dependent, limits described in this section do not apply; the limits for these Enrollees are as described in Minnesota Statutes, §256B.0652, subd. 7.

(5) If the MCO requires Service Authorization for Home Care Services, it shall comply with section 6.13. The MCO's authorization process and criteria for any Home Care Services

must be in a format specified by the STATE, and made available on the MCO's web site with a corresponding copy on the DHS public web site.

(6) Tribal Assessments and Service Plans. The MCO will accept the results of home care assessments, reassessments and the resulting service plans developed by tribal assessors for Tribal Community Members as determined by the tribe. Referrals to non-tribal providers for home care services resulting from the assessments must be made to providers within the MCO's network. This applies to home care services requested by Tribal Community Members residing on or off the reservation.

(7) See also section 6.1.5.10 regarding coordination with lead agencies about home care services.

(8) For this Contract, Home Care Services include:

(a) See section 6.7.3 for PCA, QP, and Home Care Nursing (HCN) Services.

(b) Skilled Nursing visits provided by a Medicare certified home health agency, up to the service limit described in Minnesota Statutes, §256B.0652, subd. 4, and §256B.0653, subd. 4, including telehomecare skilled nurse visits. A onetime perinatal visit does not require the face-to-face encounter described in section 6.1.24.1(1).

(c) Home Health Aide services provided by a Medicare certified home health agency, up to the service limit described in Minnesota Statutes, §256B.0652, subd. 4, and §256B.0653, subd. 3, and for Dual Eligible persons, for Medicare, as long as the Enrollee meets Medicare criteria.

(d) 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.

(e) Medical Equipment and Supplies pursuant to section 6.1.28.

(9) Home Care Access Standards. The MCO shall contract with or otherwise develop arrangements such as single case agreements to provide an adequate home care network. The rates paid for home care shall be not less than the STATE-established rate.

6.1.24.2 Skilled Nursing Facility (SNF) Services.

Medical or nursing care services provided in a Medicare certified Nursing Facility that are furnished under physician orders are covered. The benefit requires that:

(1) Require the skills of technical or professional personnel, and

(2) Are provided either directly by or under the supervision of such personnel and are required and provided on a daily basis as required under Section 1819 of the SSA and 42 CFR §§409.32 and 409.33.

(3) Medicare covers inpatient care in a SNF for up to 100 days of post-hospital care for each Benefit Period. Also see section 4.14, Payment for Skilled Nursing Facility/Nursing Facility Benefit for SNBC SNF/NF Benefit.

(4) The MCO agrees to waive the Medicare requirement under 42 CFR §409.30 of a three (3) day hospital stay prior to SNF admission for SNBC-SNP Enrollees.

6.1.25 Nursing Facility Contracting.

6.1.25.1 The MCO may develop contracts and negotiate rates with Nursing Facilities that are not less than the STATE-established rates. 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.

6.1.25.2 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-service at this level.

6.1.26 LTSS Access Report.

(1) Home Care Access. By April 15 of the Contract Year, the MCO shall report to the STATE whether the MCO's network for home care, by service, is smaller than the entire network of DHS-enrolled providers in the MCOs service area. For each service provider type for which the MCO's available network is smaller than the entire network of DHS-enrolled providers, the MCO must describe how the model meets Generally Accepted Community Standards, including:

(a) How the MCO ensures that Enrollees have a choice of providers, comparable access, high quality services, expertise for special needs, and

(b) The option for an Enrollee in need of services to reside in or near his or her home community. [42 CFR §438.68(b)(2)]

(2) NF Access. By April 15 of the Contract Year, the MCO shall report to the STATE whether they have developed a contracted network of nursing facilities. If the MCO's available network is smaller than the entire network of DHS-enrolled nursing facilities in the MCO's service area, the MCO must describe how the network meets Generally Accepted Community Standards, including

(a) How the MCO ensures choice of Providers, comparable access, high quality services, expertise for special needs, and

(b) The option for an Enrollee in of need of services to reside in or near his or her home community.

6.1.27 Pre-Admission Screening (PAS) for SNBC.

The MCO must establish that the Enrollee's PAS tool completed by Senior LinkAge Line indicates a risk of Nursing Facility admission or current need for Nursing Facility level of care (LOC) to ensure that each Enrollee eligible to receive Nursing Facility benefits under section 6.1.34(20)(a) of this Contract is screened. If the MCO cannot establish LOC the MCO shall refer the Enrollee to the Local Agency for an in-person visit. The MCO or its Subcontractor will complete the Preadmission Screening process on Enrollees entering Nursing Facilities who have been identified through a referral from the Senior LinkAge Line. [Minnesota Statutes, §256.975, subdivisions 7a, 7b, and 7c]

All Long Term Care Consultation (LTCC) functions under Minnesota Statutes, §256B.0911 shall remain the responsibility of the Local Agency.

6.1.27.1 Upon receipt of a PAS referral from the Senior LinkAge Line® for an Enrollee the MCO shall complete the PAS process as follows:

(1) For Enrollees living in the community, currently on a home and community based waiver for people with disabilities, regardless of age, and entering a Nursing Facility, the Local Agency will complete required tasks associated with admission of a waiver participant, including the provision of OBRA Level I screening documentation to the admitting nursing facility.

(2) For Enrollees living in the community, currently not on a home and community based waiver and entering a Nursing Facility, regardless of age, the MCO must complete a pre-admission screening using the most current PAS tool and Level of Care Criteria tool, including the provision of OBRA Level I screening documentation to the admitting nursing facility.

(3) For Enrollees living in an institution and entering a Nursing Facility, the MCO must complete a pre-admission screening using the most current PAS tool and Level of Care Criteria tool upon receipt of the PAS referral from the Senior LinkAge Line®, including the provision of OBRA Level I screening documentation to the admitting nursing facility, and referral to the local agency for OBRA Level II, when applicable, as outlined in 6.1.26.3.

6.1.27.2 When the MCO identifies an Enrollee for admission for whom the MCO has not received a PAS referral from the Senior LinkAge Line®:

(1) For Enrollees living in the community and on a home and community based waiver for people with disabilities, regardless of age, the MCO must contact the Local Agency who must complete required tasks associated with admission of a waiver participant, including the provision of OBRA Level I screening documentation to the admitting nursing facility.

(2) For Enrollees living in the community and currently not on a home and community based waiver for people with disabilities, regardless of age, the MCO must complete preadmission screening using the most current PAS tool and Level of Care Criteria, including the provision of OBRA Level I screening documentation to the admitting nursing facility.

(3) For Enrollees living in an institution and entering a Nursing Facility, regardless of age, the MCO must conduct a preadmission screening using the most current PAS tool and Level of Care Criteria tool, including the provision of OBRA Level I screening documentation to the admitting nursing facility.

6.1.27.3 The MCO must refer Enrollees to the Local Agency to conduct OBRA Level II evaluations for developmental disability or mental illness as determined upon completion of the OBRA Level I screening.

(1) For Developmental Disabilities OBRA Level II evaluations, the MCO will refer the Enrollee to the county of financial responsibility. The county of financial responsibility will provide the nursing facility and the MCO with documentation of the OBRA Level II evaluation and recommended plan of care.

(2) For Mental Health evaluations, the MCO will refer the Enrollee to the county or tribe where the Enrollee is located. The Local Agency or mental health authority will conduct OBRA Level II Mental Health evaluations when indicated and provide the Nursing Facility and the MCO with documentation of the OBRA Level II evaluations and recommended plan of care.

6.1.27.4 Pre-admission screenings must be entered by the MCO or its delegate into the MMIS system for Enrollees not currently receiving services on a home and community based waiver.

6.1.27.5 The MCO must inform all Enrollees that they may qualify for services under the State's HCBS or Home Care Services and refer the Enrollee to the county of residence for assistance.

6.1.27.6 The MCO must work with/communicate to the local agency using DHS Form #5181 prior to an Enrollee entering a Nursing Facility, to allow the Local Agency to send out to the Enrollee Form #3543 regarding request for payment of long term care services.

6.1.27.7 The MCO must obtain approval from the STATE for any Enrollee under twenty-one (21) years of age before payment to a Nursing Facility. For Enrollees under the age of 21, an in-

person assessment must occur before admission, regardless of projected length of stay or admission source.

The MCO will refer to the county of location for a MnCHOICES assessment and the county of location is responsible to complete the in-person assessment and forward information to the STATE for an approval of nursing facility admission. The MCO must obtain a copy of the STATE's approval of admission before paying the nursing facility. [Minnesota Statutes, §256B.0911, subd. 4d (f)]

6.1.27.8 Level of Care Change Notice. The MCO shall provide notice of changes in eligibility due to a nursing facility LOC determination to each affected Enrollee at least thirty (30) days before the effective date of the change. When nursing facility services will be terminated as a result of a determination at reassessment that an Enrollee no longer meets Nursing Facility LOC, the date of termination of services must be at least thirty (30) days from the issuance of a DTR. [Minnesota Statutes §144.0724, subd. 12, (b)]

When a DTR for this reason is issued, the MCO must also provide the Enrollee with:

(1) How to obtain further information on the changes;

(a) How to receive assistance in obtaining other services;

(2) A list of community resources; and

(3) Appeal rights.

6.1.28 Medical Emergency, Post-Stabilization Care, and Urgent Care Services.

6.1.28.1 Medical Emergency, Post-Stabilization Care and Urgent Care services must be available twenty-four (24) hours per day, seven days per week, including a 24-hour per day number for Enrollees to call in case of a Medical Emergency. [Minnesota Statutes, §62Q.55]

6.1.28.2 Except for Critical Access Hospitals, visits to a hospital emergency department that are not an emergency, Post-Stabilization Care or Urgent Care may not be reimbursed as emergency or urgent care services. [Minnesota Statutes, §256B.0625, subd. 1a] However, the MCO may reimburse such services as outpatient clinic services and may reimburse for a triage at a triage rate when only triage services are provided.

6.1.28.3 For Medical Emergency services the MCO shall not:

(1) Require an Enrollee to receive a Medical Emergency or Post-Stabilization Care Service within the MCO's network, see also section 6.15. [42 CFR §438.114 (c)(1)];

(2) Require Service Authorization as a condition of providing a Medical Emergency service [Minnesota Statutes, §62M.07, (b)];

(3) Limit what constitutes a Medical Emergency condition based upon lists of diagnoses or symptoms [CFR § 438.114(d)(1)(i)];

(4) Refuse to cover Medical Emergency services based upon the emergency department Provider, hospital, or fiscal agent not notifying the MCO of an Enrollee's screening and treatment within ten (10) calendar days of the Enrollee requiring Emergency Services [42 CFR §438.114(d)(1)(ii)];

(5) Refuse to cover services if a representative of the MCO instructed the Enrollee to seek Medical Emergency services [42 CFR §438.114(c)(1)(ii)(B)];

(6) Hold the Enrollee liable for payment concerning the screening and treatment necessary to diagnose and stabilize the condition [42 CFR §438.114(d)(2)]; nor

(7) Prohibit the treating Provider from determining when the Enrollee is sufficiently stabilized for transfer or discharge. The determination of the treating Provider is binding on the MCO for coverage and payment purposes. [42 CFR §438.114(d)(3)]

6.1.28.4 Post-Stabilization Care Services

The MCO is responsible for Post-Stabilization Care Services when [42 CFR §438.114(e), referring to 42 CFR §422.113(c)]:

(1) The services are Service Authorized; the services are provided to maintain the Enrollee's stabilized condition within one (1) hour of a request to the MCO for Service Authorization of further Post-Stabilization Care Services; the MCO could not be contacted; the MCO did not respond to a Service Authorization within one (1) hour; or the MCO and treating Provider are unable to reach agreement regarding the Enrollee's care, and an MCO physician is not available for consultation.

(2) The MCO shall continue coverage until: 1) an MCO Provider assumes responsibility for the Enrollee's care; 2) the MCO reaches an agreement with the treating Provider concerning the Enrollee's care; 3) the MCO has contacted the treating Provider to arrange for a transfer; or 4) the Enrollee is discharged.

6.1.29 Medical Equipment and Supplies.

Medical equipment and supplies includes durable and non-durable medical equipment (DME) and supplies that 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. This also includes ancillary supplies necessary for the appropriate use of such equipment. All safeguards and provider standards apply.

6.1.29.1 Covered medical supplies, equipment, and appliances suitable for use in the home or in the community where normal life activities take the Enrollee, are those that are Medically Necessary and ordered by a physician; and

(1) An order or prescription for medical supplies, equipment, or appliances must meet the requirements in 42 CFR §440.70, including:

(a) Documented in a plan of care that is reviewed and revised as medically necessary by the physician at least once a year;

(b) The initiation of medical equipment requires a documented face-to-face encounter that must be related to the primary reason the Enrollee requires medical equipment and that must occur no more than six (6) months prior to the start of services. The face-to-face encounter may be conducted by one of the following: a physician, a nurse practitioner or clinical nurse specialist, or a physician assistant. The face-to-face encounter may occur through telemedicine. [Minnesota Statutes, §256B.0625, subd. 31, (g)]

(2) Provided to the Enrollee at the Enrollee's own place of residence that is not a nursing facility or ICF, or in the community where normal life activities take the Enrollee;

(3) Not covered in the facility *per diem* rate, but must be modified for the recipient, or the item is necessary for the continuous care and exclusive use of the Beneficiary to meet the Beneficiary's unusual medical need according to the written order of a physician, will be separately reimbursed by the MCO; and

(4) 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. [Minnesota Rules, Part 9505.0287, subp. 3]

(5) Electronic tablets used as an augmentative and alternative communication system are covered. [Minnesota Statutes, §256B.0625, subd. 31(e)]

6.1.29.2 The MCO must assure that its contracted vendors of durable medical equipment are enrolled as a Medicare provider, unless exempted by the STATE. [Minnesota Statutes, §256B.0625, subd. 31, (b) and (c)]

6.1.29.3 The MCO must assure access to a wide array of DME providers providing a broad array of specialty items commonly used by people with disabilities to meet the needs of Enrollees.

6.1.29.4 The MCO must have written protocols for expedited authorization processes and alternative delivery mechanisms that might include home repair, or home delivery for wheel chair batteries, oxygen, respiratory equipment and other items that are critical to maintaining a stable and maximum level of functioning for members with disabilities.

6.1.30 Medical Equipment, Assistive Technology.

6.1.30.1 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 (also 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.

6.1.30.2 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.

6.1.30.3 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.

6.1.30.4 Adequate Supplies. The MCO shall make best efforts to ensure that assistive technology suppliers under contract will have adequate supplies for timely administration of services and supplies available to meet the needs of SNBC Enrollees.

6.1.30.5 Substitution. The Enrollee or Legal Representative 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.

6.1.30.6 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, recycled or refurbished equipment, or non-traditional suppliers of such things as batteries and tires.

6.1.31 Medical Transportation Services.

Medical transportation for obtaining emergency or nonemergency covered services is covered. The most appropriate and cost-effective forms of transportation are covered. The MCO must assure sufficient network capacity to serve the medical transportation needs of people with disabilities, ensure minimal wait times for transportation, and must implement written protocols for expedited authorization of services. [Minnesota Statutes, §256B.0625, subd. 18]

Medical transportation services includes:

6.1.31.1 Ambulance services required for Medical Emergency care as defined in Minnesota Statutes, §144E.001, subd. 2. The MCO shall require that providers bill ambulance services

according to Medicare criteria. Non-emergency ambulance services shall not be paid as emergencies. [Minnesota Statutes, §256B.0625, subd. 17a]

6.1.31.2 Non-emergency transportation (NEMT) services include the following modes of transportation. [Minnesota Statutes, §256B.0625, subd. 17, (i)]

See section 6.1.31 for transportation services covered by Local Agencies.

(1) Enrollee reimbursement, including mileage reimbursement provided to Enrollees who have their own transportation, or mileage reimbursement to family or an acquaintance who provides transportation;

(2) Volunteer transport by volunteers using their own vehicle;

(3) Unassisted transport when provided by a taxicab or public transit. If a taxicab or public transit is not available, the Enrollee may receive transportation from another NEMT provider;

(4) Assisted transport for an Enrollee who requires assistance from the NEMT provider;

(5) Lift-equipped/ramp transport for an Enrollee who is dependent on a mobility device and requires an NEMT provider with a vehicle containing a lift or ramp;

(6) Protected transport for an Enrollee who has received prescreening that determines other forms of transportation inappropriate, and who requires a provider with a protected vehicle that is not an ambulance or police car and has safety locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver; and

(7) Stretcher transport for an Enrollee who must be transported in a prone or supine position.

6.1.32 Non-emergency Transportation that is Not the Responsibility of the MCO.

6.1.32.1 The Local Agency shall remain responsible for reimbursing the Enrollee or the Enrollee's driver for mileage to non-emergency Covered Services, and meals and lodging as necessary.

6.1.32.2 The MCO shall not be responsible for providing NEMT when the Enrollee has access to private automobile transportation (not including Volunteer Drivers) to a non-emergency service covered under this Contract.

6.1.32.3 The MCO shall not be responsible for providing NEMT when an Enrollee chooses a non-emergency Primary Care Provider that is located more than thirty (30) miles from the Enrollee's home, or when an Enrollee chooses a Specialty Care Provider that is located more than sixty (60) miles from the Enrollee's home, unless the MCO approves the travel because the non-emergency primary or specialty care required is not available within the specified distance from the Enrollee's residence. [Minnesota Statutes §256B.0625, subd. 17, (g)]

See also section 6.11.2 regarding access to services for enrollees with special needs, including cultural needs or language barriers.

6.1.32.4 The Local Agency shall provide NEMT for Enrollees' access to Out of Network providers of medical services located outside of Minnesota that have been approved by the MCO.

6.1.33 Mental Health Services in General.

Mental health services shall be provided by qualified mental health professionals. In approving and providing mental health services, the MCO shall use a definition of Medical Necessity that is no more restrictive than the definition of Medical Necessity found in Minnesota Statutes, §62Q.53 or described in section 2.112.

6.1.33.1 Compliance with the Mental Health Parity and Addiction Equity Act of 2008. Pursuant to section 9.18 below, MCOs shall offer mental health services in compliance with the Mental Health Parity Rule. [42 CFR §438.900 through 438.930]

6.1.33.2 Payments for Certain Mental Health Services. Physician assistants under the supervision of a physician certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry, may bill for medication management and evaluation and management services provided to enrollees in inpatient hospital settings and in outpatient settings after the licensed physician assistant completes 2,000 hours of clinical experience in the evaluation and treatment of mental health consistent within their authorized scope of practice, defined in Minnesota Statutes, §147A.09, with the exception of performing psychotherapy, diagnostic assessments, or providing clinical supervision. [Minnesota Statutes, §256B.0625, subd. 28a]

6.1.34 Adult Mental Health Services.

Mental health services should be directed at the treatment of the mental illness of the Enrollee and at rehabilitation of the Enrollee in the least restrictive clinically appropriate setting. Services include [Minnesota Statutes, §§256B.0622, 256B.0623, 256B.0624, and 245.462]:

(1) Diagnostic assessment, psychological testing, and explanation of findings to rule out Mental Illness, or establish the appropriate Mental Illness (MI) diagnosis in order to develop the individual treatment plan. All assessments must include the direct assessment of the Enrollee. The MCO will require behavioral health Providers performing diagnostic assessments to provide:

(a) A screening for all adult Enrollees upon initial access of behavioral health services for the presence of co-occurring Mental Illness and substance use disorder using a screening tool of the Providers' choice, but must meet the following criteria:

i) Reading grade level of no more than 9th grade;

ii) Easily administered and scored by a non-clinician;

iii) Tested in a general population at the national level;

iv) Demonstrated reliability and validity;

v) Documented sensitivity of at least seventy percent (70%) and overall accuracy of at least seventy percent (70%); and

vi) Predicts a range of diagnosable major Mental Illnesses such as affective disorders, anxiety disorders, personality disorders, and psychoses, if a Mental Illness screening tool; predicts alcohol disorders and drug disorders, especially dependence, if a substance use screening tool; and both of the above, if a combined screening tool.

(b) Preferred criteria for screening tools, but not required, include:

i) Short duration of screening process taking no more than ten (10) minutes or having ten (10) or fewer items per scale;

ii) Widely used with adults; and

iii) Tool can be used in either interview or self-report format.

(c) A screening for all Enrollees 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 6.1.33(1)(a) or use one of the approved following nationally recognized screening tools on the IDDT web page: https://mn.gov/dhs/partners-and-providers/policies-procedures/adult-mental-health/.

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

(3) Residential and non-residential crisis response and stabilization services, including mental health mobile crisis intervention services. [Minnesota Statues, §256B.0624]

(4) Intensive Rehabilitative Mental Health Services (IRTS) provided during a short-term stay in an intensive residential treatment setting. [Minnesota Statutes, §256B.0622];

(5) Assertive Community Treatment (ACT). [Minnesota Statutes, §256B.0622, subd. 2 and in conjunction with federal rules and regulations, and with the MHCP Provider Manual;

(6) Forensic Assertive Community Treatment although similar to traditional ACT teams, includes the additional following elements: a) a goal of preventing arrest; b) receiving referrals from criminal justice providers (for example, Department of Corrections transition release planners, local jails and mental health courts), and; c) integration of probation personnel in treatment integration of probation personnel in treatment (for example, Ramsey County corrections supervisors and supervising agents);

(7) Adult Rehabilitative Mental Health Services (ARMHS) for Enrollees age eighteen (18) or older, which includes parenting skills services [Minnesota Statutes, §256B.0623];

(8) Certified Peer Specialist Services may be made available to Enrollees receiving IRTS, ACT, or ARMHS; or crisis stabilization and mental health mobile crisis intervention services [Minnesota Statutes, §256B.0615];

(9) Day treatment. [Minnesota Statutes, §256B.0625, subd. 23, Minnesota Rules, Parts 9505.0370 through 9505.0372 and the MHCP Provider Manual];

(10) Partial hospitalization. [Minnesota Rules, parts 9505.0370 through 9505.0372 and the MHCP Provider Manual];

(11) For IRTS, ACT, ARMHS, Day Treatment and Partial Hospitalization services identified in sections 6.1.32 (4) through (10) above, the MCO shall require its providers to use the Level of Care Utilization System (LOCUS) or another level of care tool recognized nationally with prior approval by the STATE. When determining eligibility and making referrals for these services, the LOCUS must be used in conjunction with a completed diagnostic assessment and functional assessment that reflects the Enrollee's current mental health status;

(12) Individual, family, group therapy and multiple family group psychotherapy, including counseling related to adjustment to physical disabilities or chronic illness;

(13) Inpatient treatment, including extended psychiatric inpatient hospital stay;

(14) Outpatient mental health treatment services according to Minnesota Rules, parts 9505.0370 through 9505.0372 and the MHCP Provider Manual;

(15) Health and Behavior Assessment/Intervention under a physician's order to assess an Enrollee's psychological status in relation to a medical diagnosis, or in determining treatment. If further evaluation is required to determine a mental illness or emotional disturbance, a mental health diagnostic assessment is required. See http://www.dhs.state.mn.us/main/dhs16_138236;

(16) Neuropsychological assessment, and neuropsychological rehabilitation and/or cognitive remediation training for Enrollees with a diagnosed neurological disorder who can benefit from cognitive rehabilitation services [Minnesota Rules, Parts 9505.0370 through 9505.0372 and the MHCP Provider Manual];

(17) Medication management according to Minnesota Rules, parts 9505.0370 through 9505.0372 and the Minnesota Health Care Programs Provider Manual;

(18) Travel time for mental health Providers who provide community-based mental health services covered by the MCO in the community at a place other than their usual place of work [Minnesota Statutes, §256B.0625, subd. 43, as amended by Laws of Minnesota, SS1 of 2019, Ch. 9, Art. 6, sec. 55];

(19) Mental health services that are otherwise covered by Medical Assistance as direct face-to-face services may be provided via two-way interactive video with exceptions noted in the MHCP Provider Manual. The telemedicine method must be medically appropriate to the condition and needs of the Enrollee;

(20) Consultation provided by a psychiatrist, a psychologist, or an advanced practice registered nurse certified in psychiatric mental health, a licensed independent clinical social worker or licensed marriage and family therapist to Primary Care Providers including pediatricians where relevant. 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 [Minnesota Statutes, §256B.0625, subd. 48];

(21) Mental health outpatient treatment benefits consistent with DHS guidelines and protocols for dialectical behavior therapy (DBT) for Enrollees who meet the eligibility criteria consistent with DHS guidelines for admission, continued treatment and discharge. [Minnesota Rules, parts 9505.0370 through 9505.0372 and the MHCP Provider Manual]

(22) Adult Mental Health Targeted Case Management (AMH-TCM). The MCO shall make available to Enrollees AMH-TCM services to adults with Serious and Persistent Mental Illness (SPMI). [Minnesota Statutes, §§ 245.461 to 245.486 and §256B.0625, subd. 20; and Minnesota Rules, Parts 9520.0900 to 9520.0926 ("Rule 79")].

(a) Upon notification from a mental health crisis response team, the MCO shall make available within one (1) business day information on the assigned AMH-TCM provider or entity of an Enrollee receiving services from Crisis Response Services providers within the MCO provider network.

(b) The MCO may offer substitute models of AMH-TCM services to Enrollees who meet SPMI criteria with the consent of the Enrollee, if the substitute model includes all four activities that comprise the CMS definition for targeted case management services in 42 CFR §440.169. These activities include:

i) Comprehensive assessment of the Enrollee to determine the need for any medical, educational, social or other services. The LOCUS is not required in determining eligibility for AMH-TCM. However it is required as part of AMH-TCM services, consistent with section 6.1.33(11) above to complete the LOCUS as it relates to the responsibilities of the case manager in assessment, planning, referral and monitoring of all mental health services;

ii) Development of a specific care plan that: is based on the information collected through the assessment; specifies the goals and actions to address the medical, social, educational, and other services needed by the Enrollee; includes activities such as ensuring the active participation of the Enrollee, and working with the Enrollee (or the Enrollee's authorized health care decision maker) and others to develop those goals; and identifies a course of action to respond to the assessed needs of the Enrollee.

iii) Referral and related activities to help the Enrollee obtain needed services including activities that help link the Enrollee with medical, behavioral, social, and

educational Providers; community services; or programs and services available for providing additional needed services.

iv) Monitoring and follow-up activities, including necessary Enrollee contact to ensure the care plan is implemented, and adequately addresses the Enrollee's needs. These activities or contact, may be with the Enrollee, his or her family members, Providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure the following conditions are met: services are being furnished in accordance with the Enrollee's care plan; services in the care plan are adequate; and if there are changes in the needs or status of the Enrollee, necessary adjustments must be made to the care plan and to service arrangements with Providers.

(c) All AMH-TCM services must meet the following quality standards:

i) Assure adequate access to AMH-TCM for all eligible Enrollees. [Minnesota Rules, Parts 9520.0900 to 9520.0903]

1. The MCO agrees to work with the STATE to provide adequate access to AMH-TCM. This includes adhering to the case manager average caseload standard as specified in Minnesota Rules, part 9520.0903, subpart 2, in order to attend to the outcomes specified for case management services as specified in Minnesota Rules, Part 9520.0905.

2. The STATE acknowledges that AMH-TCM Providers may provide services to Enrollees for multiple MCOs and FFS, and agrees to monitor caseload ratios and will provide feedback to the MCOs regarding the caseload ratios of all contracted Case Management Providers.

ii) Provide face-to-face contact with the Enrollee at least once per month, or as appropriate to Enrollee need. [Minnesota Rules, Part 9520.0914, subpart 2., B]

(d) Case managers for AMH-TCM services must meet the qualifications and supervision requirements listed in Minnesota Statutes, §245.462, subds. 4 (b) through (f), and 4(a), and Minnesota Rules, Part 9520.0912. Case manager associates for AMH-TCM services must meet the qualifications and supervision requirements listed in Minnesota Statutes, §245.462, subds. 4 (g) and (h).

6.1.35 Children's Mental Health Services.

All Mental Health Professional services for Children up to age twenty-one (21), unless otherwise indicated, must 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 and psychological testing, and explanation of findings to rule out MI or establish the appropriate MI 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 screen all adolescent Enrollees upon initial access of behavioral health services for the presence of co-occurring mental illness and substance use disorder using screening tools on the IDDT web page: https://mn.gov/dhs/partners-and-providers/policies-procedures/adult-mental-health/:

(2) Sub-acute psychiatric care for Children under age twenty-one (21).

(3) Children's Therapeutic Services and Supports (CTSS) to age twenty-one (21). [Minnesota Statutes, §256B.0943, subds. 1, 2, 6 and 9], including:

(a) Individual, family and group psychotherapy, and psychotherapy for crisis;

(b) Individual, family, or group skills training;

(c) Crisis assistance;

(d) Mental health behavioral aide services;

(e) Direction of a mental health behavioral aide;

(f) Mental health service plan development as defined in Minnesota Statutes §256B.0943, subd. 1(p); and

(g) Day treatment services.

(4) Intensive Treatment in Foster Care provides specific required service components to children with mental illness residing in foster family settings [Minnesota Statutes, §256B.0946]:

(a) Psychotherapy provided by a mental health professional or a clinical trainee;

(b) Crisis assistance;

(c) Individual, family, and group psychoeducation services provided by a mental health professional or a clinical trainee;

(d) Clinical care consultation provided by a mental health professional or a clinical trainee; and

(e) Service delivery payment requirements include:

i) A qualified clinical supervisor must supervise the treatment;

ii) Each Child receiving treatment services must receive an extended diagnostic assessment within thirty (30) days of enrollment in this service, unless there is a previous extended diagnostic assessment that is still accurate;

iii) Each previous and current mental health, school, and physical health treatment provider must be contacted to request documentation of treatment and assessments received and incorporate the information into the diagnostic assessment, team consultation, and treatment planning review process;

iv) Each Child receiving treatment must be assessed for a trauma history and the treatment plan must document how the assessment results will be incorporated into treatment;

v) The Child's individual treatment plan must be reviewed, evaluated, and signed every ninety (90) days using the team consultation and treatment planning process, or if there is a significant change in functioning using the team consultation and treatment planning process;

vi) Care consultation must be provided per the individual treatment plan.

vii) Crisis assistance plan completed within ten (10) days of initiating services and must demonstrate coordination with local/regional mobile crisis intervention team. The Child must have access to clinical phone support 24 hours per day, seven days per week.

viii) Services must be delivered and documented at least three (3) days per week, equaling at least six (6) hours of treatment per week, unless reduced units of service are specified in the treatment plan as part of transition or a discharge plan.

ix) Location of service delivery is in the Child's home, day care setting, school, or other community-based setting.

x) Treatment must be developmentally and culturally appropriate for the Child.

xi) Services must be delivered in continual collaboration and consultation with the Child's medical providers and with prescribers of psychotropic medications. Service team members must be aware of the medication regimen and potential side effects.

xii) Parents, siblings, foster parents, and members of the Child's permanency plan must be involved in treatment and service delivery.

xiii) Transition planning must be conducted starting with the first treatment plan and addressed throughout treatment to support the Child's permanency plan and post-discharge mental health needs.

(5) Children's Mental Health Crisis Response Services [Minnesota Statutes, §256B.0944];

(6) Clinical Care Consultation from a treating mental health professional to other providers or educators who are working with the same Child to inform, inquire and instruct regarding the Child's symptoms, strategies for effective engagement, care and intervention, treatment expectations across service settings; and to direct and coordinate clinical service components provided to the Child and family [Minnesota Statutes, §256B.0625, subd. 62];

(7) Family Psychoeducation Services provided by a mental health professional or a clinical trainee who determines it medical necessity to involve family members in the Child's care to explain, educate, and support the Child and family in understanding a Child's symptoms of mental illness, the impact on the Child's development, and needed components of treatment and skill development to prevent relapse and the acquisition of comorbid disorders, and achieve optimal mental health and long-term resilience [Minnesota Statutes, §256B.0625, subd. 61];

(8) Certified Family Peer Specialists provide nonclinical family peer support, building on the strengths of families and helping them achieve desired outcomes, collaborate with others providing care or support to the family, provide advocacy, promote the individual family culture in the treatment milieu, link parents to other parents in the community, offer support and encouragement, assist parents in developing coping mechanisms and problem-solving skills, promote resiliency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services, establish and provide peer led parent support groups, and increase the Child's ability to function better within the Child's home, school and community by educating parents on community resources, assisting with problem-solving, educating parents on mental illness, and provide support for mobile mental health crisis intervention [Minnesota Statutes §256B.0615];

(9) Assertive Community Treatment for Youth provides intensive nonresidential rehabilitative mental health services by a multidisciplinary staff using a team approach consistent with assertive community treatment adapted for Children ages sixteen (16) to twenty-one (21), with a serious mental illness or co-occurring mental illness and substance abuse addiction that requires services to prevent admission to an inpatient psychiatric hospital or placement in a residential treatment facility or who require intensive services to step down from inpatient or residential care to community-based care. Payment for these services must be based on one daily encounter rate per provider inclusive of the rehabilitative services, supports, ancillary activities, and crisis response services in section 6.1.34(5) above. Payment will be made to one entity for each Enrollee receiving service. If

services are provided by a team that includes staff from more than one entity, the team shall determine how to distribute the payment. [Minnesota Statutes §256B.0947];

(a) Intensive nonresidential rehabilitative mental health services and supports must be provided by an eligible provider agency that meets the requirements and standards outlined in in Minnesota Statutes, §256B.0947, subds. 3a (c), 4 and 5. The services, supports and ancillary activities include the following, as needed by the individual Enrollee:

i) Individual, family and group psychotherapy.

ii) Individual, family and group skills training, as defined in Minnesota Statutes, §256B.0943, subd. 1.

Provision of these intensive nonresidential rehabilitative mental health services must also comply with the service standards defined in Minnesota Statutes, §256B.0947, subd. 6. Intensive nonresidential rehabilitative mental health services and supports does not include:

iii) Inpatient psychiatric hospital treatment;

iv) Mental health residential treatment;

v) Partial hospitalization;

vi) Physician services outside of care provided by a psychiatrist serving as a member of the treatment team;

vii) Room and board costs;

viii) Children's mental health day treatment services; and

ix) Mental health behavioral aide services, as defined in Minnesota Statutes, §256B.0943, subd. 1, paragraph (m).

(b) Crisis assistance, as defined in Minnesota Statutes, §245.4871, subd. 9a, which includes recognition of factors precipitating a mental health crisis, identification of behaviors related to the crisis, and the development of a plan to address prevention, intervention, and follow-up strategies to be used in the lead-up to or onset of, and conclusion of, a mental health crisis. This is not the same as crisis response services or crisis intervention services provided in Minnesota Statutes, §256B.0944.

(c) Medication management provided by a physician or an advanced practice registered nurse with certification in psychiatric and mental health care.

(d) Mental health case management. [Minnesota Statutes, §256B.0625, subd. 20]

(e) Medication education services as defined in Minnesota Statutes, §256B.0947.

(f) Care coordination by a client-specific lead worker assigned by and responsible to the treatment team.

(g) Psychoeducation of and consultation and coordination with the Child's biological, adoptive, or foster family and, in the case of a Child Enrollee living independently, the Enrollee's immediate non-familial support network.

(h) Clinical consultation to a Child Enrollee's employer or school or to other service agencies or to the courts to assist in managing the mental illness or co-occurring disorder and to develop an Enrollee support system.

(i) Coordination with, or performance of, crisis intervention and stabilization services as defined in Minnesota Statutes, §256B.0944.

(j) Assessment of a Child's treatment progress and effectiveness of services using standardized outcome measures published by the STATE.

(k) Transition services as defined in Minnesota Statutes, §256B.0947.

(l) Integrated dual disorders treatment as defined in Minnesota Statutes, §256B.0947.

(m) Housing access support as defined in Minnesota Statutes, §256B.0947.

(10) Individual, family, and group therapy and multiple family group psychotherapy, including counseling related to adjustment to physical disabilities or chronic illness;

(11) Inpatient treatment, including extended psychiatric inpatient hospital stay as defined in Minnesota Statutes, §256.9693;

(12) Outpatient mental health treatment services. [Minnesota Rules, Parts 9505.0370 through 9505.0372 and the MHCP Provider Manual];

(13) Partial hospitalization as defined in Minnesota Rules, Part 9505.0370, subp. 24;

(14) Assessment of Enrollees whose health care seeking behavior and/or mental functioning suggests underlying mental health problems;

(15) Neuropsychological assessment, and neuropsychological rehabilitation and/or cognitive remediation training for Enrollees with a diagnosed neuropsychological or neurodevelopmental disorder who can benefit from cognitive rehabilitation services [Minnesota Rules, parts 9505.0370 through 9505.0372 and the MHCP Provider Manual];

(16) Medication management [Minnesota Rules, Parts 9505.0370 through 9505.0372 and the Minnesota Health Care Programs Provider Manual];

(17) Travel time for mental health Providers, who provide community-based mental health services covered by the MCO in the community at a place other than their usual place of work [Minnesota Statutes, §256B.0625, subd. 43, as amended by Laws of Minnesota, SS1 of 2019, Ch. 9, Art. 6, sec. 55];

(18) Mental health services that are otherwise covered by Medical Assistance as direct face-to-face services may be provided via two-way interactive video with exceptions noted in the MHCP Provider Manual. The telemedicine method must be medically appropriate to the condition and needs of the Enrollee.

(19) Consultation provided by a psychiatrist, a psychologist, an advanced practice registered nurse certified in psychiatric mental health, a licensed independent clinical social worker or licensed marriage and family therapist, 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; [Minnesota Statutes, §256B.0625, subd. 48]

(20) Children's residential mental health treatment [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 tribes, and

(c) Consistent with STATE guidelines for admission, continued stay and discharge, as published in the MHCP Provider Manual.

(21) Psychiatric Residential Treatment Facility (PRTF). PRTF is a Covered Service for Children. [Minnesota Statutes, §256B.0941]

(a) The admission criteria for PRTF include a DSM mental health diagnosis; clinical evidence of severe aggression and/or the Enrollee is at risk of harm to self or others; has inability to adequately care for his or her physical needs, and caretakers, guardians, or

family are unable to safely fulfill these needs; and other community based, less restrictive mental health services have been exhausted and/or cannot provide the level of care required. A standard diagnostic assessment and functional assessment is required before admission to the PRTF.

(b) PRTF services must be provided under the direction of a physician, and include psychiatric assessment; individual, family and group therapy; psychotropic medication; and other specialty services that are person- centered, trauma-informed and culturally responsive. Expectations include a written individual plan of care, review of the plan of care every thirty (30) days, and a discharge plan.

(c) The STATE and the MCO agree to convene a workgroup to discuss the implementation of PRTF.

(22) 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;

(23) The MCO must assure that Mental Health Professionals and clinical trainees 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; and

(24) Children's Mental Health Targeted Case Management (CMH-TCM). The MCO shall make available to Enrollees, CMH-TCM services to Children with Severe Emotional Disturbance (SED) [Minnesota Statutes, §§ 245.487 to 245.4889 and §256B.0625, subd. 20 and Minnesota Rules, Parts 9520.0900 to 9520.0926 ("Rule 79")]

(a) The MCO may offer substitute models of CMH-TCM to Enrollees who meet SED criteria with the consent of the Enrollee if the substitute model includes all four activities that comprise the CMS services definition for TCM services, including:

i) A comprehensive assessment of the Enrollee to determine the need for any medical, educational, social or other services,

ii) Development of a specific care plan that is based on the information collected through the assessment; specifies the goals and actions to address the medical, social, educational, and other services needed by the Enrollee; includes activities such as ensuring the active participation of the eligible Enrollee, and working with the Enrollee (or the Enrollee's authorized health care decision maker) and others to develop those goals; and identifies a course of action to respond to the assessed needs of the eligible Enrollee,

iii) Referral and related activities to help the Enrollee obtain needed services including activities that help link Enrollees with medical, behavioral, social, educational Providers; community services; or other programs and services available for providing additional needed services, and

iv) Monitoring and follow-up activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the Enrollee's needs. These activities, and contact, may be with the Enrollee, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met: services are being furnished in accordance with the Enrollee's care plan; services in the care plan are adequate; and if there are changes in the needs or

status of the Enrollee, necessary adjustments are made to the care plan and to service arrangements with providers.

(b) Case Management for Transitional Youth. Continued case management must be offered to a Child (or Child's legal representative) who is receiving children's case management and is turning eighteen (18) and his or her needs can be met within the children's service system. Before discontinuing case management for Children age seventeen (17) to twenty-one (21), the MCO must develop a transition plan that includes plans for health insurance, housing, education, employment and treatment.

(c) All CMH-TCM services must meet the following quality standards:

i) Assure adequate access to CMH-TCM for all eligible Enrollees [Minnesota Rules parts 9520.0900 to 9520.0903];

ii) The MCO agrees to work with the STATE to provide adequate access to CMH-TCM. This includes adhering to the case manager average caseload standard 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.

iii) The STATE acknowledges that CMH-TCM Providers may provide services to Enrollees for multiple MCOs and FFS, and agrees to monitor caseload ratios and will provide feedback to the MCO regarding the caseload ratios of all contracted case management Providers.

iv) 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. [Minnesota Rules, 9520.0914 subp. 2., A]

(d) Case managers for CMH-TCM services must meet the qualifications and supervision requirements listed in Minnesota Statutes, §245.4871, subd. 4 (b) thorough (h), and Minnesota Rules, Part 9520.0912. Case manager associates for CMH-TCM services must meet the qualifications and supervision requirements listed in Minnesota Statutes, §245.4871, subd. 4 (j) and (k).

6.1.36 Court-Ordered Mental Health Treatment.

The following procedures apply to mental health services that are court-ordered.

(1) The MCO must provide all court-ordered mental health services 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 Network Providers. [Minnesota Statutes, §62Q.535, subds. 1 and 2; §253B.045, subd. 6; and §260C.201, subd. 1]

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

(3) The MCO's liability for an ongoing mental health inpatient hospital stay at a regional treatment center (RTC) shall end when the medical director of the center or facility, or his or her designee, no longer certifies that the Enrollee is in need of continued treatment at a hospital level of care, and the MCO agrees that the Enrollee no longer meets Medical Necessity criteria for continued treatment at a hospital level of care.

(4) The MCO must provide a twenty-four (24) hour telephone number, answered in-person, that a Local Agency may call to get an expeditious response to situations involving the MCO's Enrollees where court ordered treatment and disability certification are involved.

6.1.37 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 MI who are committed, or for Enrollees whose commitment has been stayed or continued.

(2) The MCO Mental Health Targeted Case Manager shall:

(a) Work with hospitals, pre-petition screening teams, family members or representatives, and current Providers, to assess the Enrollee and develop an individual care plan that includes diversion planning and least restrictive alternatives consistent with the Commitment Act. This may include testifying in court, and preparing and providing requested documentation to the court;

(b) Report to the court within the court-required timelines regarding the Enrollee's care plan status and recommendations for continued commitment, including, as needed, requests to the court for revocation of a provisional discharge;

(c) Provide input only for pre-petition screening, court-appointed independent examiners, substitute decision-makers, or court reports for Enrollees who remain in the facility to which they were committed;

(d) Provide mental health case management coverage which includes discharge planning for up to one hundred and eighty (180) days prior to an Enrollee's discharge from an Inpatient Hospitalization in a manner that works with, but does not duplicate, the facility's discharge planning services; and

(e) Ensure continuity of health care and Case Management coverage for Enrollees in transition due to change in benefits or change in residence.

6.1.38 Obstetrics and Gynecological Services.

Such services include nurse-midwife services and prenatal care services as described below. MCO must comply with section 6.11.4, Direct Access to Obstetricians and Gynecologists..

6.1.38.1 Nurse-Midwife. Nurse-Midwife services by certified nurse-midwife services are covered. [§1905(a)(17) of the SSA, Minnesota Statutes, §256B.0625, subd. 28; and Minnesota Rules, Part 9505.0320]

6.1.38.2 Services by a certified doula including childbirth education, emotional and physical support during pregnancy, labor, birth and postpartum, are covered. [Minnesota Statutes, §256B.0625, subd. 28b]

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

(1) All pregnant Enrollees must be screened during their initial prenatal care office visit using a standardized prenatal assessment, or its equivalent, which must be maintained in the Enrollee's medical record. The purpose of the screening is to determine the Enrollee's risk of poor pregnancy outcome as well as to establish an appropriate treatment plan, including enhanced health services if the Enrollee is an at-risk pregnant woman as defined in Minnesota Rules, Part 9505.0353. A referral to the Women, Infants, Children Supplemental Food and Nutrition Program (WIC) must be made when WIC assessment standards are met.

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

6.1.38.4 Birth Centers: Services provided in a licensed birth center by a licensed health professional are covered if the service would otherwise be covered if provided in a hospital. [Minnesota Statutes, §256B.0625, subd. 54]

6.1.38.5 Inpatient Hospitalization for Childbirth is covered.

6.1.39 Outpatient Hospital Services.

Outpatient hospital services are covered and include emergency care. [Minnesota Statutes, §256B.0625, subd. 4]

6.1.40 Physician Services.

Physician Services are covered. [Minnesota Statutes, §256B.0625, subd. 3]

6.1.41 Podiatric Services.

Podiatric services are covered. [Minnesota Rules, Part 9505.0350]

6.1.42 Prescription Drugs and Over-the-Counter Drugs.

6.1.42.1 Covered Drugs. Medicaid prescriptions and over-the-counter drugs that are covered under this Contract must meet the following criteria: 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.

6.1.42.2 Over-the-Counter Drugs. Pharmacists may prescribe over-the-counter drugs. [Minnesota Statutes, §256B.0625, subd. 13, (d)]

6.1.42.3 Drugs Covered by Medicare.

- Drugs covered under the Medicare Prescription Drug Program under Medicare Part D for Medicare eligible Enrollees are not covered under Medicaid.
- For Dual Eligible Enrollees, the MCO may cover drugs from the drug classes listed in 42 USC §1396r-8(d)(2), except that drugs listed in 42 USC §1396r-8(d)(2)(E), which are covered by Part D, shall not be covered.

6.1.42.4 340B Drugs. Prescription drugs acquired through the federal 340B drug pricing program and dispensed by a 340B contract pharmacy that is not under common ownership of the 340B covered entity (contract pharmacies) are not covered. [Minnesota Statutes §256B.0625, subd. 13, (f)]

Prescription drugs acquired through the 340B program and billed to the MCO by the 340B covered entity as an outpatient pharmacy claim must be identified as 340B drugs by including the Submission Clarification Code of "20" on each claim. Prescription drugs acquired through

the 340B program and billed to the MCO by a 340B covered entity as a medical claim must be identified as 340B drugs by including the "UD" modifier on each claim line that is a 340B drug. Covered entities billing 340B medications to the MCO must record their NPI number with Health Resources and Services Administration of CMS. The MCO must require that covered entities under this NPI must use 340B purchased drugs for all claims if the prescription drug is available through the 340B program. The STATE will exclude claims with the Submission Clarification Code of "20" and "UD" modifier from the drug rebate program.

6.1.42.5 Preferred Drug List (PDL). The MCO shall adopt the STATE's preferred drugs and prior authorization criteria as follows:

(1) The MCO shall adopt the STATE's preferred drugs and clinical prior authorization criteria for direct acting antiviral drugs used to treat Hepatitis C. Upon notice of any upcoming changes to the STATE's criteria or preferred drugs for Hepatitis C, the STATE will provide to the MCO at least sixty (60) days' notice to implement the updated criteria and/or preferred drugs, on an effective date identified by the STATE. The MCO may provide comments to the STATE regarding any clinical concerns about the criteria adopted by the STATE. The comments may be delivered to the Universal Pharmacy Policy Workgroup staff representative at the STATE, and may be discussed during the UPPW meetings. The MCO may also provide public comments regarding the STATE's criteria or preferred drugs at the Drug Formulary Committee, pursuant to Minnesota Statutes, §256B.0625, meetings when the direct acting antiviral drugs used to treat Hepatitis C are on the published agenda.

(2) Effective July 1, 2019, the MCO shall adopt the STATE's Preferred Drug List (PDL) and non-preferred prior authorization criteria for all drug classes listed on the PDL. Upon notice of any upcoming changes to the STATE's PDL or non-preferred prior authorization criteria, except those resulting from a drug shortage or recall described in section 6.1.42.5(3) below, the STATE will provide to the MCO at least sixty (60) days advance notice to implement the updated criteria and/or preferred drugs on the effective date identified by the STATE. The MCO may provide comments to the STATE regarding any clinical concerns about the criteria or preferred drugs adopted by the STATE. The comments may be delivered to the Universal Pharmacy Policy Workgroup staff representative at the STATE, and may be discussed during the UPPW meetings. The MCO may also provide public comments regarding the STATE's criteria or preferred drugs at the Drug Formulary Committee meetings when the PDL or criteria are discussed on the published agenda.

(a) The MCO may apply different clinical prior authorization criteria to drugs on the STATE's PDL, with the exception of direct acting antiviral drugs used to treat Hepatitis C, but the MCO shall not disadvantage any preferred drug to another drug in the same drug class on the STATE's PDL.

(b) The MCO may apply the same clinical prior authorization criteria to an entire class of drugs listed on the STATE's PDL, with the exception of direct acting antiviral drugs used to treat Hepatitis C, but the MCO shall not disadvantage any preferred drug to a non-preferred drug listed in the same drug class.

(c) Drugs, or drug classes, not managed by the STATE on the PDL are not to be excluded from the MCO's formulary solely based on the exclusion from the STATE's PDL. The MCO shall manage these drugs or drug classes.

(d) The MCO shall follow the STATE's PDL for outpatient pharmacy claims. The MCO may utilize the PDL for drugs covered under the medical benefit.

(e) The MCO may utilize quantity limits or therapeutic duplication edits that are different than those utilized by the STATE for drugs included on the PDL so long as the

edits do not result in a preferred drug being disadvantaged to another drug in the same drug class. Edits applied to preferred drugs must conform with the drug label approved by the Food and Drug Administration or to the edits used by the STATE.

(3) Drug Shortages and Recalls

(a) Upon receipt of documentation of a confirmed drug shortage or recall of a preferred drug from a wholesaler, manufacturer, or the United States Food and Drug Administration that results in a drug class on the PDL containing one, or no preferred drugs in the drug class, the STATE may update the PDL to address the drug shortage or recall. The STATE will provide the MCO with at least seven (7) calendar days advance notice to implement the drug shortage or recall exception criteria within the updated drug class on the date identified by the STATE.

(b) Once the STATE has confirmed that a drug shortage or recall is resolved the STATE may update the PDL to reflect the resolution of the drug shortage or recall. The STATE will provide the MCO with at least seven (7) calendar days advance notice to implement the removal of drug shortage or recall exception criteria to the updated preferred drug(s) on the date identified by the STATE.

(c) A notice from the STATE of a confirmed drug shortage or recall and alternative preferred drug does not require the MCO to conduct a formulary update nor notices. A shortage or recall that exceeds a brief period of time will be determined by the STATE to be a PDL update and will follow the sixty (60) day notice process in section 6.1.42.5(2). Such a non-temporary formulary change will require the process for changes in the Medical Assistance Drug Formulary in sections 6.1.42.8 and 3.13.7.

(d) In the event that the MCO discovers a drug shortage or recall, the MCO is requested to communicate the fact to DHS as soon as the drug shortage or recall is confirmed by the MCO.

6.1.42.6 The STATE's PDL does not apply to Part D drug coverage.

6.1.42.7 UPPW Requirements

(1) The MCO shall adopt the minimum requirements for medications and policies as defined in section 2.194 of this Contract that have been recommended by the Universal Pharmacy Policy Workgroup. If the MCO chooses to have a Medical Assistance Drug Formulary, or policies for drugs which are not included in the Universal Pharmacy Policy definition, which are more restrictive than the STATE's Medical Assistance 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.

(2) The MCO, through its representatives on the UPPW, will collaborate to monitor the prescribing and dispensing patterns of Providers, using the quality improvement measures developed by the Opioid Prescribing Workgroup pursuant to Minnesota Statutes, §256B.0638.

(3) Members of the Universal Pharmacy Policy Workgroup will share information on prescribing and dispensing patterns with the goal of identifying inappropriate prescribing and dispensing activities. Using criteria and/or algorithms developed by the Universal Pharmacy Policy Workgroup, the MCO and the STATE will identify prescribers and/or dispensers engaged in potentially inappropriate prescribing and dispensing and will make referrals to the Board of Medicine or the Board of Pharmacy as appropriate.

6.1.42.8 Formulary.

(1) The MCO must post the drug formulary online for use by Enrollees, Potential Enrollees, providers, or the general public per section 3.13.7 above. The MCO must also provide the STATE with the online formulary web site link. At the time of the last quarterly formulary submission and upon the submission of a formulary change, the MCO must also submit a formulary change summary in a format approved by the STATE.

(2) The MCO shall notify the STATE of any changes in its Medical Assistance 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.

(3) For SNBC, 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.

(4) For SNBC, the MCO agrees to coordinates the provision of both Medicare and Medicaid drug coverage so that coverage is as seamless as possible for the SNBC SNP Enrollee. The MCO assures that its pharmacy benefits manager (PBM) will administer Medicaid drugs according to Medicaid requirements and shall not apply Medicare rules to Medicaid drugs.

(5) The STATE shall notify the MCO of any inadequacies in the MCO's Medical Assistance Drug Formulary. The MCO shall submit a corrective action plan, and may be subject to other sanctions listed in section 5.5. For the purposes of this section, "inadequacies" means that the MCO's formulary does not contain a formulary alternative for a drug product available through the fee-for-service benefit or the MCO is not following the STATE's PDL. For the purposes of this paragraph, a formulary alternative means a drug that is similar in safety and efficacy profile for the treatment of a disease or condition. A formulary alternative may or may not be chemically equivalent or bioequivalent.

6.1.42.9 Drugs for Mental Illness or Emotional Disturbance.

(1) The MCO must cover antipsychotic drugs prescribed to treat Emotional Disturbance or MI regardless of the MCO's Medical Assistance Drug Formulary if the prescribing Provider certifies in writing to the MCO that the prescribed drug will best treat the Enrollee's condition. 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. [Minnesota Statutes, §62Q.527]

(2) The MCO shall allow an Enrollee to continue to receive a prescribed drug to treat a diagnosed MI 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. [Minnesota Statutes, §62Q.527] See also section 6.15, Out of Network and Out of Service Area Care.

(3) 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. [Minnesota Statutes, §62Q.527, subd. 4]

6.1.42.10 Step therapy override.

(1) Transparency. The MCO's step therapy protocol, if any, shall be published on the MCO's website, with a process for requesting exceptions or "overrides."

(2) Override: [Minnesota Statutes, §62Q.184, subd. 3, (a), (3) and (4)] Effective August 1, 2019, the MCO shall grant an override to its step therapy protocol if:

(a) The Enrollee has had a trial of the required drug covered by their current or previous MCO or FFS, or a drug in the same pharmacological class with the same mechanism of action, and

i) The Enrollee was adherent during such trial for a period of time sufficient to allow for a positive treatment outcome, and

ii) The prescription drug was discontinued by the Enrollee's provider due to lack of effectiveness, or an adverse event; or

(b) If the prescriber submits an evidence-based and peer-reviewed clinical practice guideline supporting the use of the requested drug over the required drug. This section does not prohibit the MCO from requiring an Enrollee to try another drug in the same pharmacologic class with the same mechanism of action if that therapy sequence is supported by the evidence-based and peer-reviewed clinical practice guideline, Food and Drug Administration label, or pharmaceutical manufacturer's prescribing information; or

(c) The MCO shall grant an override to its step therapy protocol if:

i) The Enrollee is currently receiving a positive therapeutic outcome on the required drug covered by their current or immediately previous MCO or FFS, and

ii) If the Enrollee's prescribing health care provider gives documentation to the MCO that the change in drug required by the step therapy protocol is expected to be ineffective, or cause harm to the Enrollee based on the known characteristics of the specific Enrollee and the known characteristics of the required drug.

(d) Nothing in this section prohibits the MCO from requesting relevant documentation from an Enrollee's medical record in support of a step therapy override request; or requiring an Enrollee to try a generic equivalent drug pursuant to Minnesota Statutes, §151.21, or a biosimilar, as defined under 42 USC §262(i)(2), prior to providing coverage for the equivalent branded prescription drug.

(a) The clinical guidelines used in step therapy must be developed independently of a health plan company, pharmaceutical manufacturer, or any entity with a conflict of interest. A practice guideline includes a preferred drug list in section 6.1.42.5. [Minnesota Statutes, §62Q.184]

6.1.42.11 Drug Utilization Review.

(1) The MCO, or an organization contracted by the MCO, must administer a Drug Utilization Review (DUR) program consistent with Section 1927 of the SSA. The DUR program must satisfy all components of the section, including but not limited to: a prospective DUR program, a retrospective DUR program, application of predetermined standards, an

educational program, and oversight by a DUR committee that consists of at least one-third but no more than one-half licensed and practicing physicians and at least one-third but no more than one-half licensed and practicing pharmacists. The MCO must submit a DUR annual report, in a format approved by the STATE, on DUR activities from the previous federal fiscal year. The report is due May 1 of the Contract Year; see section 11.5.1(6).

(2) The service authorization program used by the MCO for prescription drugs must comply with section 1927(d)(5) of the SSA, including: providing a response to a prior authorization request within twenty-four (24) hours of the request and authorizing a seventy-two (72) hour supply of a covered prescription drug in emergency situations. See also section 6.13.

6.1.42.12 Rebates, credits, discounts and administrative fees

The MCO, directly or through a vendor or Subcontractor, may collect rebates, credits, discounts, or other administrative fees including fees for covered services or associated with value based contracting arrangements unless otherwise prohibited by law or this contract. The MCO shall report the entire value of all rebates, credits, discounts, or other administrative fees to the STATE quarterly in the Quarterly Financial Report described in section 11.4.1(12). The MCO may not collect rebates, credits, discounts, or administrative fees on any drug or product that is part of the STATE's Preferred Drug List unless the STATE grants the MCO prior approval to do so in writing.

6.1.42.13 Reporting of Drugs Not Eligible for Rebate.

The MCO may cover prescription drugs that meet the definition of a "covered outpatient drug" under 42 CFR §447.502 but that are not eligible for the federal Medicaid drug rebate; however, these costs must be reported by the MCO as non-covered services in the Quarterly Financial Report described in section 11.5.1(16).

6.1.43 Medication Therapy Management (MTM) Care Services.

Medication Therapy Management (MTM) Care Services are covered. MTM services are not covered for Enrollees receiving drugs covered by Medicare Part D, for whom MTM services are covered by Medicare. An eligible pharmacist within the MCO's network may provide MTM services via two-way interactive video when there are no pharmacists eligible to provide such services within a reasonable geographic distance of the Enrollee, or during a covered home health care visit [Minnesota Statutes, §256B.0625, subd. 13h and the Medication Therapy Management Services listed on the STATE's MHCP Enrolled Providers web site (http://www.dhs.state.mn.us/id_054232; MHCP Provider Update PRX-06-02R); §256B.0625, subd. 13h, (e)]

6.1.44 Prescribing, Electronic.

The MCO shall comply with Minnesota Statutes, §62J.497 and the applicable standards specified in the statute for electronic prescribing. The MCO shall also ensure that its providers involved in prescribing, filling prescriptions or paying for prescriptions, including communicating or transmitting formulary or benefit information also conform to the electronic prescribing standards for transmitting prescription or prescription-related information.

6.1.45 Prosthetic and Orthotic Devices.

Prosthetic and orthotic devices are covered, including related medical supplies. [Minnesota Statutes, §256B.0625, subd. 12 and 31]

6.1.46 Public Health Services.

Public health clinic services and public health nursing clinic services are covered, as they are described in the MHCP Provider Manual, as updated. [Minnesota Statutes, §256B.0625, subd. 29]

6.1.47 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), 45 CFR §146.180 is covered.

6.1.48 Rehabilitative and Therapeutic Services.

Rehabilitative and therapeutic services (related to evaluation and treatment) are covered and include [Minnesota Statutes, §§256B.0625, subd. 8 through 8c; 256B.0653; Minnesota Rules, Parts 9505.0385 through 9505.0390]:

6.1.48.1 Physical therapy (including specialized maintenance therapy for Enrollees age 20 and under;

6.1.48.2 Speech therapy (including specialized maintenance therapy for Enrollees age 20 and under;

6.1.48.3 Occupational therapy (including specialized maintenance therapy for Enrollees age 20 and under;

6.1.48.4 Audiology; and

6.1.48.5 Respiratory therapy.

6.1.49 Second Opinion.

See also section 8.8.7 regarding external medical review of appeals.

6.1.49.1 MCOs must provide, at MCO expense, a second medical opinion within the MCO network upon Enrollee request. [Minnesota Rules, Part 9500.1462, (A)]

6.1.49.2 Mental Health. The MCO shall provide a second medical opinion for mental health conditions by a qualified non-Network Provider. [Minnesota Statutes, §62D.103]

6.1.49.3 Substance Use Disorder. The MCO shall provide a second opinion for SUD services, by a qualified non-Network Provider. 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 treatment. [Minnesota Statutes, §62D.103]

6.1.50 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. [Minnesota Statutes, §256B.0625, subd. 3; Minnesota Statutes, §62Q.58]

The MCO's SNBC system must include the following elements:

6.1.50.1 Limited referral. The MCO shall establish guidelines by which an Enrollee may access a course of specialty care.

6.1.50.2 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.

6.1.50.3 Out-of-Network Specialists. The MCO shall have a process for prompt review of 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.

6.1.50.4 Specialists as Primary Care Providers. In consultation with the Enrollee, the Enrollee's family, or the Enrollee's Authorized Representative, the MCO shall evaluate the need, in individual cases, for permitting a specialist to function as an Enrollee's Primary Care Provider.

6.1.50.5 Referrals for Rare and Low Prevalence Conditions. The MCO must assure an adequate network including procedures for expedited review of authorized referrals to Out of Network care as necessary to provide prompt access to specialty care for rare and low incidence conditions so that Enrollees have access to appropriate expertise for such conditions.

6.1.51 Substance Use Disorder Treatment Services.

The MCO is responsible for the continuum of SUD services identified in Minnesota Statutes, §254B.05, subd. 5, (b), excluding room and board. Notwithstanding section 6.13.2, SUD treatment services shall be provided in accordance with Minnesota Statutes, §§ 245G.22, subd. 1, and 254B. Enrollees may select the Provider of their choice within the MCO's Network, within the time and distance requirements of this contract for specialty providers, up to the highest level of care recommended. Transportation to Providers is described in section 6.1.31 above and limited by section 6.1.32.2.

6.1.51.1 SUD treatment services include each service as defined in Minnesota Statutes, §254B.05, subd. 5, (b), if clinically appropriate for the Enrollee, and within the parameters of section 6.15; and for NEMT, section 6.1.31. The following services are covered:

(1) Outpatient treatment services;

(2) Comprehensive Assessment for SUD services;

(3) SUD treatment coordination services. SUD treatment coordination for SUD services is only for facilitation of referrals indicated in the SUD treatment plan and does not include coordination for medical services, except those identified in the SUD treatment plan.

(4) Peer recovery support services provided according to Minnesota Statutes, §245G.07, subd. 2, (8), as revised by Laws 2019, SS1, Ch. 9, Art. 6, sec. 19;

(5) Medication-assisted therapy services;

(6) High, medium, and low intensity residential treatment services;

(7) Hospital-based treatment services;

(8) Adolescent treatment programs licensed as outpatient treatment programs; and

(9) Withdrawal management at Level 3.2 (clinically managed) and Level 3.7 (medically monitored) will be covered. The MCO agrees to participate in a work group to implement this service.

(10) SUD assessments that are otherwise covered by Medical Assistance as direct face-to-face services may be provided via telemedicine. [Minnesota Statutes, §254A.19, subd.5]

6.1.51.2 Upon inquiry by an Enrollee, the MCO must provide the Enrollee with information that will enable the Enrollee to choose one of the assessment and treatment planning methods: "Rule 25" or Comprehensive Assessment in 6.1.50.2(1) or (2) below, respectively. The MCO must provide the Enrollee with information provided by the STATE that outlines the differences between the two assessment and treatment planning methods. The MCO must accept the assessment and treatment planning result of either "Rule 25" or Comprehensive Assessment.

(1) "Rule 25 Assessment" which is the assessment identified in Minnesota Rules, Part 9530.6615 using criteria and dimensions identified in Minnesota Rules, Parts 9530.6620 and 9530.6622. If an Enrollee selects the Rule 25 assessment, the MCO, as the placing authority, shall follow the process described in Minnesota Rules, Part 9530.6622 to determine appropriate services for the Enrollee.

(2) A Comprehensive Assessment completed as defined in Minnesota Statutes, §245G.05 by a Substance Use Disorder Professional.

(a) Enrollees may select the Provider of their choice within the MCO's Network, within the time and distance requirements of this contract for specialty providers.

(b) SUD Treatment services recommended by a Substance Use Disorder Professional shall not be subject to a separate medical necessity determination under the MCO's Service Authorization procedures. The MCO may request additional, clarifying or supporting documentation of the initial Comprehensive Assessment to ensure its completeness.

(c) The MCO may review the documentation after treatment has been initiated to determine appropriateness of the services, and may direct the Enrollee so that the Enrollee may use any Network Provider. The MCO is not a placing authority for the services subsequent to a Comprehensive Assessment.

(d) Utilization review by the MCO that includes a review of the completed Comprehensive Assessment and subsequent service recommendations must be completed by a Substance Use Disorder Professional, and the reviewer must reference with specificity the criteria in Minnesota Rules, Part 9530.6622, in any Action that that modifies the service recommendations from the Comprehensive Assessment.

(e) The Enrollee is not required to use the highest level of services described in the service recommendations and may instead use services at a lower intensity level.

6.1.51.3 SUD treatment services do not include detoxification (unless it is required for medical treatment). Detoxification is covered only when inpatient hospitalization is medically necessary because of conditions resulting from withdrawal or conditions occurring in addition to withdrawal, for example for conditions resulting from injury or accident or medical complications during detoxification, that necessitate the constant availability of physicians and registered nurses and/or complex medical equipment found only in an inpatient setting.

6.1.51.4 The MCO shall provide a representative to participate in the work group that will develop the utilization review of providers that is required under SUD Reform.

6.1.51.5 The MCO shall not be responsible for the payment of room and board services provided by residential SUD treatment providers.

6.1.52 Screening for Substance Use Disorder

(1) Substance Use Disorder services will include utilization, in primary care clinics, of a valid and reliable tool approved by the STATE, for Screening and Brief Intervention (SBI) to identify unhealthy substance use, and to provide a brief intervention when indicated.

(a) When patient screens are positive for substance abuse or dependence, the MCO agrees to require Screening Brief Intervention and/or Referral to Treatment (SBIRT) in primary care clinics.

(b) Upon federal approval and notice by the STATE, if a screen result is positive for alcohol or substance misuse, the SBIRT establishes medical necessity and approval for an initial set of SUD services identified in Minnesota Statutes, §254B.05, subd. 5. The initial set of services approved for an Enrollee whose screen result is positive may include any combination of up to four hours of individual or group SUD treatment, two hours of SUD treatment coordination, or two hours of SUD peer support services provided by a qualified individual according to chapter 245G, within the parameters of section 6.15; and for NEMT, section 6.1.31. The Enrollee must obtain an assessment in section 6.1.50.1(2) to be approved for additional treatment services. [Minnesota Statutes, §254A.03, subd. 3(c), as amended by Laws of Minnesota 2019, SS1, Ch. 9, Art. 6, sec. 40]

(2) The MCO will require clinics to utilize valid and reliable tools, approved by the STATE, and resources to provide immediate treatment options, which may include pharmacotherapy options and/or referral to specialized treatment.

(3) The MCO will require that behavioral health Providers screen all Enrollees for the presence of co-occurring substance abuse and mental illness, upon initial access to services. When patient screens are positive for substance abuse or dependence, the MCO agrees to SBI and/or Referral to Treatment (SBIRT) in primary care clinics. Clinics will utilize valid and reliable tools, approved by the STATE, and resources to provide immediate treatment options, which may include pharmacotherapy options and/or referral to specialized treatment.

(4) The STATE recommends the following nationally recognized assessment tool: "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.

6.1.53 Telemedicine Services.

Telemedicine services covers medically necessary services and consultations delivered by a licensed health care provider defined in Minnesota Statutes §62A.671, subd. 6; or a mental health provider defined in Minnesota Statutes, §§245.462, subd. 17, or 245.4871, subd. 26, working under the general supervision of a mental health professional.

6.1.53.1 Coverage is limited to three (3) telemedicine services per Enrollee per calendar week. This limit does not apply, effective August 1, 2019, if the services are for the treatment and control of tuberculosis as described in Minnesota Statutes, §256B.0625, subd. 3b, (f).

6.1.53.2 As a condition of payment, a licensed health care provider must document each occurrence of a health service provided by telemedicine to an Enrollee. Health care service records for services provided by telemedicine must meet the requirements in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document the requirements outlined in Minnesota Statutes §256B.0625, subd. 3b.

6.1.54 Transplants.

Covered transplants are: cornea, heart, kidney, liver, lung, pancreas, heart-lung, intestine, intestine-liver, pancreas-kidney, pancreatic islet cell, stem cell, bone marrow and other transplants that are listed in the MHCP 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 and currently approved by CMS as meeting the CMS conditions of participation for transplant centers at 42 CFR § § 482.72 through 482.104. Stem cell or bone marrow transplant centers must meet the standards established by the Foundation for the Accreditation of Cellular Therapy (FACT). [Minnesota Statutes, §256B.0625, subd. 27]

6.1.55 Tuberculosis Related Services.

Tuberculosis related services include Case Management and Directly Observed Therapy (DOT) which consists of direct observation of the intake of drugs prescribed to treat tuberculosis by a nurse or other trained health care Provider. The MCO shall make reasonable efforts to contract with and use the Local Public Health Nursing Agency as the Provider for direct observation of the intake of drugs prescribed to treat tuberculosis and refer for nurse case management, except for Enrollees 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. [Minnesota Statutes, §256B.0625, subd. 40]

6.1.56 Vaccines and Immunizations

Vaccines and immunizations are covered and include but are not limited to: 1) recommendations by MDH; 2) human papilloma virus (HPV) immunizations for males and females ages nine (9) to twenty-six (26); 3) shingles vaccine for Enrollees ages fifty (50) and over; and 4) Varicella for Enrollees age 19 and older.

6.1.57 Vision Care Services.

Vision care services are covered and include vision examinations, eyeglasses, optician, and optometrist and ophthalmologist services. Eyeglasses, sunglasses and contact lenses shall be provided only if prescribed by or through the MCO Network physicians or Network optometrists. The MCO must make available a reasonable selection of eyeglass frames, including specialty frames required by people who cannot wear standard 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 replacement by the same frames. [Minnesota Statutes, §256B.0625, subd. 12; Minnesota Rules, Part 9505.0277]

6.2 State-funded Covered IMD Services.

The MCO shall provide services to Medical Assistance Enrollees in an Institution for Mental Disease (IMD) for stays that exceed fifteen (15) days in a calendar month. The capitation payment will be state-funded.

6.3 In Lieu of Services Permitted.

In Lieu of Services are services or settings that are offered in place of services or settings covered under section 6.1. In Lieu of Services must be medically appropriate and cost-effective. The MCO may offer the services or settings to Enrollees and must receive Enrollee consent to use the in Lieu of Services. The health status of and quality of life as determined in collaboration with the Enrollee is expected to be the same or better using the Substitute Services in Lieu of Services as it would be using the Covered Service. The MCO shall have a mechanism for timely payment of in Lieu of Services. In Lieu of Services submitted as encounter data will be considered in calculations of MCO costs. [42 CFR §438.3(e)(2)]

6.3.1 Authorized In Lieu of Services:

The services and settings that are authorized by the STATE to be provided by the MCO as in Lieu of Services under this Contract are:

6.3.1.1 Waiver Services that are approved by the MCO, for Enrollees who are not enrolled on a waiver.

6.3.1.2 IMD stays not exceeding fifteen (15) days in a calendar month, for Enrollees under 65 years of age. An IMD is a facility providing residential mental health and SUD services, that is determined to be an IMD by the state. Services may be provided in an IMD setting under the circumstances discussed in 42 CFR §438.6(e).

(1) The MCO shall report IMD placements for SUD and mental health under this section monthly, according to report specifications published by the STATE. Thereafter the report will be cumulative and include the placements that occur each month, and will be due by the 30th day of the following month.

6.3.1.3 Non-Traditional, Ancillary, and Needs-Driven SNBC Support Devices and Services. The MCO may provide or arrange to have provided highly-individualized informal or non-traditional support services replacing State Plan services described in Article 6; for example, a medication reminder device in place of Skilled Nurse visits.

6.3.1.4 Additional and Alternative Devices and Services. This includes non-State Plan devices and services meeting the criteria described in section 6.1.28. An example is an additional durable medical device ("speaking computer") that allows the Enrollee to better advocate for him or herself, in place of interpreter services.

6.4 Additional Services Permitted.

The MCO may voluntarily provide or arrange to have provided services in addition to the services described in Article 6, as permitted by CMS under Section 1915(a) of the SSA, 42 USC §1315 et seq., for Enrollees for whom, in the judgment of the MCO's staff, the provision of such services is Medically Necessary. The provision of any such services shall not be included in the calculation of capitation rates. [42 CFR §438.3(e)(1)]

6.5 Special Education Services.

6.5.1 The MCO shall cover evaluations necessary in making a determination for eligibility for individualized education program (IEP) and individualized family service plan (IFSP) services, and medical services identified in an Enrollee's IEP and IFSP. [Minnesota Statutes §256B.0625, subd. 26]

6.5.2 The MCO may not deny the provision of or payment for Medically Necessary medical services for which the MCO is otherwise responsible under this Contract solely because, pursuant to section 6.7.1.8, those services are or could be included in a Child's IEP, or an infant's or toddler's IFSP, developed, reviewed, and revised in accordance with 34 CFR Part 300.

6.6 Limitations on MCO Services.

6.6.1 Medical Necessity.

Unless otherwise provided in this Contract, or otherwise mandated by state or federal law, the MCO shall be responsible for the provision and cost of 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 Network 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 Services that are not State Plan Services.

6.7.1.1 Circumcision. Circumcision is not covered under this Contract unless Medically Necessary. [Minnesota Statutes, §256B.0625, subd. 3f]

6.7.1.2 Cosmetic Procedures or Treatment. Cosmetic procedures or treatment are not covered under this Contract, 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.

6.7.1.3 Drugs covered under the Medicare Prescription Drug Program. Drugs covered under the Medicare Prescription Drug Program are not covered for Enrollees who are eligible for Medicare under this Contract.

6.7.1.4 Detoxification. Detoxification for SUD is not covered by this Contract unless medically necessary.

6.7.1.5 Experimental or Investigative Services. Experimental or Investigative Services are not covered under this Contract.

6.7.1.6 Fertility Drugs and Procedures. Fertility drugs are not covered under this Contract when specifically used to enhance fertility. The following procedures also are not covered: in vitro fertilization, artificial insemination, and reversal of a voluntary sterilization.

6.7.1.7 Incarceration. See section 3.1.4.18 for enrollment and services while incarcerated.

6.7.1.8 IEP and IFSP Services. Medically Necessary Medical Assistance services that would otherwise be covered by this Contract that are provided by school districts or their contractors and are either: 1) identified in an Enrollee's Individual Education Plan (IEP) or 2) the Individual Family Service Plan (IFSP), are not covered under this Contract. However, covered services include IFSP or IEP evaluations that are medical in nature and result in IFSPs or IEPs, or determine the need for continued services.

6.7.1.9 Incidental Services. Incidental services are not covered under this Contract, 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.

6.7.1.10 Out of Country Care. Medicaid payments must not be made for 1) services delivered or items supplied outside of the United States; or 2) to a provider, financial institution, or entity (including Subcontractors) located outside of the United States. For purposes of this section, United States includes the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. [§1902(a)(80) of the SSA]

6.7.1.11 Room and Board. Room and board, or Housing is not covered under this Contract when associated with

(1) Intensive Residential Treatment Services (IRTS);

(2) Children's residential mental health treatment facility; or

(3) Room and board determined necessary by the SUD assessment in section 6.1.50.

6.7.1.12 Services Provided at Federal Institutions. All claims arising from services provided by institutions operated or owned by the federal government, unless the services are approved by the MCO, are not covered under this Contract.

6.7.1.1 SSA §1903(i) Exclusions.

(1) Assisted Suicide. Payment may not be made for services described by the Assisted Suicide Funding Restriction Act of 1997. [42 USC 14401]

(2) Other Non-State Plan Expenditures. Payment may not be made for roads, bridges, stadiums, or any other item or service not covered under the State Plan.

(3) Surety Bonds. Payment may not be made for home health care services unless the home health agency is in compliance with surety bond requirements at provider enrollment (see section 6.9.1 below).

6.7.2 Services Paid by the FFS Program or Other Funding.

6.7.2.1 Abortion Services. Abortion services are not covered under this Contract.

6.7.2.2 Developmental Disability Case Management. DD Case Management (Rule 185) for Enrollees with Developmental Disabilities, pursuant to Minnesota Rules, parts 9525.0004 through 9525.0036, is not covered under this Contract.

6.7.2.3 Essential Community Supports. Services described in Minnesota Statutes, §256B.0922 are not covered under this Contract.

6.7.2.4 HIV Case Management. HIV Case Management is not covered under this Contract.

6.7.2.5 Home and Community Based waiver services. HCBS are not covered under this Contract.

6.7.2.6 ICF/DD services, including Day Training and Habilitation. ICF/DD services are not covered under this Contract.

6.7.2.7 Mileage reimbursement, consistent with section 6.1.31.1.

6.7.2.8 Moving Home Minnesota. MHM is not covered under this Contract and will be handled by the counties.

6.7.2.9 Nursing Facility Per Diem Services. Nursing Facility per diem services are not covered, except as provided for in section 4.14.1 for 100-day Nursing Facility coverage.

6.7.2.10 Officer-involved, community-based care coordination. Officer-involved, community-based care coordination is not covered under this Contract.

6.7.2.11 Relocation Service Coordination. Relocation Service Coordination is not covered under this Contract.

6.7.2.12 State and Other Institutions. All claims arising from services provided by a State regional treatment center or a state-owned long term care facility are not covered under this Contract unless the services are court-ordered pursuant to Minnesota Statutes, §62Q.535, §253B.045, subd. 6, or §260C.201, subd. 1, for Children.

6.7.2.13 Waiver Services. Waiver services are not covered under this Contract, unless used as a Substitute Service.

6.7.3 Services Paid by the FFS Program with Additional Parameters

6.7.3.1 Federally Qualified Health Centers and Rural Health Centers. The Medicaid services of Federally Qualified Health Centers provided under this Contract will be billed directly to the STATE, effective for services provided on or after July 1, 2019. The STATE will provide to the MCO a twice-monthly report on services received by its Enrollees at FQHCs. See section 3.17.

6.7.3.2 Home Care Nursing. Home Care Nursing services provided under this Contract will be billed directly to the STATE. The STATE will provide to the MCO a twice-monthly report on services received by its Enrollees.

6.7.3.3 Indian Health Services. The Medicaid services of IHS and 638 facilities provided under this Contract will be billed directly to the STATE. The STATE will provide to the MCO a twice-monthly report on services received by its Enrollees.

6.7.3.4 Personal Care Assistance, Qualified Professional and Community First Services and Supports. CFSS, PCA, QP, and CFSS services provided under this Contract will be billed directly

to the STATE. The STATE will provide to the MCO a twice-monthly report on services received by its Enrollees.

6.7.3.5 State-operated dental clinics. The services of state-operated dental clinics provided under this Contract will be billed directly to the STATE. The STATE will provide to the MCO a twice-monthly report on services received by its Enrollees at state-operated dental clinics.

6.7.4 Additional Exclusions.

All other exclusions set forth in Minnesota Statutes, §§256B.0625 and 256B.69; and Minnesota Rules, Parts 9505.0170 through 9505.0475; and Parts 9500.1450 through 9500.1464, are not covered under this Contract.

6.8 Enrollee Liability and Limitations.

6.8.1 Cost-Sharing.

Enrollees may be liable for cost-sharing under section 4.11.

6.8.2 Limitation.

Except for section 4.11, the MCO will not bill or hold the Enrollee responsible in any way for any charges or cost-sharing, for Medically Necessary Covered Services or services provided as a substitute for Covered Services, including Medicare cost sharing. The MCO shall ensure that its Subcontractors also do not bill or hold the Enrollee responsible in any way for any charges or cost-sharing for such services.

6.8.2.1 The MCO shall further ensure that an Enrollee will be protected against liability for payment when:

(1) The MCO does not receive payment from the STATE for the Covered Services;

(2) A health care Provider under contract or other arrangement with the MCO fails to receive payment for Covered Services from the MCO;

(3) 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; or

(4) A non-Network Provider does not accept the MCO's payment as payment in full.

(5) Providers may seek payment from an Enrollee for non-covered services (not otherwise eligible for payment), only under the circumstances described in Minnesota Statutes, §256B.0625, subd. 55. See also DHS forms DHS-3640 and DHS-3641.

(6) For SNBC Enrollees, if a Provider under contract or other arrangement with the MCO charges cost sharing that would exceed the amounts permitted under Medicaid if the Enrollee were enrolled only in Medicaid rather than the SNBC Dual Eligible SNP. Provider contracts shall be consistent with 42 CFR §422.504 (g)(1)(iii).

6.8.3 No Payments to Enrollees.

The MCO shall not make payment to an Enrollee in reimbursement for a service provided under this Contract. The MCO shall require its Providers to reimburse Enrollees cost-sharing erroneously charged by the Provider. [42 CFR §§447.25 and 438.704(c]

6.9 Provider Network Management

The MCO must implement written policies and procedures for the selection and retention of Providers.

6.9.1 Provider Selection and Enrollment with the STATE.

6.9.1.1 The MCO must ensure that its Network Providers are enrolled with the STATE as MHCP providers. Network Providers must comply with the provider disclosure, screening, and enrollment requirements in 42 CFR §455. [Minnesota Statutes, §256B.69, subd. 37, and 42 CFR §438.602(b)]

(1) The MCO may enter into a Network Provider contract with a provider that is not a MHCP provider for a period of up to one hundred and twenty (120) days pending the outcome of the MHCP provider enrollment process. The MCO must terminate the temporary contract upon notification that the provider cannot be enrolled as a MHCP provider, or upon expiration of the 120-day period if notification has not been received within that period. The MCO must notify each affected Enrollee of such provider contract termination.

(2) An MCO Network Provider is not required to provide services through the MHCP fee-for-service system.

6.9.1.2 In a manner and timeframe determined by the STATE, published on the STATE's web site, the MCO shall share and exchange data and information with the STATE, in accordance with and taking into consideration Minnesota Statutes §145.61, et seq., relating to provider enrollment topics, including but not limited to:

(1) Reporting information related to provider screening and enrollment actions, provider enrollment statuses, provider appeals or any other actions necessary for the STATE and MCOs to take action related to provider screening and enrollment activities under Minnesota Statutes, §256B.04, subd. 21; 42 CFR §438.602; 42 CFR §455, Subp. E; 42 USC §1396a(a)(78), and the most current version of the "*Medicaid Provider Enrollment Compendium"* published on the Medicaid.gov web site;

(2) Cooperate in verifying, updating and correcting data related to member eligibility and institutional residency issues.

6.9.2 Process for Credentialing and Recredentialing.

6.9.2.1 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.

6.9.3 Sanction Review.

The MCO shall ensure prior to entering into or renewing an agreement with a Provider, that the Provider:

(1) Has not been sanctioned for fraudulent use of federal or state funds by the U.S. Department of Health and Human Services, pursuant to 42 USC §1320a-7(a) or by the State of Minnesota; or

(2) Is not debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 (51 FR 6370, February 18, 1986) or under guidelines interpreting such order; or

(3) Is not an affiliate of such a Provider.

(4) The MCO shall not knowingly contract with such a Provider.

6.9.4 Restricting Financial Incentive.

The MCO may not give any financial incentive to a health care Provider or individual who performs utilization review based solely on the number of services denied or referrals not authorized by the Provider or individual. [Minnesota Statutes, §§ 72A.20, subd. 33 and 62M.12, and as required under 42 CFR §417.479, and for SNBC SNP Enrollees, 42 CFR §422.208]

6.9.5 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. [42 CFR §438.12]

6.9.6 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. [42 CFR §438.214]

6.9.7 Network Provider Access Standards.

The MCO shall require its Network Providers to meet the access standards required by section 6.11, 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. [42 CFR §438.206(c)(1)]

6.9.8 Health Records Maintenance by Providers.

The MCO must ensure that each Provider furnishing services to Enrollees maintains and shares an enrollee health record in accordance with professional standards. [42 CFR 438.208(b)(5)]

6.9.9 Designated Source of Primary Care and Coordination of Services.

The MCO shall have written procedures that

6.9.9.1 Ensure each Enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the Enrollee. For SNBC, such procedures include communicating with new Enrollees in order to determine whether or not an Enrollee has a primary source of care, and to facilitate finding a primary source of care when needed.

6.9.10 Fair Access to Care.

The MCO agrees that the services listed in Article 6 will be available to Enrollees during normal business hours to the same extent available to the general population. [42 CFR §438.210(a)(2)]

6.9.11 Geographic Accessibility of Providers.

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 MDH for areas where the MCO cannot meet these standards. [42 CFR §§438.206(c) and 438.207; Minnesota Statutes, §62D.124]

6.10 ACCESS STANDARDS.

The MCO shall provide the same network of Providers for all Enrollees covered under this Contract. The MCO shall provide care to Enrollees through the use of an adequate number of primary care physicians, clinics, hospitals, nursing facilities, service locations, service sites, and professional, allied and paramedical personnel for the provision of all Covered Services, pursuant to the following standards [42 CFR §§438.206 and 438.207; Minnesota Statutes, §62D.124]:

6.10.1 Primary Care.

6.10.1.1 Distance/Time. No more than thirty (30) miles or thirty (30) minutes distance for all Enrollees, or the STATE's Generally Accepted Community Standards.

6.10.1.2 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 services.

6.10.1.3 Timely Access. The MCO shall arrange for covered health care services, including referrals to Network and non-Network 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.

6.10.1.4 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.

6.10.1.5 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.

6.10.2 Specialty Care.

6.10.2.1 Transport Time. Not to exceed sixty (60) minutes, or the STATE's Generally Accepted Community Standards.

6.10.2.2 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.

6.10.3 Emergency Care.

All Emergency Care must be provided on an immediate basis, at the nearest equipped facility available, regardless of whether the hospital is in the MCO Provider Network.

6.10.4 Hospitals.

Transport time: Not to exceed thirty (30) minutes, or the STATE's Generally Accepted Community Standards.

6.10.5 Dental, Optometry, Lab, and X-Ray Services.

6.10.5.1 Transport Time. Not to exceed sixty (60) minutes, or the STATE's Generally Accepted Community Standards.

6.10.5.2 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.

6.10.6 Pharmacy Services.

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

6.10.7 LTSS Services.

LTSS Services shall meet the STATE's Generally Accepted Community Standards. Enrollees must be offered case management, per section 6.1.5, to assist in obtaining access to appropriate Providers to meet identified LTSS needs.

6.10.8 Other Services.

All other services not specified in this section shall meet the STATE's Generally Accepted Community Standards or other applicable standards.

6.11 SNBC Compliance with Service Accessibility Requirements.

The MCO shall provide service accessibility information to Enrollees and Potential Enrollees upon request, and shall make provisions for reasonably barrier-free access to its own services to Enrollees and Potential Enrollees. These provisions include, but are not limited to educating Providers to mitigate systemic barriers and arranging for services or devices to lessen communication barriers for Enrollees who need access to covered health and support services.

- The MCO shall establish and maintain a training and orientation protocol that assures that customer service employees taking calls from SNBC Enrollees are experienced in working with and have been trained regarding a variety of special needs common among people with disabilities including the use of various communication devices including TTY, and speech patterns common among certain types of disabilities.
- The MCO shall conduct a DHS approved survey on its Provider network utilizing a process required by the STATE and provide complete information about the findings. The MCO shall notify Enrollees and Potential Enrollees of the availability of provider survey information that shall be provided upon request. The MCO shall include instructions in Marketing Materials on how to obtain this information via telephone and electronic means. The MCO shall present at the DHS-led Stakeholder meeting for Seniors and People with disabilities by December 15 of the Contract Year, as set forth in section 4.12.4.2, the methods by which this information was provided to its SNBC members.

6.11.1 Around-the-Clock Access to Care.

The MCO shall make available to Enrollees access to Medical Emergency Services, Post-Stabilization Care Services and Urgent Care on a twenty-four (24) hour, seven-day-per-week basis. The MCO must provide a twenty-four (24) hour, seven day per week MCO telephone number that is answered in-person by the MCO or an agent of the MCO. This telephone number must be provided to the STATE. The MCO is not required to have a dedicated telephone line. [Minnesota Statutes, §62Q.55]

6.11.2 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.

6.11.2.1 Persons with Serious and Persistent Mental Illness (SPMI). Services for this group include ongoing medications review and monitoring, day treatment, and other community-based alternatives to conventional therapy, and coordination with the Enrollee's case

management service Provider to assure appropriate utilization of all needed psychosocial services.

6.11.2.2 Persons with a Physical Disability or Chronic Illness. Services for this group include in-home services and neurological assessments.

6.11.2.3 Abused Children and Adults, Abusive Individuals. Services for this group include comprehensive assessment and diagnostic services and specialized treatment techniques for victims and perpetrators of maltreatment (physical, sexual, or emotional).

6.11.2.4 Enrollees with Language Barriers. Services for this group include interpreter services, bilingual staff, culturally appropriate assessment and treatment.

(1) The enrollment form will indicate whether the Enrollee needs the services of an interpreter and what language she or he speaks.

(2) 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 6.1.4.

(3) In addition, whenever an Enrollee requests an interpreter in order to obtain services under this Contract, the MCO must provide the Enrollee with access to an interpreter, pursuant to section 6.1.22.

6.11.2.5 Cultural and Racial Minorities. Services for this group include culturally appropriate services rendered by Providers with special expertise in the delivery of services to the various cultural and racial minority groups.

6.11.2.6 Persons with Dual MI/DD or MI/SUD Diagnoses. Services for this group include comprehensive assessment, diagnostic and treatment services provided by staff who are trained to work with clients with multiple disabilities and complex needs.

6.11.2.7 Lesbians, Gay Men, Bisexual and Transgender Persons. Services for this group include sensitivity to critical social and family issues unique to these Enrollees.

6.11.2.8 Persons with a Hearing Impairment. Services for this group include access to TDD and hearing impaired interpreter services.

6.11.2.9 Enrollees in Need of Gender Specific MI and/or SUD Treatment. The MCO must provide its Enrollees with an opportunity to receive mental health and/or SUD services from the same sex therapist and the option of participating in an all male or all female group therapy program.

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

6.11.2.11 Persons with a Developmental Disability (DD). Services for this group include specialized mental health and rehabilitative services and other appropriate services covered by Medical Assistance services that are designed to maintain or increase function and prevent further deterioration or dependency and that are coordinated with available community resources and support systems, including the Enrollee's Local Agency DD case management service Provider, families, guardians and residential care Providers. Continuity of care should

be a major consideration in the treatment planning process. Referrals to specialists and sub-specialists must be made when medically indicated.

6.11.2.12 American Indians. Services for this group include culturally appropriate services rendered by Providers with special expertise in the delivery of services to the various tribes.

6.11.3 Client Education.

The MCO will ensure that Enrollees are advised of the appropriate use of health care and the contributions they can make to the maintenance of their own health.

6.11.4 Direct Access to Obstetricians and Gynecologists.

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. [Minnesota Statutes, §62Q.52]

6.12 SERVICES RECEIVED AT INDIAN HEALTH CARE PROVIDERS.

6.12.1 Access to Indian Health Care Providers.

American Indian Medical Assistance Enrollees, living on or off the reservation, will have direct out-of-network access to IHCPs for services that would otherwise be covered under Minnesota Statutes, §256B.0625, even if such facilities are not Network Providers, including IHCPs that are located out of Minnesota. The MCO shall not require any Service Authorization or impose any condition for an American Indian to access services at such facilities. This includes the right of the American Indian Enrollee to choose an IHCP as a Primary Care Provider, if the IHCP is a Network Provider. [42 CFR §438.14(b)(3)]

6.12.2 Referrals from Indian Health Care Providers.

6.12.2.1 When a physician in an IHCP facility refers an American Indian Enrollee to a Network Provider for services covered under this Contract, the MCO shall not require the Enrollee to see a Primary Care Provider prior to the referral.

6.12.2.2 The Network Provider to whom the IHCP physician refers the Enrollee may determine that services are not Medically Necessary or not covered.

6.12.3 Home Care Service Assessments.

The MCO will comply with 6.1.24.1(6) for requirements specific to Tribal Community Members and home care assessments.

6.12.4 Cost-sharing for American Indian Enrollees.

The MCO shall cooperate in assuring that the IHCP and Providers providing IHS Contract Health Services (IHS CHS) through referral from IHS Facilities do not charge copayments to American Indians, pursuant to section 4.11.

6.12.5 STATE Payment for IHS and 638 Facility Services.

The STATE shall pay IHS and 638 facilities directly for services provided to American Indian Enrollees under this Contract. See section 6.7.3.

6.12.6 Payment for IHCPs That Are Not IHS and 638 Facilities.

In the case of an IHCP that is not an IHS or 638 Facility nor FQHC, and for IHS Contract Health Services, the MCO must

(1) Pay for covered services (at Network or non-Network Providers) provided to American Indian Enrollees at a rate equal to the rate negotiated between the MCO and the Provider or,

(2) If such a rate has not been negotiated, the MCO must make payment at a rate that is not less than the level and amount of payment which the MCO would make if the services were furnished by a Network Provider that is not an IHCP [42 CFR §438.14(b)(2)]; and

(3) The MCO must make payment at a rate that is not less than the State Plan rate for the service.

(4) The MCO must not reduce payments to Indian Health Care Providers or Providers providing IHS Contract Health Services (IHS CHS) for cost-sharing amounts not paid by eligible American Indian Enrollees under the exceptions in section 4.11.1. The MCO must ensure refunds to Enrollees of cost-sharing collected in error. [Section 5006 (c) of the ARRA and 42 CFR §447.57]

6.12.7 Cooperation.

The MCO agrees to work cooperatively with the STATE, other MCOs under contract with the STATE, and tribal governments to find mutually agreeable mechanisms to implement this section, including but not limited to a common notification form by which tribal governments may report referrals to the MCO.

6.13 Service Authorization and Utilization Management.

6.13.1 General Exemption for Medicaid Services.

The MCO is exempt from:

- STATE Service Authorization and bulk purchasing requirements in Minnesota Rules, Part 9505.5000 through 9505.5105, except for chiropractic services in section 6.1.7 and the dental services in section 6.1.13.4(1) through (3);
- Second surgical opinion procedures at Minnesota Rules, Parts 9505.5000 through 9505.5105; and
- Certification for admission requirements at Minnesota Rules, Parts 9505.0501 through 9505.0540.

6.13.2 Medical Necessity Standard.

The MCO may require Service Authorization for services, except for Medical Emergency services and other services described in section 6.1.27. Service Authorization shall be based on Medical Necessity, pursuant to section 2.112. In the case of mental health services, Service Authorization shall also be based on Minnesota Statutes, §62Q.53, and for SUD services, in Minnesota Rules, Parts 9530.6600 through 9530.6655.

6.13.3 Utilization Review.

The MCO, and if applicable its Subcontractor, must have in place and follow written policies and procedures for utilization review that: 1) reflect current standards of medical practice in processing requests for initial or continued Service Authorization of services; and 2) meet the requirements specified in Minnesota Statutes, §§ 62M.01 through 62M.12. The MCO's policies and procedures shall ensure the following:

6.13.3.1 Consistent application of written review criteria for authorization decisions;

6.13.3.2 Consultation with the requesting Provider when appropriate;

6.13.3.3 When an initial determination is made to authorize a service, notification to the requesting Provider promptly by telephone, and written notification to the provider or an audit trail of the determination and telephone notification. Notification may also be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. [Minnesota Statutes, §62M.05, subd. 3a, (a) and (b)]

6.13.3.4 Decisions to deny an authorization request or authorize it in an amount, duration, or scope that is less than requested must be made by a Health Care Professional who has appropriate expertise in addressing the Enrollee's medical, behavioral health, or long-term services and supports needs [42 CFR 438.210(b)(3)]; and

6.13.3.5 Notification within one business day after making the determination to the requesting Provider, and written notice to the Enrollee of the MCO's decision to deny or limit the request for services in accordance with section 8.3 [Minnesota Statutes, §62M.05, subd. 3a, (c)];

6.13.3.6 Written notice to the Enrollee must conform to section 8.3, (Denial, Termination, or Reduction (DTR) Notice of Action to Enrollees.).

6.13.3.7 For drug utilization review, meet the requirements of section 6.1.41.11.

6.13.4 Criteria to be Made Available.

The MCO shall make available the criteria for medical necessity determinations made by the MCO to any Enrollee, or Network Provider upon request. [Minnesota Statutes, §62M.10, subd. 7]

6.13.5 Denials Based Solely on Lack of Service Authorization.

he 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. [Minnesota Statutes, §62D.12, subd. 19]

6.14 Timeframe to Evaluate Requests for Services.

6.14.1 General Request for Services.

The MCO must evaluate all requests for services, except requests for covered outpatient drugs under section 6.1.41, either by Network Providers or Enrollees within ten (10) business days of receipt of the request for services, pursuant to section 8.3.3. 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 timeframes in section 8.3.3. Requests for covered outpatient drugs must be evaluated in time to comply with section 1927(d)(5) of the SSA, including providing a response to a prior authorization request within twenty-four (24) hours of the request, per section 6.1.41.11 above.

6.14.2 Request for Urgent Services or Expedited Review.

If the need is for Urgent Care or for services appropriate to prevent institutionalization or if the attending health care professional believes that an expedited determination is warranted, the MCO must evaluate the request for services and communicate its decision on all requests for services to the Enrollee or his or her authorized representative and the appropriate Provider within an expedited time frame appropriate to the type of service and the need for service that has been requested. In no circumstances shall the review process, from the time of initial request to the notification, exceed seventy-two (72) hours. [Minnesota Statutes, §62M.05, subd. 3b, (b)]

6.14.3 Request for Long Term Care Consultation (LTCC).

If the MCO elects to work with a county agency to perform LTCC as described in section 6.1.26.1, then the MCO must do this within ten (10) business days. The MCO must provide for an LTCC related to nursing home placement within ten (10) business days of an Enrollee request.

6.14.4 Request for Mental Health and/or Substance Use Disorder Services.

The MCO must provide Mental Health and/or SUD services in a timely manner. Enrollees requiring SUD crisis or mental health crisis intervention services should be seen immediately. Other Enrollees in need of mental health services should have an appropriate assessment performed within two (2) weeks. For SUD services, assessment timelines may not exceed the timeframes in Minnesota Rules, Part 9530.6615, subd. 1.

6.15 Out of Network and Out of Service Area Care.

The MCO shall cover Medically Necessary Out of Network or Out of Service Area services received by an Enrollee when one of the following occurs:

6.15.1 The Enrollee requires Medical Emergency Services.

6.15.2 The Enrollee requires Post-Stabilization Care Services to maintain, improve or resolve the Enrollee's condition.

6.15.3 The Enrollee is Out of Service Area and requires Urgent Care [Minnesota Rules, Part 4685.1010, subp. 2, (G), and subp. 7]; or

6.15.4 The Enrollee is Out of Network or Out of Service Area and in need of non-Emergency medical services that are or have been prescribed, recommended or are currently being provided by a Network Provider. The MCO may require Service Authorization. When the Enrollee is authorized for Out of Network care or Out of Service Area care, the MCO shall reimburse the non-Network Provider for such services pursuant to section 6.16.4.

6.15.5 The Enrollee moves Out of the Service Area and this change is entered on MMIS after the Cut-Off Date, and a payment has been or will be made to the MCO for coverage for the Enrollee for that same or next month.

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

6.16 Transition Services.

The MCO is responsible for care in the following situations. The following is the state-defined transition of care policy required by 42 CFR §438.62.

6.16.1 Written Plan.

The MCO shall prepare a written plan that provides for transition of care in the event of Network Provider contract termination between the MCO and Primary Care Providers, specialists, or inpatient facilities; or enrollment into the MCO of an Enrollee who meets the criteria in section 6.16.3 below. The written plan must be made available to the STATE on request. The written plan must explain:

(1) How the MCO will inform affected enrollees about termination at least fifteen (15) days before the termination is effective. See also section 3.14.2 (Enrollee Notification of Terminated Provider.).

(2) How the MCO will inform the affected Enrollees about what other participating providers are available to assume care and how it will facilitate an orderly transfer of its Enrollees from the terminating Provider to the new Provider to maintain continuity of care;

(3) The procedures by which Enrollees will be transferred to other Network Providers, when special medical needs, special risks, or other special circumstances, such as cultural or language barriers, require them to have a longer transition period or be transferred to Out of Network Providers;

(4) Who will identify Enrollees with special medical needs or at special risk and what criteria will be used for this determination;

6.16.2 Termination for Cause

6.16.2.1 In the event that the Provider contract termination is for cause, the MCO will follow its Provider contract procedures, and section 3.14.1 (Material Modification of Provider Network), as applicable. If the contract termination was for cause, Enrollees must be notified of the change and transferred to Network Providers in a timely manner so that services remain available and accessible to the affected Enrollees. The MCO is not required to refer an Enrollee back to the terminating Provider if the termination was for cause.

6.16.2.2 For the purposes of this section, "for cause" includes required termination of a Provider from the MCO's Network if the STATE or CMS advise the MCO that the Provider contract must be terminated. In such an event, the MCO will cooperate with the STATE in all communications with Enrollees, including STATE approval of the content of the communications.

6.16.3 Provider Termination Not for Cause or Enrollee New to MCO.

This section describes the requirements for transition of care if the Provider contract termination is not for cause; or if the Enrollee is new to the MCO and meets the following criteria. The MCO must provide, upon request, service authorization to receive services that are otherwise covered under the terms of this Contract through the Enrollee's current Provider, for up to one hundred and twenty (120) days if the Enrollee is engaged in a current course of treatment for one or more of the following conditions:

(1) An acute condition;

(2) A life-threatening mental or physical illness;

(3) Pregnancy beyond the first trimester of pregnancy (see also section 6.16.3(3) for at-risk pregnancy);

(4) A physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death;

(5) A disabling or chronic condition that is in an acute phase;

(6) If the Enrollee is receiving culturally appropriate healthcare services (excluding NEMT services) and the MCO does not have a Network Provider with special expertise in the delivery of those culturally appropriate healthcare services within the time and distance requirements of section 6.10;

(7) If the Enrollee does not speak English and the MCO does not have a Network Provider who can communicate with the Enrollee, either directly or through an interpreter, within the time and distance requirements of section 6.10 or

(8) If a physician, advanced practice registered nurse, or physician assistant certifies that the enrollee has an expected lifetime of 180 days or less, MCO must provide, upon request, service authorization to receive services for the rest of the Enrollee's life.

6.16.3.2 Services Previously Service Authorized. The MCO shall provide Enrollees Medically Necessary Covered Services, including covered State Plan home care services, that an Out of Network or Out of Service Area provider, another MCO, or the STATE had Service Authorized before enrollment in the MCO until an SNBC 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 SUD services are covered as described in the below paragraphs of this section.

6.16.3.3 Orthodontia Care. The MCO shall provide, for Child Enrollees, continuing orthodontia care if: 1) an Out of Network or Out of Service Area Care 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. 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.

6.16.3.4 At Risk Pregnancy. When the Beneficiary 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-Network Providers for services related to prenatal care and delivery, including Inpatient Hospitalization costs for the mother and Child. The MCO is not responsible for additional out-of-plan care for the mother and Child after discharge from the hospital.

6.16.3.5 Substance Use Disorder Treatment Services. The MCO shall be responsible for SUD treatment, excluding room and board, effective upon the date of the Potential Enrollee's enrollment into the MCO. The MCO shall provide coverage for services that were authorized by the CCDTF or any other STATE contracted MCO prior to the Recipient's enrollment in the MCO, unless a new Rule 25 assessment, comprehensive assessment, or assessment update that identifies a different level of need for services is completed by the Provider.

6.16.3.6 Mental Health Services. At the time of initial enrollment in SNBC, the MCO shall consider the individual Enrollee's prior use of mental health services and develop a transitional plan to assist the Enrollee in changing mental health Providers, should this be necessary, and develop a plan to assure continuity of care for any Enrollee or family who is receiving ongoing mental health services.

6.16.3.7 Enrollee Change of MHCP. The MCO shall continue coverage of services with the Enrollee's existing provider if:

(1) The Enrollee was enrolled with the MCO in the same county, but under another contract between the STATE and the MCO;

(2) The MCO products do not have the same Network Providers; and

(3) The Enrollee chooses to receive services from the Network Providers from the prior enrollment with the MCO. The MCO must notify any affected Enrollee of his or her right to choose to remain with the original Network Providers.

6.16.3.8 Pharmacy. Upon the Enrollee's enrollment into the MCO, the MCO shall continue payment of all drugs the Enrollee is taking under a current prescription, except for those drugs being used for indications or at doses which are not supported by FDA approval or other

clinical evidence. 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. See also section 6.1.41.9.

6.16.4 Reimbursement Rate for Out of Network or Out of Service Area Care.

When the Enrollee is authorized to receive Out of Network care or Out of Service Area care, the MCO shall reimburse the non-Network Provider for the Out of Network care or Out of Service Area care.

6.16.4.1 The MCO may not reimburse more than the comparable Medical Assistance rate for emergency services furnished by non-Network Providers. [§6085 of the Deficit Reduction Act; §1932(b)(2)(D) of the SSA]

6.16.4.2 For all other services the MCO is not obligated to reimburse the non-Network Provider more than the comparable Medical Assistance or Medicare FFS rate or its equivalent (or billed charges, whichever is less), unless another rate is required by law. [Minnesota Rules, Part 9500.1460, subpart 11a]

6.16.4.3 As a condition of payment where a single case or other similar agreement is arranged, the MCO must require the non-Network Provider to agree in writing to refrain from billing the Beneficiary for any portion of the cost of the authorized service.

6.16.5 Limitations.

Transition of care payments apply only if the Enrollee's Out of Network Provider agrees to:

(1) Adhere to the MCO's service authorization requirements; and

(2) Provide the MCO with all necessary medical information related to the care provided to the Enrollee.

6.16.6 Health Records Transfer

(1) The MCO must fully and timely comply with requests from the STATE for historical utilization data in compliance with Federal and State law.

(2) The MCO shall require its Providers to maintain and make available to other Providers copies of the Enrollee's medical records, as appropriate and in compliance with Federal and State law

6.17 RESIDENTS OF NURSING FACILITIES.

If a medical service eligible for coverage under this Contract has been ordered by a Network physician or dentist for an Enrollee residing in a Nursing Facility, the MCO is responsible for providing the service and covering the cost of the service required by the physician's or dentist's order.

6.18 ACCESS TO CULTURALLY AND LINGUISTICALLY COMPETENT PROVIDERS.

To the extent possible, the MCO shall provide Enrollees with access to Providers who are culturally and linguistically competent in the language and culture of the Enrollee. For the purpose of this Contract, cultural and linguistic competence includes Providers who serve Enrollees who are deaf and use sign language or an alternative mode of communication.

- Providers. The MCO agrees to work towards increasing the Provider pool of culturally and linguistically competent Providers where there is an identified need, including but not limited to, participating in STATE efforts to increase the Provider pool of culturally and linguistically competent Providers, and participating in the STATE's needs assessment process and related planning effort to expand the pool.

● Access. Nothing in this section shall obligate an MCO to contract or continue to contract with a Provider if the MCO has determined that it has sufficient access for Enrollees to culturally and linguistically competent Providers and/or if the Provider does not meet the MCO's participation criteria, including credentialing requirements.

6.19 PUBLIC HEALTH GOALS.

The MCO will collaborate with other managed care organizations on local public health's community health assessments and the implementation of community health improvement plans as part of their responsibilities under the "Collaboration Plan" specified in Minnesota Statutes §62Q.075, in order to align their public health priority areas with those of local public health agencies. The managed care organizations will develop mutual objectives related to collaborative public health priorities identified through various channels, such as the Local Public Health Association regions, the Center for Community Health and other local public health meetings.

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ARTICLE. 7 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT.

7.1 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM.

The MCO shall provide an ongoing quality assessment and performance improvement program for the services it furnishes to all Enrollees, ensuring the delivery of high quality health care.

The Quality Assessment and Performance Improvement Program must be consistent with federal requirements under Title XIX of the SSA, 42 CFR §438, subpart E, and as required pursuant to Minnesota Statutes, Chapters 62D, 62M, 62N, 62Q and §256B.692 and related rules, including Minnesota Rules, parts 4685.1105 through 4685.1130, and applicable NCQA "*Standards and Guidelines for the Accreditation of Health Plans*," as specified in this Contract.

For SNBC SNP Enrollees, 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 SSA (42 USC §1395w-22) and the implementing regulations at 42 CFR §422.152-158.

The MCO must have mechanisms to assess the quality and appropriateness of care furnished to Enrollees using LTSS for any LTSS services covered under this contract, including assessment of care between care settings and a comparison of services and supports received with those set forth in the enrollee's treatment/service plan. The MCO shall participate as requested in the STATE's *HCBS Settings Transition Plan* to assure that MLTSS will be delivered in settings consistent with 42 CFR §441.301(c)(4).

The MCO must participate in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per 42 CFR §§441.302 and 441.730(a)), that are based at a minimum on the requirements on the State for home and community-based waiver programs per 42 CFR §441.302(h).

7.1.1 Scope and Standards.

The MCO must incorporate into its quality assessment and improvement program the standards as described in 42 CFR §438, subpart E (Quality Measurement and Improvement; External Quality Review). At least annually, the MCO must assess program standards to determine the quality and appropriateness of care and services furnished to all Enrollees. This assessment must include monitoring and evaluation of compliance with STATE and CMS standards and performance measurement.

7.1.2 Accreditation Status.

7.1.2.1 The MCO must inform the State whether it has been accredited by a private independent accrediting entity through an annual report due August 1 of the Contract Year, in a format determined by the STATE. The STATE shall publish the accreditation status for each contracted MCO on its web site, including whether each MCO has been accredited and, if applicable, the name of the accrediting entity, accreditation program, and accreditation level. [42 CFR §438.332]

7.1.2.2 If the MCO holds an accreditation, the MCO must authorize the private independent accrediting entity to provide the State a copy of its most recent accreditation review, including accreditation status, survey type, and level (as applicable); accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and expiration date of the accreditation. The report is due in conjunction with the Triennial Compliance Audit conducted by the STATE as provided in the protocols provided for the Triennial Compliance Examination. [42 CFR §438.332(b)]

7.1.3 Information System.

The MCO must operate an information system that supports initial and ongoing operations and quality assessment and performance improvement program. The MCO must maintain a health information system that collects, analyzes, integrates, and reports data, and can achieve the following objectives [SSA 1903(r)(7); 42 CFR §438.242]:

7.1.3.1 Collect data on Enrollee and Provider characteristics, and on services furnished to Enrollees;

7.1.3.2 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.

7.1.3.3 Make all collected data available to the STATE and CMS upon request.

7.1.4 Review of 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*." This structure must include an effective mechanism and written description to detect both under- and over-utilization of services. [42 CFR §438.330(b)(3)]

7.1.4.1 The MCO shall facilitate the delivery of appropriate care and monitor the impact of its utilization management program to detect and correct potential under- and over-utilization. The MCO shall:

(1) Choose the appropriate number of relevant types of utilization data, to monitor including one type related to behavioral health;

(2) Set thresholds for the selected types of utilization data and annually quantitatively analyze the data against the established thresholds to detect under- and over-utilization;

(3) Examine possible explanations for all data not within thresholds;

(4) Analyze data not within threshold by medical group or practice; and

(5) Take action to address identified problems of under- and over-utilization, and measure the effectiveness of its interventions.

7.1.4.2 The MCO shall submit to the STATE upon request a written report that includes performance measurement data summarizing identified under-utilization and overutilization of services.

7.1.5 Special Health Care Needs.

The MCO must have effective mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs. If the MCO has in place an alternative mechanism(s), or is proposing a new mechanism(s) that meets or exceeds the requirements of this section, the MCO must submit a written description to the STATE for approval. If the MCO's mechanism(s) have been approved by the STATE and there has been a material change, the MCO must timely submit a revised description to the STATE for approval (see also section 3.14.4). [42 CFR §438.330(b)(4)]

All Enrollees covered by this SNBC Contract are considered to meet the STATE's criteria for special needs.

7.1.5.1 Identification and Assessment. Pursuant to section 6.1.4, the MCO shall perform assessments on all SNBC Enrollees and identify any ongoing special conditions of the Enrollee that may require a course of treatment or regular care monitoring. The MCO must implement

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

7.1.5.2 Coordinated Care Plans. For SNBC Enrollees with special health care needs as determined through assessment, the MCO shall develop and implement a coordinated care plan. The care plan must be:

(1) Developed in conjunction with the Enrollee's Primary Care Provider and case managers as applicable, with Enrollee participation, and in consultation with any specialists caring for the Enrollee; and

(2) Approved by the MCO in a timely manner, if approval is required by the MCO.

7.1.5.3 Access to Specialists. If the assessment determines the need for a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow Enrollees to directly access a specialist as appropriate for the Enrollee's condition and identified needs. The MCO's mechanism may be to use a standing referral or an approved number of visits as appropriate for the Enrollee's condition and identified needs. 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); see also section 3.14. [Minnesota Statutes, §62Q.58]

7.1.6 Practice Guidelines.

The MCO shall adopt preventive and chronic disease practice guidelines appropriate for people with disabilities. The MCO shall adopt, disseminate and apply practice guidelines. [42 CFR §438.236]

7.1.6.1 Adoption of Practice Guidelines. The MCO shall adopt guidelines that are 1) based on valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field; 2) consider the specific needs of Enrollees who live with disabilities; 3) are adopted in consultation with contracting Health Care Professionals; and 4) are reviewed and updated periodically, as appropriate. The MCO shall ensure that guidelines are disseminated to all affected Providers and, upon request, to Enrollees and Potential Enrollees.

7.1.6.2 Application of Guidelines. The MCO shall ensure that these guidelines are applied to decisions for utilization management, Enrollee education, coverage of services, and other areas to which there is application and consistency with the guidelines.

7.1.6.3 Practice Guidelines Provided To State Upon Request. MCO agrees to provide copies of the guidelines to the STATE upon request. This copy of the developed practice guidelines will include a listing of which guidelines are being used, and how the guidelines have been adapted for the SNBC population.

7.1.7 Annual Quality Assurance Work Plan.

On or before May 1st of the 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*." The work plan shall specifically address persons with disabilities enrolled in SNBC. If SNBC quality improvement activities are incorporated into the broader quality assurance work plan, SNBC activities must be distinct and identifiable within that plan.

7.1.7.1 If the MCO chooses to substantively amend, modify or update its work plan at any time during the year, it shall provide the STATE with material amendments, modifications or updates in a timely manner. The work plan must include specific references to activities that are to be conducted during the year and impact the SNBC population. See also section 3.14.

7.1.7.2 SNBC MCOs may combine their Medicare and Medicaid Quality Assurance Work Plans to the extent specifically applicable to the SNBC SNP population and to the extent the combined plan meets the STATE's requirements. If the SNBC Dual Eligible MCO/SNP submits a separate work plan to CMS, the MCO will provide a timely copy to the STATE.

7.1.8 Annual Quality Assessment and Performance Improvement Program Evaluation.

The MCO must conduct an annual quality assessment and performance improvement program evaluation consistent with state and federal regulations, and current NCQA "*Standards and Guidelines for the Accreditation of Health Plans*." This evaluation must review the impact and effectiveness of the MCO's quality assessment and performance improvement program including performance on standard measures and MCO's performance improvement projects. The MCO must submit the written evaluation to the STATE by May 1st of the Contract Year.

7.1.8.1 For SNBC SNPs, this evaluation may be combined with the required Medicare evaluation provided it: is conducted at the Dual Eligible SNP subset level; is applicable to the SNBC population; and meets the above criteria.

7.1.9 Dental Access Improvement and Evaluation Project.

SNP and Non-SNP MCOs shall:

7.1.9.1 Continue a dental access improvement and evaluation project consistent with the *2017 SNBC Dental Access Improvement and Evaluation Guidelines.* The STATE will provide thirty (30) days' notice of the dates of presentations identified in the Guidelines.

7.1.9.2 By May 152020 MCOs shall submit to the STATE for review and approval a final report.

7.1.9.3 If required by DHS, the MCOs shall have fifteen (15) business days to make changes to the report as instructed by DHS.

7.2 PERFORMANCE IMPROVEMENT PROJECTS (PIPS).

The MCO must conduct PIPs designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction for people with disabilities. PIP topics should address the full spectrum of clinical and nonclinical areas associated with the MCO and not consistently eliminate any particular subset of Enrollees or topics when viewed over multiple years. Projects must comply with 42 CFR §438.330(b)(1) and (d), and with CMS protocol entitled "Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects." The MCO is encouraged to participate in PIP collaborative initiatives that coordinate PIP topics and designs between MCOs.

7.2.1 New Performance Improvement Project Proposal.

In 2018, the STATE selected the topic for the new PIP to be conducted over a three year period beginning in 2018 (calendar years 2018, 2019, and 2020). The PIP must be consistent with CMS' published protocol entitled "*Protocol for Use in Conducting Medicaid External Quality Review Activities: Conducting Performance Improvement Projects,*" STATE requirements, and include steps one through seven of the CMS protocol.

7.2.1.1 The MCO shall provide annual PIP progress reports to the STATE. For the 2018-2020 PIPs, the first interim report was due September 1, 2019. The second interim report will be due September 1, 2020.

7.2.1.2 For the 2018-2020 PIPs, the final report will be due September 1, 2021.

7.2.2 SNBC Quality Performance and Incentives.

7.2.2.1 The STATE will continue to convene a clinical stakeholders workgroup to review and update the list of quality measures appropriate for the populations, to be tied to financial performance and care outcomes with the ICSPs. The MCO, as part of an ICSP, will choose measures from this list to link performance metrics to payments based on appropriateness for the scope of services included in its ICSP contracts, the target population served and geographic utilization factors, ability to gather data to measure performance, and other factors as appropriate. The MCO may choose to implement new quality measure(s) not contained in the list of quality measures provided by the STATE. In this event, the MCO shall draft a written request which clearly conveys the new quality measure(s) as well as the need and desired outcome for the new quality measure(s). [42 CFR 438.110(a)]

7.2.2.2 The STATE will establish a workgroup with the MCO to develop and or determine specific clinical performance and incentive measures. The workgroup will consult with the STATE's Health Services Advisory Council and clinical representatives from the MCO in developing these measures and guidelines.

7.2.2.3 Performance measures will be developed in collaboration with the STATE, MCO, Care System and stakeholder group (including advocacy and clinical professionals experienced in serving people with disabilities).

7.2.3 PIP Collaborative for SNPs.

The MCO is encouraged to participate in PIP Collaborative initiatives that coordinate PIP topics and designs between SNPs.

7.2.4 Medicare Quality Improvement Projects.

The MCO may use its Medicare performance improvement projects to meet Medicaid requirements if they are conducted and reported at the Dual Eligible SNP subset level, applicable to the SNBC population enrolled, and all other requirements below are met. To the extent that additional, different, or separate PIPs are developed and reported to CMS, the SNBC SNP will provide the STATE with copies of PIP proposals to CMS and PIP reports submitted to CMS within fifteen (15) days of submission.

7.3 POPULATION HEALTH MANAGEMENT (PHM).

The MCO shall create and annually report to the STATE a Population Health Management Strategy or any amendment to the original PHM strategy by July 31 of the Contract Year, including structure and processes to maintain and improve health care quality, and measures in place to evaluate MCO's performance on its process outcomes (for example, clinical care, or Enrollee experience of care).

The MCO must inform the STATE within thirty (30) days if the MCO makes a modification to its PHM Strategy, consistent with section 3.14, Service Delivery Plan.

7.3.1 The MCO's PHM Strategy shall be consistent with current NCQA "Standards and Guidelines for the Accreditation of Health Plans" pursuant to the current Standards for Population Health Management (PHM). At a minimum, the comprehensive PHM Strategy shall describe: (1) Measurable goals and populations targeted for each of the four areas of focus; (2) Programs and services offered to members for each area of focus; (3) At least one activity that is not direct

member intervention (an activity may apply to more than one areas of focus); (4) How member programs are coordinated across potential settings, Providers, and levels of care to minimize the confusion for Enrollees being contacted from multiple sources (coordination activities may apply across the continuum of care and to other organization initiatives); and (5) How Enrollees are informed about available PHM programs and services (for example, by interactive contact and/or distribution of materials).

The PHM Strategy shall include the following areas of focus:

(1) Keeping Enrollees healthy,

(2) Managing Enrollees with emerging risk,

(3) Patient safety or outcomes across settings, and

(4) Managing multiple chronic illnesses.

7.3.2 PHM Reporting

7.3.2.1 The MCO shall annually describe its methodology for segmenting or stratifying its Enrollee population, including the subsets to which Enrollees are assigned (for example, high risk pregnancy) and provide to the STATE a report specifying the following: (1) number of Enrollees in each category and (2) number of programs or services for which these Enrollees are eligible.

7.3.2.2 The MCO shall annually report to the STATE a comprehensive analysis of the impact of its PHM strategy that includes at least the following factors:

(1) Quantitative results for relevant:

(a) Clinical measures (outcome or process measures);

(b) Cost of care or utilization measures; and

(c) Enrollee experience measures (for example, complaints or Enrollee feedback, using focus group or a satisfaction survey).

(2) Comparison of results, including with a benchmark or goal;

(3) Interpretation of results, including interpretation of measures.

7.3.3 The Impact Analysis report is due by July 31 of the Contract Year.

7.3.4 If the MCO chooses to delegate its PHM activities, the MCO shall provide to the STATE a comprehensive description of the structure and mechanisms to oversee delegated PHM activities. This report is due July 31 of the Contract Year and must be completed again at any time the MCO changes any of its PHM delegations.

7.3.5 The MCO shall continue to offer case management services to the most complex, highest-risk Enrollees.

7.4 ENROLLEE SATISFACTION SURVEYS.

The STATE shall conduct an annual Enrollee satisfaction survey for medical care and may add a dental component, and, if necessary, the MCO shall cooperate with the entity arranged by the STATE to conduct the survey.

7.4.1 Disability Survey Methods.

The MCO shall meet the obligations of conducting an annual Enrollee satisfaction survey by the following methods:

7.4.1.1 Disability Survey. The MCO shall conduct an annual survey of SNBC Enrollees to identify unmet health care needs and access issues specific to their disabilities. The MCO will

participate in a workgroup facilitated by the STATE, which will consult the State stakeholders group in the development of the survey.

7.4.1.2 Follow-up Plan. The MCO shall implement a follow-up plan to address specific issues identified in the SNBC disability survey.

7.4.2 SNBC Enrollee Disenrollment Survey.

Enrollee disenrollment is measured by a 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 SNBC Enrollees, the MCO must provide the STATE with a copy of the survey results in a timely manner.

7.4.3 Additional Satisfaction Surveys.

If the MCO or any of its contracted Care Systems conduct an Enrollee satisfaction survey in addition to the disability survey in 7.4.1.1 that involves SNBC 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.

7.5 SNBC Stakeholder Group.

The MCO will establish and maintain a local or regional stakeholders group and obtain periodic feedback from members on satisfaction with care, problem identification, and suggestions for improving the delivery system. The group must include at least a reasonably representative sample of the LTSS populations, or other individuals representing those Enrollees. This stakeholder group will meet at least twice per year. This process must include a way to use this information to improve access to, and quality of, the care delivered to Enrollees with disabilities. Results of consumer feedback activity mechanisms shall be shared with the STATE as described in section 4.12.2.1(3). [42 CFR §438.110 and Minnesota Statutes, §256B.69, subd. 28(2)(e)]

7.6 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. 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 (on site or by other means) 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. [42 USC §1396a(a)(30) and 42 CFR Part 438, subpart E]

7.6.1 Nonduplication of Mandatory External Quality Review (EQR) Activities.

To avoid duplication, the STATE may use information collected from Medicare or private accreditation reviews in place of information collected by the EQRO, when the following required terms are met [42 CFR §438.360]:

7.6.1.1 Complies with federal requirements;

7.6.1.2 CMS or accrediting standards are comparable to standards established by the STATE and identified in the STATE's Quality Strategy;

7.6.1.3 MCOs must have received an NCQA accreditation rating of excellent, commendable or accredited.

7.6.1.4 All Medicare or accrediting reports, findings and results related to the services provided under this Contract are provided to the STATE within thirty (30) days of receipt.

7.6.2 Exemption from EQR.

The MCO may request from the STATE, an exemption to the EQR, if the MCO meets federal requirements and is approved by the STATE [42 CFR §438.362]

7.6.3 Review of EQRO Annual Technical Report Prior to Publication.

The STATE shall allow the MCO to review a final draft copy of the EQRO Annual Technical Report prior to the date of publication. The MCO shall provide the STATE any written comments about the report, including comments on its scientific soundness or statistical validity, within thirty (30) days of receipt of the final draft report. The STATE shall include a summary of the MCO's written comments in the final publication of the report, and may limit the MCO's comments to the report's scientific soundness and/or statistical validity.

7.6.4 EQRO Recommendation for Compliance.

The MCO shall effectively address recommendations for improving the quality of services made by the EQRO in the Annual Technical Report for obligations under this Contract. [42 CFR §438.364(a)(5)]

7.7 Annual Performance Measures.

The MCO will provide the STATE the following within thirty (30) days of submittal to NCQA: 1) HEDIS report submitted to CMS for the SNBC SNP in a format determined by the STATE; and 2) upon request, the documentation submitted to CMS for the SNBC SNP Structure and Process.

7.7.1 Review of Care Systems. Reviews of Care Systems and delegated Case Management systems where applicable, shall be conducted according to the annual reviews described in Article 9.

7.7.2 The MCO shall collaborate with the STATE and other MCOs to promote Care Management /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.

7.7.3 The MCO shall cooperate with any research or evaluation of care provided by the SNBC program.

7.7.4 The MCO shall cooperate with any research or evaluation of Care and/or Case Management conducted by the STATE, CMS or their contractors.

7.7.5 The MCO shall audit a sample of Care Plans for SNBC Enrollees. The MCO may include SNBC Enrollees in the audit sample if a care plan is required for these Enrollees by the MCO. The sample must follow appropriate sampling methodology. The MCO must use a protocol submitted to and approved by the STATE that follows the Care Planning audit data abstraction protocol developed by the Care Plan audit workgroup. Audit results must be submitted to the STATE along with any Care System and/or Care Plan audits as required under section 9.4.2, by September 15th of each year. A summary of the audit results shall be submitted in a form and manner determined by the STATE.

7.8 Integrated Care System Partnerships

7.8.1 The MCO must have a total of at least two ICSPs. At least one of the ICSPs must include services designed to promote the integrations, co-location or improve the coordination of

physical and behavioral health. Providers may participate in more than one ICSP and may contract with more than one MCO.

7.8.2 MCOs are not required to make network additions to establish an ICSP. Notwithstanding section 5.3 of this Contract, the MCO's inability to establish ICSP arrangements before the Termination Date of this Contract shall not be construed as a breach or deficiency if the MCO can demonstrate good faith attempts to contract.

7.8.3 All services provided by the ICSP in coordination with the MCO, including individualized coordination of care, mental health targeted case management and other services, must be delivered in accordance with current applicable Contract requirements.

7.8.4 The MCO must comply with ICSP reporting in section 11.5.1(13) below

7.8.5 The ICSP subcontracts must establish payment arrangements tied to health outcomes and costs of care. The MCO will provide data necessary to verify reported results upon request as required under that section. All ICSP models must support consumer choice of community and institutional settings, and be designed to incent improved health outcomes.

7.9 Evaluation Plan.

The STATE and the MCO shall work cooperatively with the State's contractors and in consultation with the stakeholder group on a SNBC evaluation plan that will include some of the components described in Article 7.

7.10 Quality Workgroup Participation.

7.10.1 The MCO shall appoint representatives to participate in the following STATE workgroups:

(1) Quality Technical Committee covering EQR activities, surveys, the Quality Strategy, the State Monitoring Report, and the Medicaid Quality Rating System. Considerations of the workgroup shall include alignment of federal and state quality standards and other community quality improvement initiatives and activities, with particular focus on improving health outcomes.

(2) The STATE and MCO agree to convene a workgroup to develop strategies and potential future contract changes for:

(a) Alignment of measurable quality improvement across MHCP populations;

(b) Alignment of federal and state quality standards and other community quality improvement initiatives and activities, with particular focus on improving health outcomes;

(c) Elimination of quality measures that are outdated and not contributing to improved health outcomes; and

(d) Opportunities to make the PIPs less administratively burdensome and more aligned with state and community quality improvement goals. The workgroup may also discuss PIP reporting formats and reporting issues.

7.10.2 The MCO is encouraged to appoint a representative to participate in the following workgroup(s):

(1) Care Coordination;

(2) Clinical Practice and Performance Measurement. This group will provide input on clinical practice that includes implementing practice models based on Medical Home concepts, identifying best clinical practices and related performance measurement, and protocol requirements for people with disabilities.

7.11 Annual Quality Program Update.

Annually, the MCO shall demonstrate how the MCO's Quality Improvement Program identifies, monitors and works to improve service and clinical quality issues relevant to the MHCP Enrollees.

7.11.1 The MCO shall submit on or before May 1st of the Contract Year, a web site link to a public web page associated with the MCO describing quality improvement activities that have resulted in measurable, meaningful and sustained improved health care outcomes for the contracted populations. The MCO will describe the quality strategies, including quantitative evidence of improvements, lessons learned, and how the quality improvement outcomes will influence future activities. The web page must prominently feature the description of at least one quality improvement activity addressing health care disparities.

7.11.2 The information on the web site shall be updated at least annually by May 1st of the Contract Year.

7.11.3 The STATE will publish the web site link on the STATE's public web site and public comments will be accepted. The MCO will respond to public comments received.

7.12 Financial Performance Incentives to the MCO.

7.12.1 Compliance and Limits.

Incentive payments to the MCO, if any, must comply with the federal managed care incentive arrangement requirements The total of all payments paid to the MCO under this Contract shall not exceed 105% of the Capitation Payments as applicable to each group of Rate Cells covered under the incentive arrangement, and to the extent that funds are available. If the incentive applies to the entire population covered under the Contract, the limit will apply in aggregate. [42 CFR §438.6(b)(2)]

7.13 Minnesota Community Measurement

The STATE will work with MDH and the marketplace of purchasers and Providers on the development and application of the MN Community Measurement (MNCM) programs supporting MHCP. The MCOs shall retain and apply the race and ethnicity data supplied by DHS when needed for MNCM programs supporting MHCP.

7.14 Patient-centered Decision-making.

The MCO shall work with its providers to: 1) identify key conditions warranting shared decision-making based on potential to improve health outcomes and health care value; and 2) encourage use of shared decision-making by providers for the identified conditions. [Minnesota Statutes, §256B.69, subd. 9, (c)]

7.15 Hybrid Method HEDIS Annual Performance Measures and Rates.

7.15.1 Measures.

The MCO shall calculate and provide to the STATE the following HEDIS 2020 (based on calendar year 2019) performance measures and rates for the SNBC population using the HEDIS hybrid method. The HEDIS hybrid measures and rates shall be submitted to the STATE by September 1 of the Contract Year.

7.15.1.1 Adult BMI Assessment

7.15.1.2 Cervical Cancer Screening

7.15.1.3 Controlling High Blood Pressure

7.15.1.4 Comprehensive Diabetes Care.

7.15.2 Method of Reporting.

The MCO shall collect and report the measures for the populations covered under this contract and shall report separately for SNBC SNP and SNBC Non-SNP Enrollees.

7.15.2.1 The measures listed in section 7.15 shall be reported annually.

7.15.2.2 The MCO may not use a rate calculated from the current year's administrative rate or the prior year's reported rate to determine the medical record review sample size.

7.15.2.3 The MCO shall submit in a format determined by the STATE, the claims and medical record data elements for each eligible enrollee used in the measures or use the data elements/measures for other analysis purposes.

7.15.2.4 The measure shall be validated as "reportable" by a HEDIS NCQA Licensed Organization. The MCO shall submit documentation from the HEDIS Compliance Auditor certifying the measures are reportable. If a measure is determined to be "not reportable" by an NCQA Certified HEDIS Auditor, the MCO shall report the measure and provide an explanation of why the measures is not reportable and the corrective action steps taken by the MCO.

7.15.2.5 The MCO shall utilize all HEDIS 2020 Technical Specification optional exclusions for the measures listed in section 7.15.1.

7.15.2.6 If MCO uses supplemental database elements (internal, external, standard files or non-standard files) the source of these data elements must be indicated and provided to the STATE.

ARTICLE. 8 THE GRIEVANCE AND APPEAL SYSTEM: GRIEVANCES, NOTICES OF ACTION, APPEALS, AND STATE FAIR HEARINGS.

8.1 GENERAL REQUIREMENTS.

8.1.1 Components of Grievance and Appeal System.

The MCO must have a Grievance and Appeal System in place that includes a Grievance process, an Appeal process, and access to the State Fair Hearing (also called the state appeal) system. For SNBC this system must include a Medicare process for Medicare covered services and a Medicaid process, and SNBC SNP Enrollees shall have the right to choose which or both processes to pursue. The overall system must:

8.1.1.1 Assure compliance with Medicare and Medicaid requirements; and

8.1.1.2 Preserve SNBC Enrollees' access to all appropriate levels of Medicare and Medicaid appeals; and

8.1.1.3 To the extent possible, the STATE will work with the MCO to integrate both processes to make the system easier to navigate for the SNBC SNP Enrollee. [See also 42 CFR §§422.630, 422.631, and 422.633]

8.1.2 Timeframes for Resolution.

The MCO must resolve each Grievance or Appeal, and provide notice, as expeditiously as the Enrollee's health condition requires, but no later than timeframes set forth in this Article. For SNBC, 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 and Appeal System must meet the requirements of Minnesota Statutes, §§ 62M.05 (for utilization review), 62M.06 (for appeals), 62Q.68 through 62Q.73 (for review of complaints), and 256.045, subd. 3a (excluding the reference to Minnesota Statutes, §62D.11); and 42 CFR §438, subpart F.

For SNBC SNP Enrollees in the MCO's Medicare integrated product, the Grievance and Appeals system must also meet the requirements of 42 CFR §422, subpart M.

8.1.4 STATE Approval Required.

The MCO's Grievance and Appeal System is subject to approval by the STATE. This requires that:

8.1.4.1 Any proposed changes to the Grievance and Appeal System must be approved by the STATE prior to implementation;

8.1.4.2 The MCO must send written notice to Enrollees of significant changes to the Grievance System at least thirty (30) days prior to implementation;

8.1.4.3 The MCO must provide information specified in 42 CFR §438.10(g)(2)(xi) about the Grievance and Appeal System to Providers and Subcontractors at the time they enter into a contract; and

8.1.4.4 Within sixty (60) days after the execution of a contract with a Provider, the MCO must inform the provider of the programs under this Contract, and specifically provide an explanation of the Notice of Rights and Responsibilities, and Grievance, Appeal and State Fair Hearing rights of Enrollees and Providers under this Contract.

8.1.5 Response to Investigation.

The MCO must respond directly to county advocates, and the STATE Ombudsman for managed care, regarding service delivery. [Minnesota Statutes, §256B.69, subd. 3a; 256B.69, subds. 20 and 21]

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 about a matter regarding an Enrollee's dissatisfaction about any matter other than an MCO Action. Examples include the quality of care or services provided, rudeness of a provider or employee, or failure to respect the Enrollee's rights. A Grievance may be filed orally or in writing. [See also 42 CFR §§ 422.629 and 422.630, for integrated grievances]

8.2.2 Timeframe for Resolution of a Grievance.

8.2.2.1 Oral Grievances must be resolved within ten (10) days of receipt.

8.2.2.2 Written Grievances must be resolved within thirty (30) days of receipt.

8.2.2.3 Oral Grievances may be resolved through oral communication, but the MCO must send the Enrollee a written decision for written Grievances.

8.2.3 Timeframe for Extension of Grievance Resolution.

The MCO may extend the timeframe for resolution of a Grievance by an additional fourteen (14) days if the Enrollee or the Provider requests the extension, or if the MCO justifies that the extension is in the Enrollee's interest (for example, due to a need for additional information), [42 CFR § 438.408(c)]

8.2.3.1 The MCO must make reasonable efforts to provide prompt oral notice, and provide written notice within two (2) calendar days 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 notify the Enrollee of the right to file a Grievance regarding the delay.

8.2.3.2 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.

8.2.4.1 The MCO must mail a written acknowledgment to the Enrollee or Provider acting on behalf of the Enrollee, within ten (10) days of receiving a written Grievance, and may combine it with the MCO's notice of resolution if a decision is made within the ten (10) days.

8.2.4.2 The MCO must maintain a log of all Grievances, oral and written.

8.2.4.3 The MCO must not require submission of a written Grievance as a condition of the MCO taking action on the Grievance.

8.2.4.4 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. [Minnesota Statutes, §62Q.69]

8.2.4.5 The individual making a decision on a Grievance shall not have been involved in any previous level of review or decision-making. [42 CFR §438.406(b)(2)(i)]

8.2.4.6 If the MCO is deciding a Grievance regarding the denial of an expedited resolution of an Appeal or one that involves clinical issues, the individual making the decision must be a Health Care Professional with appropriate clinical expertise in treating the Enrollee's condition or disease. The MCO shall make a determination in accordance with the timeframe for an expedited Appeal. A grievance concerning a denial of an expedited appeal shall be processed as an expedited grievance within a timeframe of 72 hours. [42 CFR §438.406(b)(2)(ii)]

8.2.5 Notice of Resolution of a Grievance.

8.2.5.1 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. Oral resolution must include the results of the MCO investigation and actions related to the Grievance, and the MCO must inform the Enrollee of options for further assistance through the Managed Care Ombudsman and/or review by MDH. [Minnesota Statutes §62Q.69, subd. 2]

8.2.5.2 When a Grievance is filed in writing, the MCO must notify the Enrollee in writing of its resolution. The letter must include the results of the MCO investigation, MCO actions relative to the Grievance, and options for further review through the Managed Care Ombudsman, and MDH.

8.3 Denial, Termination, or Reduction (DTR) Notice of Action to Enrollees.

If the MCO denies, reduces or terminates services or claims that are: 1) requested by an Enrollee; 2) ordered by a Network Provider; 3) ordered by an approved, non-Network Provider; 4) ordered by a care manager; or 5) ordered by a court, the MCO must send a DTR notice to the Enrollee that meets the requirements of this section.

For SNP Enrollees, the MCO shall use CMS 10003-NDMCP for all Medicare services denied, terminated or reduced by the MCO; if services are provided as requested or ordered, no DTR needs to be sent to the Enrollee.

8.3.1 General DTR Notice of Action Requirements.

The MCO must provide a copy of any DTR promptly, when requested, to the Ombudsman for Managed Care as well as the STATE.

8.3.1.1 The MCO may have its Subcontractor send the DTR to the Enrollee only if MCO has received prior written approval by the STATE. The MCO must submit in advance for STATE approval any DTR notification and member rights form that will be used by the Subcontractor.

8.3.1.2 Written Notice. The DTR must meet the language requirements of 42 CFR §438.10(d). The DTR must also:

(1) Be understandable to a person who reads at the 7th grade reading level;

(2) Be available in alternative formats as required by section 3.11.3.2;

(3) Be approved in writing by the STATE, pursuant to section 3.11;

(4) Maintain confidentiality for Family Planning Services, (i.e. ensure that all information related to Family Planning is provided only to the Enrollee, in a confidential manner); and

(5) Be sent to the Enrollee.

8.3.2 Content of the DTR Notice of Action.

The DTR must include [42 CFR §438.404 and Minnesota Statutes, § 62M.05]:

- The date the DTR was issued;
- Identification of the Enrollee and the provider of the service;
- The first date of service, if the Action is for denial, in whole or in part, of payment for a service;
- 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;
- The effective date of the Action if it results in a reduction or termination of ongoing or previously authorized services;
- The Action that the MCO has taken or intends to take;
- The type of service or claim that is being denied, terminated, or reduced;
- A clear detailed description in plain language of the reasons for the Action;
- The specific federal or state regulations that support or require the Action, whichever applies. Nothing in this section prevents the MCO from providing more specific information;
- The STATE's language block with an MCO phone number that Enrollees may call to receive help in interpretation of the notice;
- A phone number at the MCO that Enrollees may call to obtain information about the DTR;
- An offer of a copy of the information used to make the decision [Minnesota Statutes, §62M.07, subd. 3a, (c)]; and
- The "Your Appeal Rights" notice provided and/or approved by the STATE, which includes but is not limited to:
    - The Enrollee's right (or Provider on behalf of Enrollee with the Enrollee's written consent) to file an Appeal with the MCO within sixty (60) calendar days of the date of

the DTR. More time may be allowed if the Enrollee has a good reason for missing the deadline [42 CFR §§438.402 and 438.404];

- The requirements and timelines for filing an MCO Appeal [42 CFR §438.402];
- The Enrollee's right to file a request for a State Fair Hearing after first exhausting the MCO's Appeal procedures, or up to one hundred and twenty (120) days after the MCO's final determination of the Appeal;
- The process the Enrollee must follow in order to exercise these rights;
- The circumstances under which expedited resolution is available and how to request it for an Appeal or State Fair Hearing;
- The Enrollee's right to continuation of benefits upon request within the time frame allowed, how to request that benefits be continued, and under what circumstances (consistent with State policy) the Enrollee may be required to pay the costs of these services if the Enrollee files an Appeal at the MCO or requests a State Fair Hearing; and
- The right to seek an expert medical opinion from an external organization in cases of Medical Necessity at the STATE's expense, for consideration at State Fair Hearings, consistent with section 8.8.7.

8.3.2.1 Notice to Provider. The MCO must notify the Provider of the Action. For denial of payment, notice may be in the form of an Explanation of Benefits (EOB), explanation of payments, or remittance advice. The MCO must also notify the Provider of the right to Appeal a DTR pursuant to section 8.4.2, 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. [Minnesota Statutes, § 62M.05, subd. 3a, (b) and (c); Minnesota Statutes, §§62J.51 and 62J.581]

8.3.2.2 Notice to Enrollee of Right to Quality Improvement Organization Review. The MCO shall ensure that affected SNBC SNP Enrollees are notified of the right to request an immediate Quality Improvement Organization (QIO) review if the Enrollee believes she or he is being prematurely discharged 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 8.3.1.

8.3.2.3 The MCO shall ensure that the SNBC Enrollee receives notification of termination of Medicare services provided by a skilled nursing facility, home health agency or comprehensive outpatient rehabilitation facility in accordance with 42 CFR §422.624. The SNBC Enrollee shall also have the right to appeal such termination to an Independent Review Entity (IRE) under 42 CFR §422.626. This provision supersedes the otherwise required STATE DTR notice under section 8.3.1 of this Contract.

8.3.3 Timing of the DTR Notice.

The MCO must immediately notify the STATE and the Ombudsman for Managed Care if the MCO becomes aware that DTRs are not being issued timely.

8.3.3.1 Previously Authorized Services. For termination, suspension, or reduction of previously authorized services, the MCO must mail the Notice to the Enrollee and the attending Provider at least ten (10) days before the effective date of the proposed Action [42 CFR §438.404(c)(1), referring to 42 CFR §431.211] The exceptions to advance notice at 42 CFR §431.213 shall not apply. However, the MCO may apply the shortened notice period described in 42 CFR §431.214 in cases of probable fraud.

The following criteria must also be met:

(1) The previously authorized service must have been ordered by a Network or authorized non-Network Provider who is a treating physician, osteopath, dentist, Mental Health Professional, nurse practitioner or chiropractor;

(2) The service must be eligible for payment according to Minnesota Statutes, §256B.0625 and Minnesota Rules, Parts 9505.0170 through 9505.0475; and

(3) All procedural requirements regarding Service Authorization must have been met.

8.3.3.2 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.

8.3.3.3 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 Provider and hospital by telephone or fax within one business day after making the determination, consistent with Minnesota Statutes, §62M.05, subd. 3a; and

(3) To the Provider, Enrollee and hospital, in writing which must include the process to initiate an appeal, within ten (10) business days following receipt of the request for the service, unless the MCO receives an extension of the resolution period, pursuant to section 8.3.3.5.

8.3.3.4 Expedited Authorizations. For expedited Service Authorizations, the MCO must provide the determination as expeditiously as the Enrollee's health condition requires, not to exceed seventy-two (72) hours of receipt of the request for the service. Expedited Service Authorizations are for cases where the Provider indicates, or the MCO determines that following the standard timeframe could seriously jeopardize the Enrollee's life or health, or ability to attain, maintain or regain maximum function.

8.3.3.5 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 time. The MCO must issue a determination no later than the date the extension expires. The STATE may review the MCO's justification upon request.

8.3.3.6 Covered outpatient drug decisions. For all covered outpatient drug authorization decisions, provide response by telephone or other telecommunication device within twenty-four (24) hours of a request for prior authorization, as described in section 1927(d)(5)(A) of the SSA.

8.3.3.7 Delay in Authorizations. For Service Authorizations not reached within the timeframe specified in 42 CFR §438.210(d)(1), (which constitutes a denial and is thus an Action), the MCO must provide a notice of denial on the date the timeframe expires.

8.4 MCO Appeals Process Requirements.

8.4.1 One Level of Appeal.

The MCO may have only one level of appeal for Enrollees. Multiple reviews by different personnel within the MCO are not construed as multiple levels of appeal. Regardless of the personnel reviewing an appeal, the review must not extend any of the timeframes specified in 42

CFR §438.408 and must not disrupt the continuation of benefits in 42 CFR §438.420. [42 CFR §438.402]

8.4.2 Filing Requirements.

The Enrollee, or the Provider acting on behalf of the Enrollee with the Enrollee's written consent, may file an Appeal within sixty (60) days of the date of the DTR Notice of Action or for any other Action taken by the MCO as it is defined in section 2.3.

8.4.2.1 An attending Health Care Professional may appeal a utilization review decision at the MCO level without the written signed consent of the Enrollee. [Minnesota Statutes, §62M.06]

8.4.2.2 An Appeal may be filed orally or in writing. The initial filing determines the timeframe for resolution.

8.4.2.3 For SNBC, if the Enrollee chooses to file an Appeal through the Medicare process under 42 CFR §422.582, the Enrollee must file an Appeal within sixty (60) days unless the Enrollee shows good cause. Nothing shall prevent an SNBC Enrollee from pursuing both the Medicare and Medicaid process simultaneously.

8.4.2.4 If the Appeal is filed orally the MCO must assist the Enrollee, or Provider filing on behalf of the Enrollee, in completing a written signed Appeal. Once the oral Appeal is reduced to a writing by the MCO, and pending the Enrollee's signature, the MCO:

- May promptly resolve the Appeal in favor of the Enrollee, regardless of receipt of a signature, or
- If no signed Appeal is received within thirty (30) days, the MCO may resolve the Appeal as if a signed appeal were received.

8.4.3 Medicare Requests for Hearing for SNBC SNP Enrollees.

The SNBC Enrollee may choose the Medicare process of the MCO's system for Medicare covered services as required in 8.1.1.3. The MCO must follow 42 CFR §§ 422.600 to 616 that includes Enrollee access to review by an independent review entity, Administrative Law Judge, Medicare Appeals Council and Judicial Review.

8.4.4 Timeframe for Resolution of Appeals and Expedited Appeals.

8.4.4.1 Standard Appeals. The MCO must resolve each Appeal as expeditiously as Enrollee's health requires, not to exceed thirty (30) days after receipt of the Appeal. [42 CFR §438.408 (b)(2); Minnesota Statutes, §62M.06, subd. 3, (b)]

8.4.4.2 Expedited Appeals.

(1) 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. [42 CFR §438.408(b)(3); §62M.06, subd. 2, (b)].

(2) If the MCO denies a request for expedited Appeal, the MCO shall transfer the denied request to the standard Appeal process, preserving the first filing date of the expedited Appeal. The MCO must notify the Enrollee of that decision orally within twenty-four (24) hours of the request and follow up with a written notice within two (2) days. [42 CFR §438.410(c)]

(3) When a determination not to certify a health care service is made prior to or during an ongoing service, and the attending health care professional believes that an expedited Appeal is warranted, the MCO must ensure that the Enrollee and the attending health care professional have an opportunity to appeal the determination over the telephone. In such

an Appeal, the MCO must ensure reasonable access to the MCO's consulting physician. [Minnesota Statutes, §62M.06, subd.2(a)]

8.4.4.3 Deemed Exhaustion of Appeals. In the event that the MCO fails to adhere to the notice and timing requirements of section8.4.4 and 8.4.8, the Enrollee is deemed to have exhausted the Appeals process, and may proceed to a State Fair Hearing. [42 CFR §438.408 (c)(3)]

8.4.5 Timeframe for Extension of Resolution of Appeals and Expedited Appeals.

An extension of the timeframes of resolution of Appeals, and expedited Appeals, of fourteen (14) days is available 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 make reasonable efforts to provide prompt oral notice, and provide written notice within two (2) calendar days 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 notify the Enrollee of the right to file a Grievance regarding the delay, including an expedited Grievance about a delay in an expedited Appeal. The MCO must issue a determination no later than the date the extension expires. The STATE may review the MCO's justification. [42 CFR §438.408(c)]

8.4.6 Handling of Appeals.

8.4.6.1 All oral inquiries challenging or disputing a DTR Notice of Action or any Action as defined in section 2.3 shall be treated as an oral Appeal and shall follow the requirements of section 8.4.2. [42 CFR §438.406(b)(3)]

8.4.6.2 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 has been made within the ten (10) days. [42 CFR §438.406(b)]

8.4.6.3 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. [42 CFR §438.406(a)]

8.4.6.4 The MCO must ensure that individuals making the decision were not involved in any previous level of review or decision-making, nor are subordinates of the person making the previous decision.

8.4.6.5 If the MCO is deciding an Appeal regarding denial of a service based on 1) lack of Medical Necessity, 2) a Grievance regarding denial of expedited resolution of an Appeal, or 3) a Grievance or Appeal that involves clinical issues; then 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. The MCO must take into account all comments, documents, records, and other information submitted by the Enrollee or representative without regard to whether the information was submitted or considered in the initial Action. [42 CFR §438.406(b)(3)(ii); Minnesota Statutes, §§62M.06, 62M.09]

8.4.6.6 The MCO must provide the Enrollee with a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person or by telephone as well as in writing. For expedited Appeal resolutions, the MCO must inform the Enrollee of the limited time available to present evidence in support of the Appeal. [42 CFR §438.406(b)(4)]

8.4.6.7 The MCO must offer and provide the Enrollee and his or her representative the Enrollee's case file upon request. This includes medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO (or at the direction of the MCO), in connection with the Appeal of the Action. Such information includes medical necessity criteria and any evidentiary standards used in setting coverage

limits. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals. [42 CFR §438.406(b)(5), and (c); Minnesota Statutes, §62M.10, subd. 7]

8.4.6.8 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. [42 CFR §438.406(b)(6)]

8.4.6.9 The MCO must not take punitive action against a Provider who requests an expedited resolution or supports an Enrollee's Appeal. [42 CFR §438.410(b)]

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. The new Appeal will follow the procedures and timeframes of section 8.4.

8.4.8 Notifying Enrollees and Providers of Resolution of Appeal.

8.4.8.1 The MCO must provide a written letter of resolution for all Appeals, and must include in the text of the letter [42 CFR §438.408(e)]:

- The results of the resolution process and date it was completed; and
- The Enrollee's right to request a State Fair Hearing if the resolution was not wholly favorable to the Enrollee, and how to do so, and
- The Enrollee's right to continuation of benefits. The MCO must include with the letter a copy of the STATE's notice "Your Appeal Rights," which includes information on potential liability for the cost of continued benefits if the State Fair Hearing decision upholds the MCO's decision. See also section 8.5 below

8.4.8.2 For Appeals of Utilization Management (UM) decisions, the written letter of resolution of the Appeal shall be sent to the Enrollee and the attending Provider. [Minnesota Statutes, §62M.06, subd. 3, (b)]

8.4.8.3 The MCO must notify the Enrollee and attending Provider by telephone of its determination on an expedited appeal as expeditiously as the Enrollee's medical condition requires, but no later than seventy-two (72) hours after receiving the expedited Appeal. [Minnesota Statutes, §62M.06, subd. 2, (b)]

8.4.8.4 If an Enrollee or attending Provider is unsuccessful in an appeal of the UM determination, the MCO must provide: 1) a complete summary of the review findings, 2) qualifications of the reviewer, 3) the relationship between the Enrollee's diagnosis and the review criteria used, including the specific rationale for the reviewer's decision. [Minnesota Statutes, §62M.06 subd. 3(f)]

8.4.9 Reversed Appeal Resolutions.

If a decision by an MCO is reversed by the Appeal or State Fair Hearing process, the MCO must [42 CFR §438.424]:

8.4.9.1 Authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires but no later than seventy-two (72) hours from the date the MCO receives notice reversing the determination, if the services were not provided during the Appeal process; and

8.4.9.2 Pay for any services the Enrollee already received that are the subject of the Appeal or State Fair Hearing.

8.5 Continuation of Benefits Pending Appeal or State Fair Hearing

8.5.1 Continuation of Benefits Pending Resolution of Appeal.

8.5.1.1 If an Enrollee files an Appeal with the MCO and requests continuation of benefits within the time allowed, the MCO may not reduce or terminate the service until ten (10) days after a written decision is issued in response to that Appeal or thirty (30) days in the case of Nursing Facility Level of Care determinations as described in section 6.1.13(H), unless the Enrollee withdraws the Appeal. Providers may not request continuation of benefits. "Within the time allowed" means the request is made on or before the date that is ten (10) days after the MCO sends the DTR, or the effective date of reduction or denial of services on the DTR, whichever is later. The time period of the original authorization must not have expired. [42 CFR §438.420(b)] See also 42 CFR §§422.632 and 422.629(l)(10(iv) for continuation of Medicare benefits during an appeal of Medicare benefits.

8.5.1.2 In the case of a reduction or termination of ongoing (previously authorized) services, services must be continued pending the outcome of the Appeal if there is an order for services by an authorized Provider. [42 CFR §438.420(b)(3)]

8.5.2 Continuation of Benefits Pending Resolution of State Fair Hearing.

8.5.2.1 If the Enrollee files a written request for a State Fair Hearing with the STATE and requests continuation of benefits within the time allowed, the MCO 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. "Within the time allowed" means the request is made on or before the date that is ten (10) days after the MCO sends its notice of resolution of Appeal. [42 CFR §438.420(b); Minnesota Statutes, §256B.69, subd. 18]

8.5.2.2 In the case of a reduction or termination of ongoing services under section 8.3, services must be continued pending outcome of all Appeal or State Fair Hearings if there is an existing order for services by an authorized Provider. [42 CFR §438.420(b)(3)]

8.5.3 Upheld Appeal Resolutions.

If the final resolution of the appeal is adverse to the Enrollee, that is the MCO decision is upheld the MCO may institute recovery procedures against the Enrollee (consistent with State policy) for the cost of the services furnished to the Enrollee while the Appeal or State Fair Hearing was pending, to the extent that the services were furnished solely because of the requirements of 42 CFR §438.420(d).

8.6 Maintenance of Grievance and Appeal Records.

The MCO must maintain and make available upon request by the STATE its records of all Grievances, DTRs, Appeals and State Fair Hearings.

8.7 Reporting of DTRs, Grievances and Appeals to the STATE.

The MCO must submit to the STATE electronic reports of all DTRS, oral and written Grievances, and oral and written Appeals, respectively, with the following requirements:

8.7.1 Each report shall be submitted quarterly as a comma-delimited text file, with data elements specified by the STATE and per STATE technical specifications, including identifying oral and written Grievances and Appeals separately in order to track both types of filed grievances;

8.7.2 The reports are submitted through the Online Grievance/DTR/Appeals Reporting Web Application (ORWA), via MN-ITS;

8.7.3 The reports are due on or before the 30th day of the month following the end of the quarter, for:

8.7.3.1 All DTRs issued in the previous quarter;

8.7.3.2 All oral and written Grievances resolved in the previous quarter, and

8.7.3.3 All oral and written Appeals resolved in the previous quarter.

8.8 STATE FAIR HEARINGS.

8.8.1 Matters Heard by State Fair Hearing Human Services Judge.

The State Fair Hearing Human Services Judges may review any Action by the MCO, as Action is defined in section 2.3. The parties to the State Fair hearing include the MCO, the Enrollee, his or her representative, or the legal representative of a deceased Enrollee's estate. [42 CFR §438.408(f)(3); Minnesota Statutes, §§256.045 and 256.0451]

8.8.2 Standard Hearing Decisions.

8.8.2.1 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 after exhaustion of the MCO's Appeals process but no later than one hundred and twenty (120) days from the Appeal decision. [42 CFR §438.408(f)(2)]

8.8.2.2 The STATE must take final administrative action on any request for a State Fair Hearing within ninety (90) days of the date the request for a State Fair Hearing was filed. [42 CFR §431.244(f)]

8.8.2.3 The MCO must cooperate with the STATE in determining the date the Enrollee filed an Appeal with the MCO, including but not limited to:

(1) The MCO shall name a specific contact for the State Fair Hearing Office to contact for information about: a) an Appeal of the same issue filed at the MCO, b) the date the Appeal was filed, and c) the date of resolution of the Appeal;

(2) The MCO shall respond with the following information about an Appeal within five (5) business days of receiving the request from the State Fair Hearing Office: a) whether an Appeal was filed with an MCO; b) the date the Appeal was filed; c) the resolution of the Appeal; and d) the date it was resolved; and

(3) The MCO shall notify the STATE and the State Fair Hearing Office of changes to the name or phone number of the contact within one (1) business day of any change.

8.8.3 Costs of State Fair Hearing.

The MCO shall provide reimbursement to the Enrollee for transportation, child care, photocopying, 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. [42 CFR §431.250]

8.8.4 Expedited Hearing Decisions.

8.8.4.1 The STATE must take final action within three (3) business 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).

8.8.4.2 The MCO must send the case file to the State Fair Hearing Office as expeditiously as the Enrollee's health requires, not to exceed one (1) business day.

8.8.5 Compliance with State Fair Hearing Resolutions.

8.8.5.1 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.

8.8.5.2 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 authorize or pay for any services the Enrollee received that are the subject of the State Fair Hearing. Services must be provided as expeditiously as the Enrollee's health condition requires but not later than within seventy-two (72) hours after notice to the MCO. [42 CFR §438.424]

8.8.5.3 Upheld State Fair Hearing Resolutions. If the MCO's Action is sustained by the State Fair Hearing decision, the MCO may institute procedures against the Enrollee (consistent with State policy) to recover the cost of medical services furnished solely by reason of section 8.5. [42 CFR §438.424(b)]

8.8.6 Representation and Defense of MCO Determinations.

The MCO agrees that it is the responsibility of the MCO to represent and defend all MCO determinations at the State Fair Hearing including compliance with the access to files and appeal summary requirements of Minnesota Statutes, §256.0451, subds 2 and 3, and at any subsequent judicial reviews involving that determination. The MCO must receive the advice and consent of the STATE before appealing any subsequent judicial decisions adverse to the Commissioner's Order. The MCO agrees that the STATE shall provide necessary information, but that the STATE shall not assume any costs associated with such representation. The STATE shall notify the MCO in a timely manner of any State Fair Hearings that involve the MCO.

8.8.7 External Review or Medical Review Participation.

In the course of a State Fair Hearing, an Enrollee may request an external review pursuant to 42 CFR 438.408(f) and 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, subds. 6 and 8.

8.8.8 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.

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ARTICLE. 9 COMPLIANCE WITH REQUIRED PROVISIONS.

9.1 COMPLIANCE WITH FEDERAL, STATE AND LOCAL LAW.

The MCO and its Subcontractors shall comply with all applicable federal and state statutes and regulations, as well as local ordinances and rules now in effect and hereinafter adopted, including but not limited to Minnesota Statutes, §§ 62J.695 through 62J.76 (Minnesota Patient Protection Act), Minnesota Statutes, §62Q.47 (Alcoholism, Mental Health, and Substance Use Disorder Services), Minnesota Statutes, §62Q.53 (Mental Health Coverage; Medically Necessary Care), Minnesota Statutes, §62Q.58 (Standing Referral for Access To Specialty Care), Minnesota Statutes, §62Q.19 (Essential Community Providers); and Minnesota Statutes, §256.969, subds. 3b and 4a, with 42 CFR § 438.3(g) and 42 CFR §447.26, (Provider-Preventable Conditions).

9.1.1 Required MCO Participation in STATE Programs.

The MCO must comply with Minnesota Statutes, §§ 256B.0644 and 62D.04, subd. 5.

9.1.2 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. In the event any necessary permit, license, or certificate is canceled, revoked, suspended or expires during the term of this Contract, the MCO agrees to so inform the STATE immediately.

9.1.3 HMO and CISN Requirements For County Based Purchasing Entities.

The MCO shall comply with state statutes and regulations applicable to HMOs or community integrated service networks (CISNs), including: Minnesota Statutes, §62A.0411 (48-hour hospital stay for Maternity Care); Minnesota Statutes, §§ 62J.695 through 62J.76 (Patient Protection Act); and Minnesota Statutes, §§ 62D.03, subd. 4(a) through (d), (h), (i), (k), (m), (n), (p), (r), and (s); 62D.041, subd. 3 and 9; 62D.06 through .08; 62D.11; 62D.123; 62M.04 through .12; 62N.28; 62N.29; 62N.31 and 72A.201; Minnesota Rules, part 4685.0300, subparts 2(A) and (B); 4685.1010, 4685.1115, 4685.1120, 4685.1900; and 4685.3300, subpart 9 (HMO and CISN requirements, to the extent the Commissioner of Health has interpreted them to apply to county-based purchasers).

9.1.4 Compliance with Contract Terms.

Failure to comply with the terms of this Article may result in the imposition of any applicable sanctions or remedies authorized under the law and/or as defined in Article 5 of this Contract.

9.2 MCO SOLVENCY STANDARDS ASSURANCE; RISK-BEARING ENTITY.

9.2.1 If the MCO is a not a Federally Qualified HMO, the MCO must provide written assurance to the STATE by April 30th of the Contract Year, and any time thereafter, if there is significant change

in the MCO or the Contract, that its provision against the risk of insolvency is adequate to ensure that its Enrollees will not be liable for the MCO's debts if it becomes insolvent. [42 CFR §438.106]

9.2.2 All MCOs must meet the solvency standards established by the State for Health Maintenance Organizations 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 current, in writing, fully executed, and, include a specific reference to the SNBC product and a description of payment arrangements for the SNBC product. 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 CMS. The MCO must provide education to new Providers about the SNBC product and special needs of SNBC Enrollees.

9.3.1.1 MCO subcontracts that include delegation of program integrity responsibilities must require Subcontractors to comply with program integrity obligations under state and federal law and section 9.9.1 of this contract. If an MCO engages with a Subcontractor and does not delegate its program integrity responsibilities to the Subcontractor, the MCO shall remain responsible for all program integrity responsibilities under state and federal law and section 9.9.1.1 with respect to the Subcontractor's services.

9.3.1.2 Current and fully executed agreements for all Subcontractors, including bargaining groups, must be maintained for all administrative services that are expensed to MHCP. Subcontractor agreements determined to be material, as defined by the STATE, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the Subcontractor services relate to MHCP. [Minnesota Statutes, §256B.69, subd. 5a]

9.3.1.3 Upon request, the STATE shall have access to all Subcontractor documentation under this section.

9.3.1.4 Nothing in this section shall allow release of information that is nonpublic data pursuant to Minnesota Statutes, §13.02.

9.3.2 Provision of SNBC Information.

The MCO shall inform and educate its Subcontractors, Primary Care Providers and Care Systems about the integrated Medicare and Medicaid benefits available to SNP-eligible Enrollees with disabilities and the special needs of persons eligible to enroll under the SNBC program. The MCO shall assure that Subcontractors and Primary Care Provider clinics are educated and understand the product covered by this Contract prior to listing the clinic in the Provider Directory. Upon request by the STATE, the MCO shall provide to the STATE a written description of these efforts to educate Primary Care Providers.

9.3.3 Subcontractors Audit.

The MCO shall require that all Subcontractors shall provide CMS, the HHS Inspector General, the Comptroller General, or their designees, and the STATE with the right to inspect, evaluate, and audit any premises, physical facilities, equipment, pertinent books, financial records, documents, papers, and records of any Subcontractor involving financial transactions related to this Contract. If CMS, the HHS Inspector General, the Comptroller General, or their designees, or the STATE determines that there is a reasonable probability of fraud or similar risk, CMS, HHS Inspector General, the Comptroller General, or their designees, or the STATE may audit the Subcontractor

at any time. 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.

9.3.4 Compliance with Federal Law.

All subcontracts shall comply with 42 CFR §434.6(b) for Medical Assistance services, 42 CFR §422.502 for Medicare services, and 42 CFR §§438.3(k) and 42 CFR 434, Subpart A.

9.3.5 Subcontractual Delegation.

The MCO shall oversee and is ultimately accountable for any functions and responsibilities that it delegates to any Subcontractor. The MCO shall [42 CFR §438.230]:

9.3.5.1 Prior to any delegation, evaluate the prospective Subcontractor's ability to perform the activities to be delegated.

9.3.5.2 Have a written agreement that: 1) specifies the activities and reporting responsibilities delegated to the Subcontractor; and 2) provides for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate. In addition, the written agreement shall extend the Subcontractor's recordkeeping and reporting obligations after termination, so that the MCO may comply with the recordkeeping and reporting obligations of this Contract.

9.3.5.3 Monitor at least annually the Subcontractor's performance through a formal review process that results in a written report.

9.3.5.4 Upon request by the STATE, provide a copy of the formal delegation review process for approval.

9.3.5.5 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.

9.3.5.6 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.

9.3.5.7 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 material on site.

9.3.6 Business Continuity Plans.

The MCO shall ensure that its Subcontractors that provide Priority Services have in place a written Business Continuity Plan (BCP) that complies with the requirements of section 15.1.

9.4 PROVIDERS' SERVICES.

Notwithstanding the delegation in section 9.3.5, the MCO may contract with Providers of services to provide services to Enrollees of the MCO. Subcontracts with other Providers of services shall not abrogate or alter the MCO's primary responsibility for performance under this Contract.

9.4.1 Providers Without Numbers.

The MCO shall submit to the STATE, in a format provided by the STATE, required demographic data for each provider who does not already have a NPI or UMPI.

9.4.2 Annual Care Management Reviews.

The MCO shall conduct an annual review of each Care System or Care Management delegate system the MCO owns or with whom the MCO has a delegated arrangement or subcontract for Enrollees covered under this Contract.

9.4.2.1 Written audit reports of each Care System and/or Case Management system risk sharing arrangement must be submitted to the STATE by September 15th of each Contract Year in accordance with Article 3.

9.4.2.2 Annual reviews and written reports must include:

(1) A description of the organizational, service delivery, and Case Management responsibilities and structures, including any significant changes to the MCO's Care Management system;

(2) The Care System or Case Management risk sharing arrangement with the SNP or MCO;

(3) The process used by the MCO to conduct the review and Care Plan audits as specified under section 7.7.1.5;

(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.

(6) The MCO/SNP will work with the STATE and other MCO/SNPs on methods for coordinating County Care Coordination System and SNBC Case Management System reviews among MCO/SNPs and across counties and other delegated entities, including development of joint review protocols and summary reporting formats. MCO/SNPs may use a joint contractor to conduct such reviews, while meeting applicable HIPAA requirements. The MCO/SNP will also work with the STATE to develop a method to identify delegates with consistently high performance at review, and to develop recommendations for a process that may allow for these identified delegates to be reviewed on a schedule other than annually and/or utilizing alternative review methods. Any process and/or method developed must continue to meet state and federal requirements for review of care plans and the purposes of the review.

9.4.3 FQHCs and RHCs Contracting Requirements.

If the MCO negotiates a Provider agreement with a federally qualified health center (FQHC) as defined in §1905(l)(2)(B) of the SSA, 42 USC §1396d(l)(2)(B), or a rural health clinic (RHC) as defined in 42 CFR §440.20, for services under this Contract, the negotiated payment rates must be comparable, but no less than the rates negotiated with other Providers who provide similar health services. The STATE may require the MCO to offer to contract with an FQHC or RHC in the MCO's Service Area that has been designated under Minnesota Statutes, §62Q.19 as an essential community provider (ECP). The MCO is not required to pay any settle-up payments in addition to the negotiated payment rate. [§1903(m)(2)(A)(ix) of the SSA; Minnesota Statutes, §256L.11, subd. 2]

9.4.4 Nonprofit Community Health Clinics, Community Mental Health Centers, and Community Health Services Agencies Contracting Requirements.

The MCO shall contract with nonprofit community health clinics (community health clinic), as defined in Minnesota Statutes, Chapter 145A, including all FQHCs that are also nonprofit community health clinics, community mental health centers, or community health 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. The MCO may reasonably require a nonprofit community health clinic, community mental health center, or community health services agency to comply with the same or similar contract terms that the MCO requires of the MCO's other Network 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. [Minnesota Statutes, §256B.69, subd. 22]

9.4.5 Essential Community Providers Contracting Requirements.

The MCO shall offer to contract with any designated ECP, as described in a listing provided by the STATE, located within its Service Area. The MCO shall offer to contract with all ECPs in their service area for medical services. The MCO may contract, but is not required to do so, for non-medical services the ECP is certified to provide. [Minnesota Statutes, §62Q.19]

9.4.6 Children's Mental Health Collaborative Contracting Requirements.

The MCO must subcontract with a children's mental health collaborative organized under Minnesota Statutes, §§ 245.491 through 245.495, that:

9.4.6.1 Has an integrated services system approved by the Children's Cabinet;

9.4.6.2 Has entered into an agreement with the STATE to provide Medical Assistance services;

9.4.6.3 Is capable of providing inpatient and outpatient mental health services in return for an actuarially based capitated payment from the MCO to be determined by the STATE; and

9.4.6.4 Requests to become a Subcontractor.

9.4.7 Enrollees Held Harmless by Subcontractors and Providers.

9.4.7.1 Except for Medical Assistance cost-sharing pursuant to section 4.11, the MCO shall ensure [42 CFR §438.106]

(1) That the Enrollee is not held liable for any charges associated with the Enrollee's care received from the MCO Subcontractor or Network Provider, nor an Out of Network Provider with whom the MCO has negotiated a single-case agreement for providing the Enrollee services covered under this Contract.

(2) 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. See MHCP Provider Manual under "Noncovered Services" for DHS Form 3640 and 3641.

(3) If an Enrollee receives Medical Emergency Services, Post-Stabilization Care Services or Urgent Care Out of Service Area or Out of Network, the MCO shall pay the Out of Service Area or Out of Network Provider on the condition that the Provider hold the Enrollee harmless for any financial liability.

(4) 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 (for example, anesthesiologist or radiologist). [Minnesota Statutes, §62Q.556]

9.4.8 Medical Necessity Definition.

The MCO shall include in all subcontracts for the delivery of services under this Contract a requirement that the Subcontractor follow the definition of Medical Necessity in section 2.112, and in subcontracts for the delivery of mental health services that the Subcontractor additionally

follow the Medical Necessity definition in Minnesota Statutes, §62Q.53. Subcontracts shall include the definition in section 2.112, and the definition in Minnesota Statutes, §62Q.53 where applicable.

9.4.9 Care System Complaint Reporting.

The MCO shall require:

9.4.9.1 Network Primary Care Providers to report quality of care complaints pursuant to Minnesota Rules, Part 4685.1110, subpart 9, (A), and

9.4.9.2 Care Systems to report any complaints relating to SNBC Enrollees to the MCO on a quarterly basis.

9.4.10 Patient Safety.

The MCO shall encourage its Network Providers 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.

9.4.11 Vulnerable Persons Reporting.

The MCO will communicate to employees and Subcontractors who are mandated reporters their duty to report the suspected maltreatment of a vulnerable adult or child as required under Minnesota Statutes, §§ 626.557 or 626.556. MCOs must inform employees and providers that web-based training is available at no cost to all mandated reporters: http://registrations.dhs.state.mn.us/WebManRpt/ for adults and http://www.dhs.state.mn.us/id_000152 for children.

9.4.12 Provider and Enrollee Communications.

The MCO may not prohibit, or otherwise restrict, a Provider acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee, with respect to the following [42 CFR §438.102]:

9.4.12.1 The Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

9.4.12.2 Any information the Enrollee needs in order to decide among all relevant treatment options;

9.4.12.3 The risks, benefits, and consequences of treatment or non-treatment; or

9.4.12.4 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.

9.4.13 Relationships with Providers for SNBC SNP Enrollees.

The MCO shall comply with all applicable Provider requirements in 42 CFR §422 subpart E, including, but not limited to provider certification requirements; anti-discrimination requirements; provider participation and consultation requirements; the prohibition on interference with Provider advice; limits on Provider indemnification; rules governing payments to Providers; and limits on Physician Incentive Plans.

9.4.14 Automatic Termination of Subcontract Clause (SNP Requirement).

The following provision is required to be included in all contracts and/or subcontracts entered into by the MCO, with the exception of contracts for the purchase of items and equipment,

including leases of real property which exceed the term of this Contract, unless CMS agrees to its omission.

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 unallowable the related costs incurred after the effective date of the non-renewal or termination. The clause is as follows:

9.4.14.1 "In the event the Medicare contract between CMS and the MCO is terminated or non-renewed, the contract between the STATE and _____ (name of MCO) shall be terminated unless CMS and the STATE agree to the contrary. Such termination shall be carried out in accordance with the termination requirement stated in 42 CFR §422.506 and §422.512."

9.5 Maintenance, Retention, Inspection and Audit of Records.

9.5.1 Record Maintenance and Access.

The MCO agrees to maintain such records and prepare such reports and statistical data as may be deemed reasonably necessary by the STATE and the CMS Office of the Inspector General, the Comptroller General, and their designees. It is further agreed that all records must be made available to authorized representatives of the STATE and CMS during normal business hours and at such times, places, and in such manner as authorized representatives may reasonably request for the purposes of audit, inspection, examination, and for research as specifically authorized by the STATE to the MCO in fulfillment of state or federal requirements. It is understood and agreed that the MCO shall be afforded reasonable notice of a request by an authorized representative of the STATE or CMS to examine records maintained by the MCO or its agents, unless otherwise provided by law. [42 CFR §438.3(h)]

9.5.2 Record Retention by MCO.

The MCO agrees to maintain and make available to the STATE and CMS all records related to administration of 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. Records retained must include those in 42 CFR §§438.416, 438.5(c), 438.8(k), and the data, information, and documentation specified in §§438.604, 438.606, 438.608, and 438.610, to the extent that the MCO creates or receives such records as required under this Contract or any applicable law or regulation. [42 CFR §438.3(u)]

9.5.3 Records Inspection and Audits.

The MCO shall provide that the STATE, CMS or the Comptroller General, or their designees, may audit or inspect any books, records and documents, financial records, claims history records, policies and procedures, provider review history, complaints, payment methodology, provider contracts and all other related agreements 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. This right shall include, at any time, inspection of the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. [42 CFR §438.3(h)]

9.5.4 State Audits.

The books, records, documents, and accounting procedures and practices of the MCO and its employees, agents, or Subcontractors relevant to this Contract shall be made available and subject to examination by the state, including DHS, Legislative Auditor, and State Auditor for a minimum of six years from the end of this Contract. [Minnesota Statutes, §§16C.05, subd. 5, and 256B.69, subd. 9d]

9.5.4.1 The STATE, to the extent of available funding, shall conduct ad hoc audits of MCO administrative and medical expenses. This includes: financial and encounter data reported under section 3.16.1, including payments to providers and Subcontractors; supporting documentation for expenditures; categorization of administrative and medical expenses; and allocation methods used to attribute administrative expenses to state public health care programs. These audits also must monitor compliance with data and financial report certification requirements for the purposes of capitation payment rate-setting. The MCO shall fully cooperate with the audits in this section. [Minnesota Statutes, §256B.69, subd. 9d, (e)]

9.5.5 Quality, Appropriateness, and Timeliness of Services.

The MCO shall provide that the STATE and CMS or their agents may evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under this Contract. [42 CFR §434.6(a)(5)]

9.5.6 Enrollment and Disenrollment Records Evaluation.

The MCO must provide that the STATE and CMS may evaluate, through inspection or other means, the enrollment and disenrollment records of the MCO when there is reasonable evidence of need for such inspection. [42 CFR §438.242(a)]

9.5.7 Timelines for Records Inspection, Evaluation or Audit.

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 the Contract Year unless: 1) the STATE or CMS determines there is a special need to retain a particular record or records for a longer period of time and the STATE or CMS notify the MCO at least thirty (30) days prior to the normal record disposition date; 2) there has been a termination, dispute, Fraud, or similar default by the MCO, in which case the record(s) retention may be extended to ten (10) years from the date of any resulting final settlement; or 3) the STATE or CMS determined that there is a reasonable possibility of Fraud and the record may be reopened at any time. [42 CFR §438.3(u)]

9.6 Settlement Upon Termination.

Upon termination of the Contract according to section 5.2, or at such time an Enrollee terminates enrollment in SNBC and in the MCO according to section 3.7, 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.

9.7 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 informationas defined in Minnesota Statutes, §13.37, subd. 1(b). Protected Information includes but is not limited to Marketing and other business plans Materials still in draft form, rates paid to Providers, or Medicare bid information. The MCO must identify information and mark as trade secret prior to or at the time of its submission for the STATE to consider classifying it as non-public. Rates paid to the MCO, the STATE's rate methodology, and this Contract are not trade secrets. [Minnesota Rules, Part 9500.1459]

9.7.1 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.

9.7.2 Trade secret information may be shared with CMS. The STATE must notify CMS that such information is considered trade secret.

9.7.3 In the event of disclosure of the MCO's information that is protected by this section 9.7, the STATE shall, within five (5) business days after learning of such non-permitted disclosure, report the disclosure to the MCO by secure e-mail.

9.8 Ownership of Copyright

If any copyrightable material is developed in the course of or under this Contract, the STATE and the U.S. Department of Health and Human Services shall have a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use, the work for government purposes. [41 CFR §105-71.134]

9.9 Fraud and Abuse Requirements; Program Integrity.

9.9.1 Integrity Program.

9.9.1.1 MCO Program Integrity Functions. The MCO shall establish functions and activities governing program integrity in order to reduce the incidence of Fraud and Abuse and shall comply with all state and federal program integrity requirements, including but not limited to, the applicable provisions of the SSA, §§ 1128, 1128A, 1128B, 1902, 1903, and 1932; 42 CFR §§431, 433, 434, 435, 438, 441, 447, and 455; 45 CFR Part 75; 2 CFR Parts 180 and 376 (the implementing regulations for Executive Order 12549, for debarment and suspension from federal programs for procurement and non-procurement transactions), Minnesota Statutes and Rules, and this Contract.

(1) If the MCO subcontracts any portion of the program integrity responsibilities of its Special Investigations Unit (SIU) in this section, the MCO shall provide to the STATE the names, addresses, telephone numbers, e-mail addresses and fax numbers of the entity with which the MCO subcontracts.

(2) The MCO shall provide to the STATE copies of any new or existing executed subcontracts, attachments, exhibits, addendums or amendments thereto, within thirty (30) days following the effective date of this Contract or after execution of the new subcontract that includes program integrity responsibilities.

(3) If the MCO does not subcontract for the responsibilities of the SIU, the MCO will notify the STATE in writing within thirty (30) days of the effective date of this Contract.

9.9.1.2 Administrative and Management Procedures. The MCO shall have administrative and management arrangements or procedures, including a mandatory compliance plan and a Special Investigations Unit (SIU), as defined in section 2.170, whose responsibilities include the detection and investigation of fraud and abuse by its Enrollees and providers, that are designed to guard against Fraud, Abuse and improper payments. The arrangements or procedures of the MCO's SIU shall include the following [42 CFR §438.608]:

(1) Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable Federal and State standards;

(2) Enforcement of standards through well-publicized disciplinary guidelines;

(3) Compliance Officer and Regulatory Compliance Committee

(a) The designation of a regulatory compliance committee on the Board of Directors and at the senior management level charged with overseeing the MCO's compliance program and its compliance with the requirements of this Contract;

(b) Effective training and education for the Compliance Officer and the MCO's employees, including training to all applicable divisions within the MCO to enhance information sharing and referrals to the SIU regarding fraud, waste and abuse within the MCO's program;

(c) Effective lines of communication between the Compliance Officer and the MCO's employees;

(d) The MCO shall identify to the STATE the compliance officer who is responsible for implementation of the integrity program.

(4) Internal monitoring and auditing standards, including:

(a) Provision for regular internal monitoring and auditing, including prepayment monitoring and auditing of Network Providers and subcontracted services to detect Fraud, Abuse and improper payments;

(b) Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to this Contract;

(c) Provision for post-payment edits and audit, including profiling Provider services and Enrollee utilization that identifies aberrant behavior and/or outliers;

(d) Policies and procedures that safeguard against unnecessary or inappropriate use of services and against excess payments for services;

(e) Policies and procedures that safeguard against failure by Subcontractors or Network Providers to render Medically Necessary items or services that are required to be provided to an Enrollee covered under this Contract;

(f) Policies and procedures that safeguard against Fraud, waste or Abuse in services that are provided under this Contract. The STATE's SIRS may, upon review of these policies and procedures, require that specified changes be made within a designated time, in order for the MCO to remain in compliance with the terms of this Contract;

(g) A certification process that demonstrates that the policies and procedures specified under this section were reviewed and approved by the MCO's Compliance Officer or regulatory compliance committee;

(h) Provision for identifying, investigating, and taking corrective action against fraudulent and abusive practices by Providers, Subcontractors, and Enrollees, or MCO employees, officers and agents; and

(i) Provision for the MCO's Network Providers to make reports to the MCO when the Network Providers receive an overpayment, to return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and to notify the MCO of the reason for the overpayment. [Section 1128J(d) of the SSA]

(j) Provision for maintaining the confidentiality of the names of good faith reporters, unless the reporter gives consent that the reporter's name may be disclosed, or the disclosure of the reporter's name is compelled by a court or criminal proceeding. [Minnesota Statutes, §256B.064, subd. 5]

(5) SIU Staffing. The SIU shall have at least one SIU Investigator. The MCO's SIU shall have one SIU Investigator for every 60,000 Enrollees; this Enrollee threshold shall be based upon the prior quarter's enrollment totals across all MHCP services. The SIU Investigator's time shall be designated to include the detection of Fraud, waste and Abuse in MHCP services.

(6) Service Delivery Verification. The MCO must implement a method to verify whether services under this Contract, paid for by the MCO, were actually furnished to the Enrollees as required in 42 CFR §455.1(a)(2). The MCO shall utilize direct methods for verifying the provision of any covered services to Enrollees. MCOs are not precluded from using a variety of direct methods to verify services, especially with provider types that have been identified by the STATE or the MCO as high risk for program integrity issues such as transportation, PCAs, medical supply, and interpreters. The MCO's direct methods and results shall be described in the Annual Integrity Program Report under section 9.9.2.

(a) Direct methods include:

i) Confirming clinic visits or linking authorization and payment of transportation and interpreter services to clinic visits;

ii) Expansion of HEDIS and PIP chart review contracts to require notification to the MCO of any discrepancy in charts against paid claims;

iii) Individual notices to Enrollees within forty-five (45) days of the payment of claims, in the form of an Explanation of Benefits (EOB) as described in Minnesota Statutes, §§ 62J.51 and 62J.581. Notices should be provided to a sample group of at least ten percent (10%) of Enrollees who received services from the provider type being verified. Notices must include a statement that the notice is not a bill. Notices must include the MCO's phone number that Enrollees can call to ask questions or obtain information about the services identified on the notice;

iv) Care manager or care coordinator follow up with Enrollees to confirm services and notification to MCO when services were not delivered,

v) Clinic authorization of a patient incentive that confirms a completed office visit;

vi) Specific service confirmation questionnaires; or

vii) Post-payment review of provider documentation of services for a sample of claims.

(b) Indirect methods such as DTRs, hotlines, billing monitoring, or customer satisfaction surveys are important program integrity practices and methods but they are not sufficient to verify services.

(7) The MCO shall utilize an SIU Data Analyst to conduct data mining and analytics to identify potential and actual instances of Fraud, Abuse, error and overutilization and shall meet the contractual reporting requirements. Data mining and analytics shall be reported to the STATE on the MCO's quarterly report.

(8) The MCO shall incorporate into its claim processing and claims payment system the National Correct Coding Initiative editing programs for the Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes to promote correct coding and control coding errors, except for allowable NCCI edit exclusions. [42 CFR §§433.116]

9.9.2 Annual Integrity Program Report.

(1) The MCO shall report to the STATE in writing, by April 30 of the Contract Year, detailing the MCO's integrity program during the previous Contract Year. The report shall include 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 9.9.1, and must specifically describe the activities it has undertaken to safeguard against Fraud and Abuse. The report shall provide the following

summary information about reports of provider fraud and abuse investigated by the MCO [42 CFR §438.66(b)(9)]:

(a) Identify the direct methods and results for verification of services required in section 9.9.1.2(6)(a) above;

(b) Description of pre-payment and post-payment edits used to identify potential fraud and abuse;

(c) Total number of reports, for each Provider type and for Enrollees in aggregate;

(d) Number of opened cases, number of cases resolved, and number remaining open;

(e) Number and types of penalties or sanctions imposed;

(f) Dollar amounts recovered which had been paid on behalf of Enrollees; and

(g) Number of referrals to the Medicaid Fraud Control Unit (MFCU).

(2) The MCO shall include a section in this report to the STATE describing the MCO's integrity program plan for the next Contract year and, at a minimum, must include:

(a) A written description or chart outlining the organizational arrangement of the MCO's personnel, or Subcontractor's personnel who are responsible for the investigation and reporting of possible overpayment, abuse or fraud;

(b) A description of the MCO's procedures for detecting and investigating possible occurrences of overpayment, Fraud or Abuse, including the pre- and post-payment edits that will be used to identify potential overpayment, Fraud or Abuse;

(c) A description of the MCO's procedures for the mandatory reporting of possible overpayment, Fraud or Abuse to the STATE's OIG/SIRS;

(d) The direct methods that will be employed to verify services as required in section 9.9.1.2(5) above.

(e) The name, address, telephone number, e-mail address and fax number of the individual responsible for carrying out the program integrity plan.

9.9.3 Corrective Actions, Violation Reporting, and Adverse Provider Actions.

9.9.3.1 The MCO shall document all activities and corrective actions taken under its integrity program.

(1) Violation Report Process. The MCO shall establish and adhere to a process for reporting to the STATE, MFCU, the STATE's OIG/SIRS (in a format approved by SIRS), and CMS the Office of Inspector General for the U.S. Department of Health and Human Services and the appropriate law enforcement agency credible information of violations of law by the STATE, the MCO, Network 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 program, the MCO shall refer the case to an appropriate law enforcement agency as mandated in 42 CFR §455.15(b).

(2) Monthly Reporting of Adverse Provider Actions. The MCO shall report monthly to the STATE the name, specialty, address, and reason for Adverse Provider Action (in a form approved by the STATE) of Providers whose participation have been denied at enrollment, credentialing or recredentialing, and providers whose active participation status the MCO has taken action to terminate or not renew during the previous month. The report is due by the fifteenth (15th) day of the following month. The STATE shall forward the report to the Office of the Inspector General at the federal Department of Health and Human Services [42 CFR 1002.4(b)]

(3) The STATE may distribute to other MCOs all Adverse Provider Actions taken by the MCOs and shall share the report with all MCOs providing Medical Assistance and MinnesotaCare services.

9.9.3.2 The Compliance Officer, SIU Manager, the SIU Investigator and representatives of Subcontractors who perform SIU responsibilities, if any, shall meet with the STATE SIRS periodically, when specifically requested by the STATE, to discuss the MCO's anti-Fraud and Abuse activities.

9.9.4 Fraud and Abuse by MCO, Its Subcontractors, or Network Providers.

9.9.4.1 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.

9.9.4.2 The STATE will receive and investigate information from whistleblowers relating to the integrity of the MCO, Subcontractors, or Network Providers receiving Federal funds under this Contract [42 CFR 438.602(f)]

9.9.4.3 The MCO and its Subcontractors shall, upon the request of the MFCU, make available to MFCU all administrative, financial, medical, and any other records that relate to the delivery of items or services under this Contract. The MCO shall allow the MFCU access to these records during normal business hours, except under special circumstances when after-hours admissions shall be allowed. Such special circumstances shall be determined by the MFCU. [42 CFR §455.21]

9.9.4.4 The MCO shall provide written disclosure to the STATE of any prohibited affiliation the MCO, or any of its Subcontractors, has under 42 CFR §438.610(c) in addition to the disclosures under section 9.10, within ten (10) business days of the discovery of the prohibited affiliation.

9.9.5 Audits, Investigations and Monitoring

(1) Joint investigations or audits between the STATE's OIG/SIRS, and the MCO shall be conducted at the STATE's SIRS discretion. The MCO may request a joint investigation.

(2) The State shall have the right to audit and investigate Network Providers and Enrollees. A notification may be communicated to the MCO when SIRS initiates an investigation of the MCO's claims, unless otherwise prohibited by law. The MCO shall not initiate a review of a Network Provider after the STATE's OIG/SIRS advises the MCO of an open review or investigation by the STATE's OIG/SIRS, its designee, or another state or federal agency or their designee, without written authorization from the STATE's OIG/SIRS to proceed.

(3) The STATE's OIG/SIRS may direct the MCO to monitor one of its providers or Subcontractors, or take such corrective action with respect to that provider or Subcontractor as the STATE's SIRS deems appropriate, when, in the opinion of the STATE's SIRS, good cause exists.

9.9.6 Monetary Recovery

9.9.6.1 The MCO shall obtain approval from the STATE's OIG/SIRS before recovering or withholding improper payments under this section when more than one year has passed since adjudication of the original claim submitted. OIG/SIRS shall grant the MCO approval unless one or more conditions in section 9.9.6.3 below is met.

9.9.6.2 The MCO shall attempt to recover improper payments from Network Providers when the MCO identifies improper payments in an audit or investigation that the MCO solely conducts.

9.9.6.3 The STATE shall notify the MCO that the MCO is prohibited from taking any actions to recover or withhold improper payments already paid or due to a Provider when the issues, services, or claims upon which the recovery or withhold meet one or more of the following criteria:

(1) The improper claims have already been recovered by the STATE's OIG/SIRS directly or as a part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to False Claims Act cases; or

(2) The improper payments have already been recovered by the STATE's Recovery Audit Contractor (RAC); or

(3) When the issues, services or claims that are the basis of the recovery or withhold are currently being investigated by the STATE's OIG/SIRS, are the subject of pending state or federal litigation or investigation, or are being audited by the STATE's RAC.

9.9.6.4 The STATE's OIG/SIRS shall have the right to recover improper payments to Providers identified in audits and investigations the STATE's OIG/SIRS, CMS, or their agents solely conduct.

9.9.6.5 Reverse Recovered Claims. The MCO shall void (or reverse) all encounter claims that are a result of Fraud or Abuse, that have been recovered as a result of the MCO's integrity program. Reversal or void must occur within thirty (30) days of the recovery. This provision does not apply to recoveries due to settlement or statistical sampling of claims and extrapolation, where identification of individual claims is impossible. Fraud or Abuse does not include recovery activities conducted under the Supplemental Recovery Program in section 10.7.

9.9.6.6 The MCO shall report in writing to the STATE any Fraud related to Medicaid funds that the MCO knows or has reason to believe has been committed by a provider, vendor, MCO employee, Subcontractor or Enrollee within five (5) business days after the MCO learns of or has reason to believe such Fraud has been committed. The MCO shall cooperate fully in any investigation of the Fraud by the STATE and MFCU and in any subsequent legal action that may result from those investigations. This may include investigation of claims paid by the MCO.

(1) The MCO shall maintain a detailed log (in a form approved by the STATE) of all reports of provider Fraud and Abuse investigated by the MCO or its Subcontractors which shall be submitted to the STATE on a quarterly basis by the fifteenth (15th) day following the end of the quarter for investigations opened or closed in that quarter.

(2) The MCO shall report in writing to the STATE any abusive billing by Providers that warrant investigation within ninety (90) days of identification of the problem. The MCO may use the quarterly detailed log in section 9.9.6.6(1) above for this reporting requirement.

(3) Sanctions for failure to report. If an MCO fails to report any final adverse action or other adjudicated action or decision against a health care provider that is required to be reported to the National Practitioner Data Bank (https://www.npdb.hrsa.gov/), the MCO shall be subject to a civil monetary penalty of not more than $25,000 for each such adverse action not reported. See section 5.5 above. [42 USC §1320a-7e(B)(6)(a)]

9.9.6.7 Except when the MCO has good cause, as described in 9.9.6.9 below, the MCO must suspend all payments under this Contract to a Provider after the following:

(1) The STATE has notified the MCO that it has suspended all payments under this Contract to the provider based on a determination there is credible allegation of Fraud against the

provider for which an investigation of payments made under the Medicaid program is pending; or

(2) The MCO determines there is a credible allegation of Fraud against the provider for which an investigation is pending under the program,

9.9.6.8 The suspension of payments under this section will be temporary and will not continue after either of the following:

(1) The STATE or the MCO or the prosecuting authorities determine there is insufficient evidence of Fraud by the provider and the STATE or MCO has notified the other party of the lack of evidence; or

(2) Legal proceedings related to the provider's alleged fraud are completed.

9.9.6.9 The STATE shall have the right to direct the MCO to suspend payments from a MCO's providers or Subcontractors. The MCO may request a decision by the STATE to exercise the good cause exceptions not to suspend payments or to suspend payments only in part. An MCO may also find good cause exists not to suspend payments, not to continue a payment suspension previously imposed, or to suspend payment only in part if any of the provisions of 42 CFR §455.23 (e) or (f) are applicable. For purposes of implementing a good cause exception under the provisions of 42 CFR §455.23(e) and (f), "MCO" determinations shall be substituted for "STATE" determinations. The MCO will notify the STATE in writing of the basis for any good cause determination to not suspend payments, not to continue a payment suspension, or to suspend only in part. Whenever an MCO investigation leads to the initiation of a payment suspension by the MCO, the MCO shall make a written fraud referral to the STATE and MFCU not later than the next business day after the suspension is imposed. Following a conviction for a crime related to the provision, management, or administration of a health service under MHCP, a payment held by the MCO pursuant to 9.10.6.7 shall be forfeited to the MCO, regardless of the amount charged in the criminal complaint or the amount of criminal restitution ordered, effective August 1, 2019 [42 CFR §455.23; Minnesota Statutes, §256B.064, subd. 2]

9.9.6.10 For purposes of a payment suspension under section 9.9.4, "credible allegation of fraud" means an allegation, which has been verified by the STATE or the MCO from any source, and which has indicia of reliability. In determining whether there is a credible allegation of fraud, the MCO must review all allegations, facts, and evidence carefully and act judiciously on a case-by-case basis. [42 CFR §455.23]

9.9.6.11 The MCO shall notify the STATE within thirty (30) days when it becomes public that the MCO joins or becomes a party to a class action or *qui tam* litigation involving MHCPs.

9.9.6.12 The MCO shall notify the STATE's OIG/SIRS within thirty (30) days when it obtains recoveries from class action and qui tam litigation involving any of the programs administered and funded by the STATE.

9.9.6.13 Retention of Recoveries Resulting from False Claims Act Settlements.

(1) 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 Enrollees;

(b) The State has not duplicated this recovery (see section 9.9.6.3; and

(c) Such recovery is not prohibited by federal or state law.

(2) The MCO is not entitled to retain any amounts recovered through the efforts of the STATE or MFCU. There is no time limit for the time within which the STATE or MFCU must recover these funds.

9.9.7 Fraud and Abuse by Beneficiaries.

The MCO shall report in writing via e-mail to the STATE any suspected Fraud and/or patterns of Abuse by Enrollees and Beneficiaries, in accordance with section 9.9.3

9.9.8 False Claims.

9.9.8.1 If the MCO receives or makes Medicaid payments totaling five million dollars ($5,000,000) or more within a Federal fiscal year (October 1st through September 30th), the MCO must establish, implement and disseminate written policies and procedures to all employees including management, contractors and agents that includes detailed information pertaining to the False Claims Acts (federal and state) and other provisions named in §1902(a)(68)(A) of the SSA. These policies must include detailed provisions regarding the MCO's procedures for detecting and preventing fraud, waste, and abuse. The MCO shall certify to the STATE by February 1st of the Contract Year that it has complied with this requirement for the previous Contract Year, using as its certification the DHS Deficit Reduction Act (DRA) Assurance Statement posted on the STATE's Managed Care web site.

9.9.8.2 In addition, the MCO must include in its written policies and procedures (and in employee handbooks, if any) specific discussions of the following:

(1) The False Claims Act, 31 USC §§ 3729 through 3733;

(2) Administrative remedies for false claims and false statements established under 31 USC §§ 3801, et seq.;

(3) The Minnesota False Claims Act, Minnesota Statutes, §15C.02, and any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) The rights of employees to be protected as whistle-blowers, including the employer restrictions listed in Minnesota Statutes, §15C.14; and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

9.10 Program Integrity Disclosures

9.10.1 Exclusions of Individuals and Entities; Confirming Identity.

9.10.1.1 The MCO must confirm the identity and determine the exclusion status of Providers and any Person with an Ownership or Control Interest or who is an agent or managing employee of the MCO or its Subcontractors, or an affiliate, upon contract execution or renewal and credentialing, through routine checks of state and Federal databases. The databases to be checked are the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), and the Excluded Provider Lists maintained by the STATE.

For purposes of program integrity, "affiliate" is defined as an associated business concern or individual if, directly or indirectly, either one controls or can control the other; or a third party controls or can control both. [42 CFR §438.610 referring to 48 CFR §2.101; 42 CFR §455.436; Minnesota Statutes, §256B.064]

9.10.1.2 The MCO and its Subcontractors must search monthly, and upon contract execution or renewal, and credentialing, the OIG List of Excluded Individuals/Entities (LEIE), Excluded Parties List System (EPLS, within the HHS System for Awards Management) database (and may search the Medicare Exclusion Database), and the Excluded Provider Lists maintained by the STATE, 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 by the state nor under §§ 1128 or 1128A of the SSA; and

(2) Have not been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the programs under Title XX of the SSA. [42 CFR §§455.436; 438.602(d); 438.610]

9.10.1.3 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.

9.10.1.4 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 SSA.

9.10.1.5 The MCO shall report any excluded Provider to the STATE within seven (7) days of the date the MCO receives the information, or determines that a Network Provider, Person with an Ownership or Control Interest of a Network Provider, agent or Managing Employee of the MCO, Subcontractor or affiliate has become excluded or the MCO has inadvertently contracted with an excluded Provider.

9.10.1.6 In addition to complying with the provisions of section 9.9, the MCO shall not enter into any subcontract that is prohibited, in whole or in part, under §4707(a) of the Balanced Budget Act of 1997 or under Minnesota Statutes, §62J.71.

9.10.2 Disclosure of Ownership and Management Information (MCO).

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

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

(2) A statement as to whether any Person with an Ownership or Control Interest in the MCO or in any Subcontractor as identified in section 9.10.2.1(1) (if an individual) to any other Person with an Ownership or Control Interest as a spouse, parent, child, or sibling;

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

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

(5) This information must be accompanied by a data certification pursuant to section 11.6.

9.10.3 Disclosure of Transactions.

(1) The MCO must report to the STATE or CMS information related to business transactions with Subcontractors (as defined below) [42 CFR §455.105(b)]

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

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

(c) Any sale or exchange, or leasing of any property between the MCO and a party in interest as defined under 42 USC §300e-17, paragraph (b);

(d) Any furnishing for consideration of goods, services (including management services), or facilities between the MCO and a party in interest, not including salaries paid to employees for services provided in the normal course of their employment; and

(e) Any lending of money or other extension of credit between the MCE and a party in interest.

For purposes of this section, 42 CFR §455.101 defines Subcontractor as an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its Enrollees.

9.10.4 Disclosure of Ownership and Management Information (Subcontractors).

In order to assure compliance with 42 CFR §455.104, the MCO, before entering into or renewing a contract with a Subcontractor, must request the following information:

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

(2) A statement as to whether any Person with an Ownership or Control Interest in the disclosing entity as identified in 9.10.4(1) is related (if an individual) to any other Person with an Ownership or Control Interest as spouse, parent, child, or sibling;

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

(4) The name, address, date of birth, and social security number of any Managing Employee of the disclosing entity.

(5) For purposes of this section, Subcontractor means an individual, agency, or organization to which a disclosing entity has contracted, or is a person with an employment, consulting or other arrangement with the MCO for the provision of items and services that are significant and material to the MCO's obligations under its contract with the STATE.

(6) MCO Disclosure Assurance. The MCO must submit to the STATE by September 1st of the Contract Year, a letter of assurance stating that the disclosure of ownership information has been requested of all Subcontractors, and reviewed by the MCO prior to MCO and Subcontractor contract renewal. The letter should identify all databases that were included in the review. A data certification pursuant to section 11.6 is required with this assurance.

(7) Upon request, Subcontractors must report to the MCO information related to business transactions. Subcontractors must be able to submit this information to the MCO within

fifteen (15) days of the date of a written request from the STATE or CMS. The MCO must report the information to the STATE within ten (10) days of the MCO's receipt from the Subcontractor.

9.11 EXCLUSIONS AND CONVICTED PERSONS.

The MCO shall not pay for any items or services furnished, ordered or prescribed by excluded individuals or entities [Section 1903(i)(2) of the Act; 42 CFR §1001.1001]

9.11.1 The MCO shall not include in their business entity a director, officer, partner or Person with an Ownership or Control Interest, nor Subcontractor, who is excluded from participation in Medicaid under §§ 1128 or 1128A of the SSA. This includes entities owned or controlled by a sanctioned person. [42 CFR §1001.1001]

9.11.2 The MCO shall not make an employment, consulting or other agreement with an individual or entity for the provision of items or services that are significant and material to the MCO's obligations under its contract with the STATE where the individual or entity is excluded from participation in Medicaid under §§ 1128 or 1128A of the SSA. Significant and material services include, but are not limited to health care, utilization review, medical social work, or administrative services. [42 CFR 438.602]

9.11.3 The MCO shall not have any business relationship with agents, Managing Employees, or Persons with an Ownership or Control Interests who have been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program. [42 CFR §455.106]

9.11.4 The MCO shall report to the STATE, within ten (10) business days of receipt of the following:

(1) Any information regarding excluded or convicted individuals or entities, including those in paragraph (D) above; and

(2) Any occurrence of an excluded, convicted, or unlicensed entity or individual who applies to participate as a Provider.

9.11.5 The MCO shall promptly notify the STATE of any administrative action it takes to limit participation of a Provider in the Medicaid program as mandated by 42 CFR §§ 455.106(a)(2) and 1002.4(a).

9.11.6 Long Term Services and Supports. [Minnesota Statutes, §256B.064]

(1) As part of monitoring, auditing and investigating Network Providers and subcontracted services to detect Fraud, Abuse and improper payments, the MCOs shall have mechanisms in place to review documentation maintained by providers of long term services and supports to ensure compliance with the billing requirements set out in Minnesota Statutes, §256B.4912.

(2) In the event of a termination of a home health agency due to sanction by DHS or an MCO action, the MCO must make reasonable efforts to assure that home health care agencies have provided or will provide each Enrollee with a copy of the home care bill of rights under Minnesota Statutes, §144A.44 at least thirty (30) days before terminating services to an Enrollee.

The MCO shall collaborate with the STATE and home health care Providers in notifying Enrollees that payments have been or will be withheld, or that the Provider's participation in MHCP has been or will be suspended or terminated, if a home health care Provider

determines that it is unable to continue providing services to an Enrollee, effective August 1, 2019. [Minnesota Statutes, §256B.0651, subd. 17]

(3) If a home health care agency determines it is unable to continue providing services to an Enrollee because of any action under Minnesota Statutes, §256B.064, the home health care agency must notify the MCO, the Enrollee, the Enrollee's responsible party if applicable, and the STATE thirty (30) days prior to terminating services to the Enrollee. The MCO and home health care agency must cooperate in supporting the Enrollee in transitioning to another home health care provider of the Enrollee's choice within the MCO's network.

(4) In the event of a sanction of a home health care agency, a suspension of participation, or a termination of participation of a home health care agency by DHS or from the MCO, the MCO must inform the Ombudsman for Managed Care for all Enrollees with care plans with the home health care agency. The MCO must contact Enrollees to ensure that the Enrollees are continuing to receive needed care, and that the Enrollees have been given choice of provider (within the MCO's network) if they transfer to another home health care agency.

9.12 Conflicts of Interest.

Pursuant to 42 CFR §438.58 and 438.602(h), and Minnesota Statutes, §§256B.0914 and 256B.6926, subd. 4, the MCO shall have in effect conflict of interest rules at least as effective as those in section 27 of 41 USC §423.

9.13 Federal Audit Requirements and Debarment Information.

9.13.1 Single Audit Act.

MCO will certify that it will comply with federal procurement regulations as applicable. The MCO shall obtain a financial and compliance audit made in accordance with the Single Audit Act, and Code of Federal Regulations, title 2, subtitle A, chapter II, part 200, as applicable. Failure to comply with these requirements could result in forfeiture of federal funds.

9.13.2 Debarment, Suspension and Responsibility Certification.

Federal Regulation 45 CFR §92.35 prohibits the STATE from purchasing goods or services with federal money from vendors who have been suspended or debarred by the federal government. Similarly, Minnesota Statutes, §16C.03, subd. 2, provides the 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.

For purposes of this section, "principals" includes any director, officer, or partner of the MCO. [42 § CFR 438.610(a)(1) and (2); 42 CFR § 438.610(c)(1) and Executive Order No. 12549]

BY SIGNING THIS CONTRACT, MCO CERTIFIES THAT IT AND ITS PRINCIPALS:

9.13.2.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from transacting business by or with any federal, state or local governmental department or agency; and

9.13.2.2 Have not within a three-year period preceding this Contract: 1) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (federal, state or local)

transaction or contract; 2) violated any federal or state antitrust statutes; or 3) committed embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property; and

9.13.2.3 Are not presently indicted or otherwise criminally or civilly charged by a governmental entity for: 1) commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (federal, state or local) transaction; 2) violating any federal or state antitrust statutes; or 3) committing embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property;

9.13.2.4 Are not aware of any information and possess no knowledge that any Subcontractor(s) that will perform work pursuant to this Contract are in violation of any of the certifications set forth above; and

9.13.2.5 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.

9.14 Compliance with Public Health Service Act for SNBC.

The MCO shall comply with:

9.14.1 Sections 1318(a) and (c) of the Public Health Services Act, 42 USC §300e-17(a)(2), that pertain to disclosure of certain financial information;

9.14.2 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

9.14.3 The reporting requirements in 42 CFR §422.516 that pertain to the monitoring of an organization's continued compliance.

9.15 Receipt of Federal Funds.

The MCO will receive federal payments and is therefore subject to laws which are applicable to individuals and entities receiving federal funds. The MCO shall inform all related entities, contractors and/or Subcontractors that payments they receive are, in whole or in part, from federal funds.

9.16 Formal Presentations.

The MCO shall provide to the STATE copies of any formal presentation by the MCO or its Administrative Services Organization (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 SNBC Contract.

9.17 Restricted Recipient Program.

The MCO shall place an Enrollee in the Restricted Recipient Program (RRP) for the conduct described in Minnesota Rules, Part 9505.2165. Placement in the RRP means requiring that for a period of twenty-four (24) or thirty-six (36) months of eligibility, the Enrollee must obtain health services from designated Providers. These providers shall include one Primary Care Physician located in the

Enrollee's local trade area as defined by Minnesota Rules, Part 9505.0175, subp. 22; one clinic; one hospital used by the Primary Care Physician, and one pharmacy. The MCO may designate other Provider types to the extent deemed necessary. For purposes of this section, "Primary Care Physician" means a licensed physician, or a licensed practitioner such as a licensed nurse, under contract with or employed by the MCO, who provides Primary Care as defined in section 2.151.

The STATE shall place an Enrollee in the RRP for conduct regarding use of PCA or CFSS services described in Minnesota Statutes, §256B.0646.The MCO shall coordinate with the STATE to implement restrictions related to use of PCA services under Minnesota Statutes, §256B.0646.

9.17.1 Notice to Affected Enrollees.

The MCO must notify Enrollees in writing if the Enrollee is to be placed in the RRP. The notice must be sent at least thirty (30) days prior to placement. The notice to the Enrollee must state:

9.17.1.1 Placement in the RRP will not result in a reduction of services or loss of eligibility or disenrollment from the MCO;

9.17.1.2 The factual basis for placement;

9.17.1.3 The right to dispute the MCO's factual allegations;

9.17.1.4 The right to request an Appeal with the MCO and request a State Fair Hearing, and the right to request a State Fair Hearing after exhausting the MCO's Grievance and Appeal procedures; and

9.17.1.5 A reference to the Enrollee's rights listed in the "Member Rights for Placement in the Restricted Recipient Program" document.

9.17.2 Enrollee's Right to Appeal.

An Enrollee may Appeal and, after exhausting the MCO's Grievance and Appeal procedures, may request a State Fair Hearing to dispute placement in the RRP. If the Enrollee Appeals or requests a State Fair Hearing prior to the date of the proposed placement, the MCO may not impose the placement until the Appeal or State Fair Hearing is resolved in the MCO's favor. [Minnesota Statutes, §256.045]

9.17.3 Reporting of Restrictions.

9.17.3.1 Until the MCO has access to enter data directly into MMIS the MCO must report to the STATE, the names and PMI numbers of all Enrollees placed in the RRP, the date of placement, placement reason codes, and the names of the designated Providers with their addresses and Provider numbers. This information shall be reported to the STATE during business hours before the day the restriction is effective.

9.17.3.2 Once the MCO has access to enter data directly into MMIS, the MCO shall enter into MMIS the names and PMI numbers of all Enrollees placed in the RRP, the date of placement, placement reason codes, and the names of the designated Providers with their addresses and Provider numbers. This information shall be entered into MMIS during business hours before the day the restriction is effective.

9.17.3.3 If an MCO allows the use of a non-designated pharmacy, after exercising due diligence, the pharmacy must be entered into MMIS for the date or dates of service within one (1) business day of allowing the use of the non-designated pharmacy.

9.17.4 Program Administration.

9.17.4.1 The MCO will administer the RRP consistent with RRP criteria and process developed jointly with the MCOs and Minnesota Rules, parts 9505.2160 through 9505.2245.

9.17.4.2 The MCO must comply with the Prescription Monitoring Program (PMP) access criteria found in Minnesota Statutes, §152.126 subd. 6, (b)(9). The MCO shall use the PMP when reviewing Enrollees for possible placement in the RRP. The MCO may have no more than two designated staff accessing the PMP. Approval for access will be through the STATE. MCOs will have in place security measures that will guard against unauthorized access to the PMP and meet the criteria for PMP access posted on the STATE's public web site. The MCO shall query only Enrollees who are members of the MCO. Queries will only be made to identify Enrollees whose use of health services may warrant placement or continuation in the RRP and for managing Enrollees already in the RRP. The MCO shall establish a process to quarterly audit the utilization of the PMP for instances of improper use. Any unauthorized use of the PMP shall be reported to the STATE within one (1) business day of discovery.

9.17.4.3 When an Enrollee has changed enrollment to a new MCO within the last 12 months, and he or she is a current recipient in the RRP or is being considered for placement in the RRP, the new MCO may request data from claims and other case details from the previous MCO, or in the case of a previous FFS enrollee from the STATE.

9.17.4.4 The previous MCO or in the case of FFS coverage, the STATE, will share data from claims and other related case history details with the new MCO upon request. Any data or information shared will meet the minimum necessary requirement and only pertain to services necessary to review for restriction purposes only, excluding services for SUD in compliance with 42 CFR Part 2. No more than one year of data from claims may be shared.

9.17.4.5 Restricted Recipient Program Reports.

(1) Annual Reports. The MCO shall report to the STATE in writing, by August 31 of the Contract Year, summarizing the MCO's Restricted Recipient program results for the previous state fiscal year. The report shall include investigative activities, and results according to a format determined by the STATE. The report shall include, but not be limited to the following summary information about the reports of Enrollee fraud and abuse investigated by the MCO:

(a) Description of the MCO's procedures and analytics that were used for detecting and investigating possible acts of abuse by Enrollees that may result in restriction;

(b) A description and results of any cost-effectiveness study of the RRP program undertaken by the MCO;

(c) Number of investigations of acts of abuse by Enrollees regardless of whether the investigation resulted in actual restriction,

(d) Number of Enrollees who were restricted by the MCO for a 24-month period, and

(e) Number of Enrollees who were restricted by the MCO for a 36-month period.

(2) Quarterly Report. The MCO shall report to the STATE in writing, by the 15th of each month following the end of the quarter. The report shall include data on the following investigative activities, and submitted in a format determined by the STATE. The report shall include, but not be limited to, information on the following:

(a) Number of investigations of acts of abuse by Enrollees, regardless of whether the investigation resulted in actual restriction for each month of the preceding quarter;

(b) Number of Enrollees who were restricted or re-restricted by the MCO in the preceding quarter.

9.18 MENTAL HEALTH PARITY RULE COMPLIANCE

9.18.1 Compliance with the Mental Health Parity Rule.

The MCO shall demonstrate its compliance with the Mental Health Parity Rule, in a form and format determined by the STATE. The MCO shall submit its documentation of compliance to the STATE annually no later than October 1 of each Contract Year. [42 CFR 438 subpart K]

9.18.2 Benefit Requirements.

The MCO shall provide all benefits in the manner described in this Contract and the State Plan and as required by federal or state law. The MCO must provide mental health (MH) and substance use disorder (SUD) benefits in every classification (inpatient, outpatient, emergency care, or prescription drugs) in which medical/surgical benefits are provided. Whether a benefit may be classified as inpatient, outpatient, emergency, or prescription benefit will be predetermined by the STATE. The MCO may not reassign a benefit to a different category for any analyses required for compliance.

9.18.3 Financial, and Quantitative and Non Quantitative Treatment Limitations.

The MCO shall be responsible for submitting documentation demonstrating compliance with parity in the following areas:

9.18.3.1 Financial Requirements. The MCO may not apply any cumulative financial requirements for MH or SUD benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification. Any financial requirements imposed by MCOs must meet the "substantially all" and "predominant" tests described in 9.18.3.2.

9.18.3.2 Quantitative Treatment Limitations. Plans may not impose quantitative treatment limitations as defined at 42 CFR §438.900 on MH or SUD benefits within a benefit category unless such limitations are imposed on "substantially all" (two-thirds) of the medical/ surgical benefits within the same category. The quantitative limitation imposed on MH and SUD benefits within a given classification must be the same or less than the predominant (50% or greater) limitation applied to medical/ surgical benefits within a given classification.

9.18.3.3 Non-Qualitative Treatment Limitations (NQTLs). The MCO may not impose NQTLs as defined at 42 CFR §438.900 for MH or SUD benefits in any classification unless, under the policies and procedures of the MCO as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH or SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. [42 CFR §438.910(d)]

ARTICLE. 10 THIRD PARTY LIABILITY AND COORDINATION OF BENEFITS.

10.1 AGENT OF THE STATE.

The STATE hereby authorizes the MCO as its agent to obtain Third Party Liability and Medicare reimbursement by any lawful means including asserting subrogation interest, filing interventions, asserting independent claims, and to coordinate benefits, for MCO Enrollees, except in instances described in section 10.2.4, 10.4.7 and 10.8. [42 CFR §433, subpart D and Minnesota Statutes, §§ 256B.042, subd. 2; 256B.056, subd. 6; 256.015, subd. 1; 256B.37, subd. 1; and 256B.69, subd. 34]

10.2 PROMPT RESOLUTION OF TPL CASES.

10.2.1 The MCO, and its Subcontractors, shall pursue TPL recovery for funds under this Contract in a manner that is consistent with state and federal law and that will not interfere with the recovery activities of the STATE nor other MCOs under contract with the STATE.

10.2.2 The MCO and its Subcontractors shall respond to all inquiries from any party regarding third party litigation within thirty (30) days of receiving the request.

10.2.3 The MCO and its Subcontractors shall resolve all cases for funds under this Contract within ninety (90) days after receipt of a settlement offer or demand.

10.2.4 If any case is not resolved within ninety (90) days, the MCO must refer the case to the STATE for review and potential resolution.

10.2.5 Upon referral, the STATE shall have ten (10) business days to review the case. If, in the sole judgment of the STATE, the MCO and its Subcontractors have made a good faith effort to resolve the case, it shall be referred back to the MCO and its Subcontractors and the STATE may assist with finalizing the settlement. If a case is referred to the STATE for resolution, and is not returned after ten (10) business days, the case will be resolved by the STATE, and the MCO is no longer entitled to retain any amounts recovered.

10.2.6 The MCO and its Subcontractors shall submit a monthly report (Tort Settlement Tracking) to the STATE with the age of all settlement offers or demands. The report is due on the 25th of the month following the report month, in a form and format determined by the STATE.

10.3 THIRD PARTY RECOVERIES.

The MCO must take reasonable measures to determine the legal liability of third parties to pay for services furnished to MCO Enrollees. To the extent permitted by state and federal law, the MCO shall use Cost Avoidance and/or Post Payment Recovery Processes, as defined in Article 2, and subject to section 10.8 to ensure that primary payments from the liable third party are utilized to offset medical expenses. [42 CFR 433 Subpart D; Minnesota Statutes, §§256B.042, 256B.056, subds. 6, 8 and 9; and 256L.04]

10.3.1 Known Third Parties. The STATE shall include information about known Third Party Liability resources on the electronic enrollment data given to the MCO every two weeks, or on a schedule determined by the parties. Any new Third Party Liability resources learned of by the STATE through its contractor(s) are added to the next available data file. The STATE and MCO agree to work together to determine and implement mechanisms to improve the accuracy and timeliness of Third Party Liability resource data.

10.3.1.1 Additional Resources. The MCO shall report to the STATE any additional third party resources available to an Enrollee discovered by the MCO on a form provided by the STATE, within ten (10) business days of verification of such information. The MCO shall report any known change to health insurance information in the same manner. The STATE shall use its best efforts to include reported Third Party Liability resource information in the next available Third Party Liability resources data file.

10.3.2 Cost Benefit.

(1) The MCO's efforts to determine liability and use Post Payment Recovery Processes shall not require that the MCO spend more on an individual claim basis than the threshold limits established by the State Plan, which currently include:

(a) Tort/personal injury insurance: under $100.00

(b) Health insurance claims: under $50.00

(c) Workers' Compensation: under $500.00

(d) Motor vehicle insurance: under $200.00

(2) The MCO shall use Cost Avoidance Procedures to avoid payment on any claim where TPL is on file, other than those in section 10.4.5 below.

10.3.3 Retention of Recoveries.

For recoveries listed in section 10.4.6.1, the MCO is entitled to retain any amounts recovered through its efforts, provided that:

(1) Total payments received do not exceed the total amount of the MCO's financial liability for those services provided by the MCO to the Enrollee;

(2) STATE FFS and reinsurance benefits have not duplicated this recovery;

(3) Such recovery is not prohibited by federal or state law, and

(4) The recovery or recoveries took place within eight (8) months after the date the claim was Adjudicated.

(5) The MCO is entitled to retain any amounts recovered through its efforts for recoveries listed in section 10.4.6.1(2), except in instances described in section 10.2.4. There is no time limit for the time within which an MCO must recover these funds

10.3.3.2 Return of Payments. The MCO must require its Providers to return any third party payments to the MCO for Third Party Liability described in 10.4.6.1(1) if the Provider received a third party payment more than eight (8) months after the date the claim was Adjudicated. The MCO will then return the payment to the STATE. Mechanisms for return of the payment from the MCO to the STATE, and return of payments from the STATE to the MCO, will be specified by the STATE.

10.3.3.3 Unsuccessful Effort. If the MCO is unsuccessful in its efforts to obtain necessary cooperation from an Enrollee to identify potential third-party resources after sixty (60) days of such efforts, the MCO must inform the STATE in a format to be determined by the STATE that efforts have been unsuccessful. [Minnesota Statutes, §256B.056, subd. 8 and 42 CFR §§ 433.145 and 433.147]

10.4 COORDINATION OF BENEFITS.

For Enrollees who have private health or long term care coverage, the MCO must coordinate benefits. [Minnesota Rules, Part 9505.0070 and Minnesota Statutes, §62A.046]

10.4.1 Coordination of Benefits includes paying any applicable cost-sharing on behalf of an Enrollee, except for Medical Assistance cost-sharing pursuant to section 4.11.

10.4.2 Medicare Cost-Sharing Part of COB.

For Enrollees who are also eligible for Medicare, coordination of benefits includes paying any applicable cost-sharing ("crossover") on behalf of an Enrollee, whether the claim is from a Network or Out of Network provider. The amount paid shall be as defined in Minnesota Statutes, §256B.0625, subd. 57 and its exclusions for mental health (except certain physician and advanced practice registered nurse services), dialysis, FQHCs and RHCs; and effective upon federal approval and notice by the STATE, IHS facilities.

10.4.3 Medicare COB Agreement.

Pursuant to 42 CFR §483.3(t), the MCO shall enter into and maintain a coordination of benefits agreement with CMS and must participate in the automated claims crossover process. Medicare

COB shall be conducted in accordance with the Coordination of Benefits and Third Party Liability (COB/TPL) in the Medicaid Handbook, as updated, found at https://www.medicaid.gov/medicaid/eligibility/downloads/tpl-cob/training-and-handbook.pdf.

10.4.4 Medicare SNF Days Review.

When the STATE requests review of Medicare coverage of SNF days within one hundred and eighty (180) days of the service date, the MCO shall cooperate with the STATE in reviewing such claims, including MCO review of medical records, submitting medical records, and having a dedicated individual available to discuss findings with the STATE.

10.4.5 Cost Avoidance.

Except as described in paragraph 10.4.5.3, the MCO shall use a Cost Avoidance procedure for all claims or services that are subject to third-party payment to the extent permitted by state and federal law, and must deny payment for a service to an Enrollee if the MCO has established the probable existence of Third Party Liability at the time the Provider submits the claim.

10.4.5.1 The MCO shall not pay for services that would have been covered by the primary coverage if the applicable rules of that coverage had been followed.

10.4.5.2 Cost-effectiveness. The MCO must determine whether it is more cost-effective to provide the service or pay the cost-sharing to a Non-Network Provider. If the MCO refers an Enrollee to a third-party insurer for a service that the MCO covers, and the third-party insurer requires payment in advance of all cost-sharing, the MCO shall make such payments in advance or at the time such payments are required.

10.4.5.3 Exceptions. For 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. [42 CFR §433.139]

10.4.6 Post-Payment Recoveries.

10.4.6.1 Post-Payment Recoveries to be Pursued by the MCO. The MCO shall recover funds post payment in cases where the MCO was not aware of third-party coverage at the time services were rendered or paid for, or the MCO was not able to use a Cost Avoidance Procedure. The MCO shall use information from the STATE and shall identify and pursue all potential Third Party Liability payments. Potentially liable third party coverage sources include, but are not limited to:

(1) Third Party Insurance Coverage:

(a) Medicare;

(b) Third party liability insurance (for example, group health plans including medical, dental, pharmacy and vision; self-insured plans; managed care organizations; pharmacy benefit managers; long-term care insurance; union and other fraternal organizations; and certain other state or federal programs);

(2) Tort/Auto/Workers Compensation

(a) Uninsured/underinsured motorist insurance;

(b) Awards as a result of a tort action;

(c) Workers' compensation;

(d) Medical payments insurance for accidents (otherwise known as "med pay" provisions or benefits of policy); or

(e) Indemnity/accident insurance.

10.4.7 Recoveries Not to be Pursued by the MCO.

(1) The MCO shall not pursue reimbursement under estate recovery or medical support recovery provisions. This applies to recoveries of medical expenses paid for an Enrollee because the following subsequent recovery actions are taken by a Local Agency or the STATE: 1) Medical Assistance lien or estate recovery; 2) special needs or pooled trusts; 3) annuities; or 4) recovery from a custodial or non-custodial parent under a court order for medical support.

(2) The MCO shall not pursue recoveries for Third Party insurance coverage described in 10.4.6.1(1) above after the first eight (8) months after a claim has been Adjudicated.

(3) The MCO shall not pursue recoveries for Tort/Auto/Workers Compensation described in section 10.4.6.1(2) above after the case has been referred to the STATE for resolution pursuant to section 10.2.4 above.

10.4.7.2 The MCO shall develop procedures to identify trauma diagnoses and investigate potential liability, and pursue recoveries.

10.5 REPORTING OF RECOVERIES.

The MCO shall report on the encounter claim all Third Party Liability payments.

10.6 CAUSES OF ACTION.

If the MCO becomes aware of a cause of action to recover medical costs for which the MCO has paid under this Contract, the MCO shall file an intervention or assert a claim or a subrogation interest in the cause of action. The MCO shall follow the STATE's policy guidelines in settlement of any claim.

10.7 DETERMINATION OF COMPLIANCE.

The STATE may determine whether the MCO is in compliance with the requirements in this Article by inspecting source documents for: 1) appropriateness of recovery attempt; 2) timeliness of billing; 3) accounting for third party payments; 4) settlement of claims; and 5) other monitoring deemed necessary by the STATE.

10.8 SUPPLEMENTAL RECOVERY PROGRAM.

The MCO shall comply with Minnesota Statutes, §256B.69, subd. 34 and work with the STATE in its efforts to collect third party liability payments for services rendered to Enrollees covered under this contract. The STATE will establish reports to the MCO on recoveries the STATE makes under section 10.4.7(2); and will work with the MCO to establish mechanisms to ensure no duplication of efforts for coordination of third-party collections, and mechanisms to address concerns or issues with collections and reconciliations.

10.8.1 Eight Months Recoveries Recovery Report. The MCO shall, on a quarterly basis, disclose to the STATE all Post Payment Recovered amounts occurring after the eight-month timeframe in section 10.3.3(4). The report shall include medical, dental, and pharmacy claims. The report is due by the sixtieth (60th) day following the end of the quarter.

10.8.2 Following receipt of the STATE's invoice, in a form and manner specified by the STATE, the MCO shall have thirty (30) days to return the invoice stub with a check payment for the invoiced amount.

ARTICLE. 11 REPORTING AND DELIVERABLES

The parties agree to provide the following information.

11.1 New Reports.

With any new report required under this section, the STATE will provide the MCO the technical specifications for the report at least 60 days prior to the effective date of when the report is to be submitted, unless the State determines that a shorter time period is necessary. This provision does not apply to *ad hoc* reports requested by the STATE.

11.2 Reports with No Change

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.

11.3 Non-Business Days.

If due dates for reporting requirements fall on the weekend or on a holiday, the report will be due to the State on the following business day

11.4 Deliverables from the STATE to the MCO

The STATE shall provide the following information to the MCO:

(1) PECD File. The STATE shall provide the MCO with an electronic listing of all enrolled MHCP Providers and their NPI or UMPI numbers on a monthly basis. The MCO must update the Provider identification numbers by submitting, for Providers who are new to the MCO and do not already have a STATE Provider number, UMPI or NPI and current complete demographic information about the Provider, on a form approved by the STATE. If a Provider will only be serving MCO Enrollees, the MCO shall follow the process established by the STATE for MCO-only Providers;

(2) Enrollee eligibility review dates, referred to in section 3.6.6;

(3) An annual MMIS schedule referred to in section 3.8.4;

(4) Prior notice of STATE notices and materials, referred to in section 3.11.9;

(5) Technical specifications and calculations for the encounter data reporting, as applicable, referred to in section 3.16.1;

(6) Provider-preventable conditions, referred to in section 3.16.6;

(7) Risk adjustment information referred to in section 4.5;

(8) The calculation for the Health Insurance Providers Fee, if applicable, as referred to in section 4.8;

(9) The amount of the family deductible as it changes from year to year referred to in section 4.11.2;

(10) Technical specifications for the withholds referred to in section 4.12;

(11) Notices referred to in sections 5.1 through 5.8;

(12) The additional payment or recovery report for CCBHCs described in section 6.1.19.3;

(13) Prescription drug reports and standards referred to in section 6.1.41;

(14) Twice-monthly reports on carved out services described in section 6.7.3;

(15) Information on IHS and 638 facilities referred to in section 6.12;

(16) EQRO reports referred to in section 7.6;

(17) Technical specifications for the appeals and grievances reporting referred to in section 8.7.

(18) A list of certain provider types referred to in section 9.4.4, upon request;

(19) Program integrity information in response to reporting under section 9.9.1;

(20) Third Party liability information under sections 10.2 through 10.8; and

(21) Updates or modifications to the templates or formats referred to throughout this Contract.

11.4.1.2 Payment for *ad hoc* Reporting.

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

11.5 DELIVERABLES FROM THE MCO TO THE STATE.

11.5.1 The following reports, not described elsewhere in the contract, are required:

(1) Audit Items Required for Review and Evaluation by the STATE. The MCO shall submit to the STATE the Care Plan, Case Management and Care System audit reports and audit protocols as required in sections 7.7 and 9.4.2 by September 15th of the Contract Year for review and evaluation by the STATE.

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

(3) Dental CHIPRA Data Files Submission. The MCO shall submit quarterly data files to the STATE that include information about dental providers in the MCO's network, including data certification described in section 11.6. If for any reason the data needs to be corrected, a new data certification will be required. If there are no changes to the data file from the previous quarterly submission, the MCO does not have to send the subsequent quarterly data file submission, but must provide a data certification indicating that there have been no changes since the last quarterly submission The MCO must send a complete data submission at least once annually, even if there are no changes. The data files shall comply with the specifications and submission guide outlined in the document entitled, "*Insure Kids Now (IKN) Provider Data Submission Technical Information*" modified by the STATE and posted on the DHS managed care web site. [42 USC §1397hh(e)]

(4) Care Management and Case Management Systems. The MCO will provide to the STATE descriptions of changes in Care Management and Case Management systems annually by September 15th of each year. Descriptions must include, but not be limited to a copy of the SNP Model of Care as submitted to CMS and the results of the annual review of case management systems. The MCO may use a delegate review reporting template developed jointly by the STATE and managed care organizations as required in section 9.4.2 below.

(5) Documentation of Care Management. The MCO shall maintain documentation sufficient to support its Care Management responsibilities set forth in section 6.1.4. Upon the reasonable request of the STATE, the MCO shall make available to the STATE, or the STATE's designated review agency, access to a sample of Enrollee Care Management plan documentation.

(6) DUR Reports. The MCO must submit Drug Utilization Review Program reports:

(a) As a quarterly summary meeting the requirements of 42 USC §1396r-8 (d)(5), including the number of authorization requests received; the numbers completed and not completed within the timeframes required; and what corrective action has been taken for authorization requests not completed within the timeframes required. The

report is due twenty (20) days after the last day of the quarter, in a form and format determined by the STATE.

(b) Annually, in a format approved by the STATE, on DUR activities from the previous federal fiscal year, consistent with 42 CFR §438.3(s) and section 6.1.41 below. The report is due May 1 of the Contract Year; see section 6.1.41.11 above.

(7) Enrollee Eligibility-Related Change. Upon implementation and notice by the STATE, the MCO shall promptly notify the STATE if the MCO receives information about changes in an Enrollee's circumstances that may affect the Enrollee's MHCP eligibility, including changes in the Enrollee's county of residence or the death of an Enrollee. [42 CFR §438.608(a)(3)]

(8) Enrollee and Marketing Materials. Enrollee and Marketing Materials described in section 3.11.The MCO must report changes in web site links to the STATE before the links change for materials required to be made available electronically, including Enrollee Handbooks, Provider Directories, and Formularies.

(9) Federal MLR. The MCO shall calculate and report a federal Medical Loss Ratio (MLR) [42 CFR §438.8]

(a) The MCO will aggregate data for all Medicaid eligibility groups covered under this Contract.

(b) The initial federal MLR report is due December 13, 2019, and annually thereafter. [42 CFR 438.8(k)(2)]

(c) The MCO must require any third party vendor providing claims adjudication activities to provide all underlying data associated with federal MLR reporting to the MCO within one hundred and eighty (180) days of the end of the federal MLR reporting year or within thirty (30) days of being requested by the MCO, whichever comes sooner, regardless of current contractual limitations.

(d) In the event that the STATE makes a retroactive change to the capitation payments for a federal MLR reporting year where the report has already been submitted to the State, the MCO must re-calculate the federal MLR for all reporting years affected by the change and submit a new report(s) meeting the requirements of this section.

(e) In the event that the MCO fails to meet the federal MLR of eighty-five percent (85%), the MCO must provide a remittance to the STATE to meet the federal MLR of eighty-five percent (85%). [42 CFR §438.8(j)]

(10) HCC Risk Adjustment. The MCO SNP will notify the STATE or its actuarial firm of its restated mid-year HCC risk adjustment score and additional HCC Frailty factor score. Scores will be from restated data based upon the preceding calendar year as reported by CMS. The MCO SNP will send this information to the STATE, or its actuaries, within thirty (30) days of CMS making it available to the MCO. The actuarial firm may share information about the risk score with the STATE, but the STATE will not receive copies of this information. The MCO must identify this information as trade secret prior to, or at the time of its submission for the STATE to consider classifying it as non-public, as described in section 9.7.

(11) Health Care Home and HCH Alternatives.

(a) HCH payment is reported on the quarterly financial report in section 11.5.1(16) below. As applicable, the STATE and MCO will work collaboratively on how to implement the collection of data on pediatric care coordination to be included in the report.

(b) Reporting Requirement if using an alternative arrangement for Health Care Homes. The MCO shall annually provide a description of each comprehensive payment arrangement, and its proposed outcome or performance measures that the MCO uses as an alternative to Health Care Homes payment in a reporting template provided by the STATE. The template shall include the following:

- Identify each Certified Health Care Home for whom the MCO is paying a comprehensive payment arrangement instead of the standard Health Care Home care coordination fee:
- Number of Enrollees served under each arrangement;
- Description of payment arrangements;
- Scope of the services included in the arrangement (for example, if the model includes a total cost of care arrangement, whether long term care, Medicare and Medicaid costs and substance use, mental and/or behavioral health services are included, and whether any services are carved out of the arrangement);
- Describe the MCO's process for overseeing the entities and evaluating their performance;
- Describe quality indicators used to measure performance;
- Describe the benchmarks used to determine whether the Provider entity is within the cost of care expectations.
- The completed report on the comprehensive payment arrangement is due September 1 of the Contract Year.

(12) HOS Health Survey. The SNBC SNP will share Health Outcomes Survey (HOS) survey results with the State within thirty (30) days of receiving the results.

(13) Reporting Requirement for ICSP. The MCO shall annually provide information on ICSPs described in section 7.8 and ICSP outcome or performance using formats provided by the STATE.

(a) The MCO shall report aggregate ICSP payments and recipients, separated by payment type and project type by September 1 of the Contract Year, as requested by the STATE and using the template provided.

(b) The MCO shall cooperate with the STATE to document ICSP case study briefs by September 1 of the Contract Year, as requested by the STATE and using the template provided.

(c) The MCO must provide briefs for at least the minimum required number and type of ICSP arrangements, and is encouraged to provide briefs describing all ICSP arrangements. The briefs shall be used for the purpose of identifying innovations due to the program.

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

(15) Provider Network Information. The MCO will submit to the STATE a complete listing of its Provider Network in accordance with the specifications outlined in the STATE's provider network template posted on the STATE's web site. The MCO will submit its entire Provider network on the fifth of every month to the STATE's provider data repository. The MCO will work with the STATE to ensure that its monthly provider network data submission is

complete, accurate, and timely and will resolve any issues necessary to successfully submit the data. [42 CFR §438.604]

(16) Quarterly Financial Report. [Minnesota Statutes, §256B.69, subd. 9c]

(a) Financial and other information as specified by the STATE to determine the MCO's financial and risk capability, 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.

(b) The MCO shall provide to the STATE the information described in Minnesota Statutes, §256B.69, subd. 9c in a format and manner specified by the STATE in accordance with STATE guidelines developed in consultation with the MCO. The MCO will submit the information on a quarterly basis consistent with the instructions included in the STATE's financial reporting template. The fourth quarter report shall also include audited financial statements, parent company audited financial statements, an income statement reconciliation report, and any other documentation necessary to reconcile the detailed reports to the audited financial statements. Audited financial statements submission must be consistent with 42 CFR §438.3(m).

(c) Comparison to FFS Payment. The MCO shall identify aggregate payment information for specific Provider categories and assess the information as to how it compares to FFS payment information. As part of the assessment the MCO will also be expected to provide an explanation of the basis for how the Provider category payment was determined.

(d) In the event a report is published or released based on data provided under this section, the STATE shall provide the report to the MCO fifteen (15) days prior to the publication or release of the report. The MCO shall have fifteen (15) days to review the report and provide comments to the STATE.

(17) Requests for Time-Sensitive Data. The STATE may collect data or contract with external vendors for studies, including but not limited to, data validation, service validation, and quality improvement.

(a) 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.

(b) The MCO must notify the STATE within one week of any issues concerning the data specifications.

(c) 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.

(d) The MCO must submit accurate and complete data within the time periods that meet the data specifications.

(18) County Survey. The STATE seeks input from the counties for contract renewal input to comply with Minnesota Statutes, §256B.69, subd. 3a. The MCO shall submit the County Survey Follow Up report, in a format approved by the STATE. This report is due annually by December 31st of the Contract Year.

11.5.2 The following reports, described elsewhere in the contract, are required:

(1) LEP Plan. The MCO must annually by November 1 of the Contract Year, submit a Limited English Proficiency (LEP) Plan described in section 3.11.2.2 above;

(2) Material Modification to Service Delivery Plan, as listed in section 3.14.4;

(3) Health Risk Assessment data referred to in sections 3.15 and 6.1.5.2;

(4) Claim-level data on all post-payment recoveries for pharmacy claims from liable third parties described in section 3.16.1.2(8)

(5) A detailed plan for a survey regarding transportation access for persons with disabilities, as described in section 4.12.2.1(2).

(6) Stop-Loss reporting referred to in section 4.2;

(7) A detailed plan for a survey regarding transportation access for persons with disabilities, as described in section 4.12.4.2.

(8) Formulary Changes, as described in section 6.1.41.8;

(9) Enrollees Resident in IMD for SUD and MH described in section 6.3.1.2(1);

(10) SNBC Accessibility Survey; the MCO shall provide the STATE with a copy of the presentation described in section 6.11;

(11) Quality Assurance Work Plan. The MCO shall submit its Quality Assurance Work Plan, pursuant to section 7.1. If the MCO has submitted this report under either its Families and Children or MSHO/MSC+ contract, and that report addresses SNBC Enrollees, this report is waived;

(12) Accreditation Status reports described in section 7.1.2;

(13) Annual Quality Assessment and Performance Improvement Program Evaluation described in section 7.1.8;

(14) SNBC Dental Access Improvement reporting referred to in section 7.1.9;

(15) Annual PIP Proposal, Interim or Final PIP Report as described in section 7.2;

(16) Annual reports on Population Health Management described in section 7.3;

(17) Reports on the activities of the Stakeholder Group as described in section 7.5;

(18) Annual Quality Program Update web link notification, described in section 7.9;

(19) HEDIS Measures listed in section 7.15;

(20) Reporting of Appeals, Grievances, and DTRs as required under section 8.7;

(21) MCO Solvency Standards Assurance as described in section 9.2;

(22) Annual schedule identifying Subcontractors and delegated functions as described in section 9.3.5.5;

(23) Deficit Reduction Act (DRA) Assurance Statement as described in section 9.9.8.1

(24) Subcontractual Delegation of SIU Responsibilities described in section 9.9.1.1(1);

(25) Annual Integrity Program Report as described in section 9.9.2;

(26) Adverse Provider Actions Monthly Report described in section 9.9.3.1(2);

(27) Provider Fraud, Waste and Abuse Log, described in section 9.9.6.6;

(28) Deficit Reduction Act Training Assurance Statement described in section 9.9.8.1;

(29) Program Integrity Disclosures as listed in section 9.10;

(30) Mental Health Parity Compliance described in section 9.18;

(31) Annual Restricted Recipient Program Report as described in section 9.17;

(32) Tort Settlement Tracking, as described in section 10.2.6;

(33) Third Party Resources. Pursuant to section 10.3.1.1, the MCO shall report to the STATE any additional Third Party Liability resources in a format provided by the STATE, including

Long Term Care Insurance, except for Medicare, during any interim when Medicare capitation is not yet available;

(34) Third Party Payments. Pursuant to section 10.5, the MCO shall report all recovery and Cost Avoidance amounts on the encounter claim as Third Party Liability 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;

(35) Eight-Month TPL Recoveries described in section 10.8.1.1;

(36) Physician Incentive Plans Disclosure described in section 11.8;

(37) Change of Emergency Preparedness Response Coordinator, and any other Emergency Preparedness Response reports in section 15.1.

11.6 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. [42 CFR §438.604]

11.6.1 Certification of Data and Reporting Submitted to STATE.

The MCO shall provide to the STATE a certification for the following data or reports:

11.6.1.1

(1) Encounter data;

(2) Data and reports associated with the reporting requirements of the managed care withhold in section 4.12;

(3) Data submissions as requested by the STATE for the development of rates;

(4) Quarterly Financial Reports under section 11.5.1(16);

(5) Third Party Liability reports under section 10.8 (A); and

(6) Disclosure information on ownership and control interests pursuant to section 9.10.

(7) The MCO's report of overpayment recoveries in the Program Integrity Report in section 9.9.2

(8) The MCO's MLR report submitted in section 11.5.1(9).

(9) Any other data or document determined by the STATE to be necessary to comply with 42 CFR §438.604. The data certification is required upon the STATE's written request and is due within five (5) days of the request.

11.6.2 Requirements.

Each data or report certification listed above shall meet the following requirements:

11.6.2.1 Include an attestation as to the accuracy, completeness and truthfulness of the data or documents being submitted.

11.6.2.2 Provide that the attestation is based upon the best knowledge, information and belief of the one certifying on behalf of the MCO; and

11.6.2.3 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.

11.6.2.4 Certification must be submitted concurrently with the data.

11.7 BUSINESS DISCLOSURE REQUIREMENTS.

The MCO must consent to and cooperate with any financial, character, and other inquiries by the STATE.

11.7.1 General Disclosures.

Upon request by the STATE, the MCO must disclose the following information:

11.7.1.1 The MCO shall notify the STATE in a timely manner of changes to the MCO's Government Programs staff and management;

11.7.1.2 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;

11.7.1.3 The MCO's full legal or corporate name and any trade names, aliases, and/or business names currently used;

11.7.1.4 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;

11.7.1.5 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;

11.7.1.6 Whether the MCO is directly or indirectly controlled to any extent or in any manner by another individual or entity. If so, the MCO must disclose the identity of the controlling entity and a description of the nature and extent of control; and

11.7.1.7 Any agreements or understandings that the MCO has entered into regarding ownership or operation of the MCO.

11.7.2 Disclosure of Management/Fiscal Agents.

The MCO must disclose upon request of the STATE the following, if applicable:

11.7.2.1 A description of the terms and conditions of any contract or agreement between the MCO and the management or fiscal agent;

11.7.2.2 All corporations, partnerships or other entities providing management or fiscal agent services;

11.7.2.3 The management or fiscal agent's full legal or corporate name and any trade names currently used. The legal name, aliases, and previous names of management personnel, to the extent known;

11.7.2.4 The jurisdiction of the management or fiscal agent and date of incorporation, along with any articles of incorporation and by-laws, if applicable, along with state and federal tax returns for the current period and the past five periods. Copies of any agreements creating or governing the organization must be submitted if the management or fiscal agent is an organization other than a corporation; and

11.7.2.5 The date the management or fiscal agent commenced doing business in Minnesota; and if they are incorporated outside of Minnesota, a copy of their certificate of authority to do business in Minnesota.

11.8 DISCLOSURE OF, COMPLIANCE WITH, AND REPORTING OF PHYSICIAN INCENTIVE PLANS.

The MCO may operate a Physician Incentive Plan, as defined in 42 CFR §438.3(i), only if no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician group as an incentive to reduce or limit medically necessary services to an Enrollee, per 42 CFR §422.208(c)(1), and if the following requirements are met.

11.8.1 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 §§438.3(i), 422.208 and 422.210. The MCO shall maintain in its files the following information in sufficient detail to enable the STATE or CMS to determine the MCOs compliance and shall make that information available to the STATE or CMS upon request. The MCO must take into consideration its contractual relationship with all its Subcontractors, including the relationship between its Subcontractors and other Providers down to the level of the physician. These relationships include:

11.8.1.1 The physician/physician group for which risk has been transferred for services not furnished by the physician/physician group, such as referral services;

11.8.1.2 The type of incentive arrangement such as withhold, bonus or capitation associated with the transfer of risk for the physician/physician group;

11.8.1.3 The percent of the potential payment to the physician/physician group that is at risk for referrals;

11.8.1.4 The panel size, and if patients are pooled, the pooling method used to determine if substantial financial risk (SFR) exists for the physician/physician group;

11.8.1.5 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 (for example, per member per year or aggregate); and

11.8.1.6 If the MCO has Physician Incentive Plans that place physicians or physician groups at SFR for the cost of referral services it must conduct Enrollee surveys and provide a summary of the survey results, consistent with 42 CFR §§438.3(i), 422.208, 417.479(h) and 417.479(g)(1).

11.8.2 Disclosure to Enrollees.

The MCO must provide the following information to any Enrollee or Potential Enrollee upon request [42 CFR §438.10(f)(3)]:

11.8.2.1 Whether the MCO or its Subcontractors use a Physician Incentive Plan that affects the use of referral services;

11.8.2.2 The type of incentive arrangement(s) used;

11.8.2.3 Whether stop-loss protection is provided; and

11.8.2.4 If the MCO was required to conduct an Enrollee survey under 42 CFR §§417.479(h) and 417.479(g)(1), a summary of the survey results.

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ARTICLE. 12 COMPLIANCE WITH STATE AND FEDERAL LAWS.

The MCO shall comply with all applicable state and federal laws and regulations in the performance of its obligations under this Contract. Any revisions to applicable provisions of federal or state law and implementing regulations, and policy issuances and instructions, except as otherwise specified in this Contract, apply as of their effective date. If any terms of this Contract are determined to be inconsistent with rule or law, the applicable rule or law provision shall govern.

In the performance of obligations under this Contract, the MCO agrees to comply with provisions of the following laws:

12.1 CONSTITUTIONS.

The Constitutions of the United States and the State of Minnesota.

12.2 MEDICAID LAWS.

The MCO shall comply with Title XIX of the Social Security Act (42 USC §1396 et seq.), applicable provisions of 42 CFR §431.200 et seq. and 42 CFR Part 438; waivers or variances approved by CMS; and the Rehabilitation Act of 1973.

12.3 PROHIBITIONS AGAINST DISCRIMINATION.

12.3.1 Title VI of the Civil Rights Act of 1964 and pertinent regulations at 45 CFR §80;

12.3.2 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;

12.3.3 Section 504 of the Rehabilitation Act of 1973 and pertinent regulations at 45 CFR §84;

12.3.4 Section 508 of the Rehabilitation Act of 1973, as amended (29 USC 794d);

12.3.5 Age Discrimination Act of 1975 and pertinent regulations at 45 CFR Part 91;

12.3.6 Minnesota Statutes, Ch. 363A, including §363A.36 (Certificates of Compliance for Public Contacts); §363A.11 (Public Accommodations); and §363A.12 (Public Services);

12.3.7 Title IX of the Education Amendments of 1972;

12.3.8 The MCO shall cooperate with the STATE's Medicare Revenue Enhancement Program (MREP) to ensure that Skilled Nursing Facility days are covered pursuant to Medicare guidelines. Cooperation includes but is not limited to filing Requests for Redetermination for which DHS must be allowed up to one hundred and twenty (120) days from the date of denial:

12.3.9 Title II of the Americans with Disabilities Act of 1990, 42 USC §12101, et seq., and regulations promulgated pursuant to it, including 28 CFR Part 35. The MCO shall also 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;

12.3.10 Section 1557 of the Affordable Care Act, and

12.3.11 Any other laws, regulations, or orders that prohibit discrimination on grounds of medical condition, health status, receipt of health care services, claims experience, medical history and genetic information, disability (including mental or physical impairment), marital status, age, sex

(including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, public assistance status, or political beliefs.

12.4 Additional Federal Laws, and Clauses required by 2 CFR §200.326:

12.4.1 Environmental Requirements.

The MCO shall comply with all applicable standards, order or requirements issued under §306 of the Clean Air Act (42 USC §1857(h)), §508 of the Clean Water Act (33 USC §1368), the Federal Water Pollution Control Act as amended (33 U.S.C. 1251-1387), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Part 15).

12.4.2 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.

12.4.3 Anti-Kickback Provisions.

The MCO shall be in compliance with the Copeland "Anti-Kickback" Act, 18 USC §874, as supplemented by Department of Labor regulations, 29 CFR Part 3, "Contractors and Subcontractors on Public Building or Public Work financed in whole or in part by Loans or Grants from the United States," as applicable. If the MCO or its Subcontractors violate 42 USC §1320a-7b, the MCO and its Subcontractors may be subject to the criminal penalties stated therein.

12.4.4 Davis-Bacon Act.

The MCO shall be in compliance with the Davis-Bacon Act, as amended (40 USC §§ 276a to 276a-7), as supplemented by Department of Labor regulations (29 CFR Part 5), as applicable.

12.4.5 Contract Work Laws.

The MCO shall be in compliance with the Contract Work Hours and Safety Standards Act (40 USC §§ 327-330), as supplemented by Department of Labor regulations (29 CFR Part 5), as applicable.

12.4.6 Rights to 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.

12.4.7 Lobbying Disclosure.

The MCO certifies that, to the best of its knowledge, understanding, and belief, that:

12.4.7.1 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 USC §1352, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, the modification of any Federal contract, grant, loan, or cooperative agreement, or in any activity designed to influence legislation or appropriations pending before Congress.

12.4.7.2 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.

12.4.7.3 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 USC §1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

12.4.8 CLIA Requirements.

All laboratory testing sites providing services under this Contract must comply with the Clinical Laboratory Improvement Amendment (CLIA) requirements in 42 CFR §493. The MCO shall obtain the valid CLIA certificate numbers from laboratories used by the MCO, and shall ensure that the certificates remain current. The MCO shall make a written report to the STATE of any laboratories it discovers to be non-CLIA certified.

12.5 STATE LAWS.

Minnesota Statutes, §256B.69 et seq.; Minnesota Rules, Parts 9500.1450 to 9500.1464; Minnesota Statutes, §256L.01 et. seq.; and Minnesota Rules, Parts 9506.0010 to 9506.0400.

12.5.1 Workers' Compensation.

In accordance with the provisions of Minnesota Statutes, §176.182, the MCO shall provide acceptable evidence of compliance with the workers' compensation insurance coverage requirement of Minnesota Statutes, §176.181, subd. 2.

12.5.2 Affirmative Action.

The MCO certifies that it has received a certificate of compliance from the Commissioner of Human Rights pursuant to Minnesota Statutes, §363A.36. County administered MCOs are exempt from this statute.

12.5.3 Voter Registration.

The MCO certifies that it will comply with Minnesota Statutes, §201.162.

12.5.4 Prohibition on Weapons.

MCO agrees to comply with all terms of the Minnesota Department of Human Service's 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.

12.5.5 Certification of Nondiscrimination.

MCO certifies that it does not engage in discrimination against Israel, or against persons or entities doing business in Israel, when making decisions related to the operation of its business. For purposes of this section, "discrimination" includes but is not limited to engaging in refusals to deal, terminating business activities, or other actions that are intended to limit commercial relations with Israel, or persons or entities doing business in Israel, when such actions are taken in

a manner that in any way discriminates on the basis of nationality or national origin and is not based on a valid business reason. [Minnesota Statutes, § 16C.053]

ARTICLE. 13 INFORMATION PRIVACY AND SECURITY.

The MCO will comply with the following requirements regarding Protected Information:

13.1 COVERED ENTITY AND BUSINESS ASSOCIATE.

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.

13.2 TRADING PARTNER.

The MCO exchanges electronically transmitted PHI with the STATE, and is a "Trading Partner" in accordance with the Privacy Regulation. Pursuant to the Privacy Regulation, Trading Partners must comply with the requirements of the Privacy Regulation as it relates to conducting standard transactions. The purpose of this section is to assure and document that the parties comply with the requirements of the Privacy Regulation, including, but not limited to, the Business Associate contract requirements at 45 CFR Part 164 and the Administrative requirements for transaction standards between Trading Partners specified at 45 CFR Part 162.

13.3 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.

13.4 HIPAA TRANSACTIONS AND SECURITY COMPLIANCE.

The MCO shall be in compliance with the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act (HIPAA), and any regulations 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 Subchapter C, except as provided in section 3.16.1.2 above.

13.4.1 The MCO shall be in compliance with these requirements consistent with the applicable effective dates contained in state or federal law.

13.4.2 The MCO shall use appropriate safeguards and comply with 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the Protected Information other than as provided for by this Contract. This includes, but is not limited to the use of 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.

13.5 INFORMATION PRIVACY GENERAL OVERSIGHT RESPONSIBILITIES.

MCO shall be responsible for ensuring proper handling and safeguarding by its workforce members (as defined in the Privacy Regulation), Subcontractors, Business Associates, and authorized agents of Protected Information collected, created, used, maintained, or disclosed on behalf of STATE. This responsibility includes:

13.5.1 Training.

Ensuring that employees and agents comply with and are properly trained regarding, as applicable, the laws listed in section 2.155 above, and

13.5.2 Minimum Necessary Access to Information.

MCO shall comply with the "minimum necessary" access and disclosure rule set forth in the HIPAA and the MGDPA, and shall ensure that its Business Associates comply. 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." [45 CFR §164.502(b) and §164.514(d), and Minnesota Statutes, §13.05 subd. 3]

13.6 USE OF INFORMATION.

MCO shall:

13.6.1 Use PHI for the proper management and administration of MCO or to carry out the legal responsibilities of MCO.

13.6.2 Not use or further disclose Protected Information created, collected, received, stored, used, maintained or disseminated in the course or performance of this Contract other than as permitted or required by this Contract or as required by law, either during the period of this Contract or hereafter.

13.6.3 Use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the Protected Information by its workforce members, Subcontractors and agents other than as provided for by this Contract.

13.6.4 Report to STATE any breach of unsecured protected health information. [45 CFR §164.410]

13.6.4.1 Breach excludes the circumstances described in 45 CFR 164.402, paragraph (1):

(1) Unintentional acquisition, access, or use of protected health information that does not result in further use or disclosure;

(2) Inadvertent disclosure by a person authorized to access PHI at the MCO or its Business Associate to another person authorized to access PHI at the MCO or its Business Associate;

(3) Disclosure of PHI where the MCO or its Business Associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

13.6.4.2 A disclosure is presumed to be a breach unless the MCO or Business Associate, as applicable, demonstrates that there is a low probability that the PHI has been compromised, based on a risk assessment using the factors in 45 CFR §164.402, paragraph (2).

13.6.4.3 The report to the STATE must be in writing and must be sent to STATE not more than five (5) business days after learning of such non-permitted use or disclosure.

13.6.4.4 The report must, at a minimum: 1) Identify the nature of the non-permitted use or disclosure; 2) Identify the PHI used or disclosed; 3) Identify who made the non-permitted use or disclosure, and who received the non-permitted or violating disclosure, if known; 4) Identify what corrective action was taken or will be taken to prevent further non-permitted uses or disclosures; 5) Identify what was done or will be done to mitigate any deleterious effect of the non-permitted use or disclosure; and 6) Provide such other information, including any written documentation, as STATE may reasonably request.

13.6.5 Report to the STATE in writing not more than five (5) business days after learning of a Privacy Incident under state laws in section 2.154 or Security Incident under section 2.164.

13.6.6 In cooperation with the STATE, MCO must attempt to mitigate harmful effects resulting from the disclosure. [45 CFR §164.530]

13.6.7 In accordance with HIPAA, upon obtaining knowledge of a breach or violation by a Subcontractor, take appropriate steps to cure the breach or end the violation, and if such steps are unsuccessful, terminate the agreement.

13.6.8 MCO will cooperate with the STATE in the event the MCO is required to provide notice required by 45 CFR §§ 164.404 through 164.408 to affected individuals, news media, and/or the Office of Civil Rights, Department of Health and Human Services.

13.6.9 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. [45 C.F.R. §§164.502(e)(1)(ii) and 164.308(b)(2)]

13.6.10 Make available PHI in accordance with 45 CFR §164.524, and Minnesota Statutes, §13.04, subd. 3, according to the timeframes in those laws, or within ten (10) business days of receipt of a written request by the STATE.

13.6.11 Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526 according to the timeframes in that law, or within fifteen (15) days of receipt of written request by the STATE.

13.6.12 Document such disclosures of PHI and information related to such disclosures as would be required for the MCO or the STATE to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528. Either:

13.6.12.1 Provide to STATE, information required to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528 within fifteen (15) days of receipt of written request by the STATE; or

13.6.12.2 Upon the STATE's request, respond directly to the individual requesting an accounting of disclosures from the MCO.

13.6.13 STATE Information Management System Access.

If STATE grants MCO access to Protected Information maintained in a STATE information management system (including a STATE "legacy" system) or in any other STATE application, computer, or storage device of any kind, such access will be contingent upon the MCO agreeing to comply with any additional system- or application-specific requirements as directed by the STATE.

13.7 MCO RESPONSIBILITY.

To the extent the MCO is to carry out one or more of the STATE's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the STATE in the performance of such obligation(s).

- Not use or disclose PHI in a manner that would violate Subpart E of 45 C.F.R. Part 164 if the use or disclosure were performed by the STATE.
- Under Minnesota Statutes, Ch. 13, all of the data created, collected, received, stored, used, maintained, or disseminated by the MCO in performing the STATE's functions is subject to the requirements of this chapter and the MCO must comply with those requirements as if it were a government entity.

13.7.1 Audit.

The MCO shall 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 the purposes of determining compliance with the Privacy Rule and Security Standards, subject to attorney-client and other applicable legal privileges.

13.7.2 Compliance.

The MCO shall comply with any and all other applicable provisions of the HIPAA Privacy Rule and Security Standards, including future amendments thereto.

13.8 STATE DUTIES.

The STATE shall:

- Only release information that it is authorized by law or regulation to share with MCO.
- Obtain any required consents, authorizations or other permissions that may be necessary for it to share information with MCO.
- 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.
- Not request MCO to use or disclose Protected Information in any manner that would not be permitted under law if done by STATE.

13.9 DISPOSITION OF DATA UPON COMPLETION, EXPIRATION, OR CONTRACT TERMINATION.

If feasible and upon completion, expiration, or termination of this Contract, MCO will return or destroy all Protected Information that the MCO still maintains received from the STATE or created or received by the MCO for purposes associated with this Contract. MCO will retain no copies of such Protected Information, provided that if both Parties agree such return or destruction is not feasible, or if MCO is permitted or required by the applicable regulation, rule or statutory retention schedule to retain beyond the life of this Contract, MCO will extend the protections of this Contract to the Protected Information and refrain from further use or disclosure of such information, except for those purposes that make return or destruction infeasible, for as long as MCO maintains the information.

13.10 SANCTIONS.

In addition to acknowledging and accepting the terms set forth in this Contract relating to liability, the parties acknowledge that violation of the laws and protections described above could result in limitations being placed on future access to Protected Information, in investigation and imposition of sanctions by the U.S. Department of Health and Human Services, Office for Civil Rights, the Internal Revenue Service (IRS); CMS; the Office of the Minnesota Attorney General and/or in civil and criminal penalties.

13.11 EFFECT OF STATUTORY AMENDMENTS OR RULE CHANGES.

The Parties agree to take such action as is necessary to amend this Contract from time to time as is necessary for compliance with the requirements of the laws listed in section 2.155 or in any other applicable law. However, any requirement in this Contract or in the DHS Information Security Policy that is based upon HIPAA Rules or upon other federal or state information privacy or security laws

means the requirement as it is currently in effect, including any applicable amendment(s) to the law, regardless of whether the Contract has been amended to reflect such amendments(s).

13.12 INTERPRETATION.

Any ambiguity in this Contract shall be interpreted to permit compliance with the laws listed in section 2.155 or in any other applicable law.

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13.13 PROCEDURES AND CONTROLS.

The MCO agrees to establish and maintain procedures and controls so that no information contained in its records or obtained from the STATE or CMS or from others in carrying out the terms of this Contract shall be used by or disclosed by it, its agents, officers, or workforce members except as provided in Minnesota Statutes, Chapter 13 and in §1106 of the SSA and implementing regulations.

13.14 REQUESTS FOR ENROLLEE DATA.

Federal law at 42 CFR §431.301 (pursuant to 1902(a)(7) of Title XIX and 42 USC §1396a(7)) requires the STATE to ensure that disclosures of data concerning Enrollees and Potential Enrollees be limited to purposes directly connected with the administration of the State Plan, as defined in 42 CFR §431.302. The STATE has not delegated to the MCO the authority to determine whether such disclosures of data (for purposes not directly connected with the administration of the State Plan) are appropriate for any population covered under this Contract. The MCO must obtain prior approval from the STATE for such disclosures.

13.14.1 Disclosure of Enrollee Data; Exceptions.

The MCO may disclose Enrollee data to other parties for studies or research that receive Institutional Review Board approval, or when using aggregated data for studies or for program evaluations, without prior approval by the STATE. Clinical trials are not included in this exception. Any report or presentation associated with studies, research or evaluations by the MCO or produced under this section must be sent to the STATE prior to release of the report or presentation.

13.14.2 Data Sharing for C&TC.

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.

13.14.3 State-Certified Health Information Exchange Service Providers.

The STATE authorizes the MCO to enter into data sharing or subscriber agreements with any Health Information Exchange service providers certified by the Minnesota Department of Health.

13.15 AUTHORIZED REPRESENTATIVES.

The 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).

13.16 INDEMNIFICATION.

Notwithstanding section 16.6, and except as required below for MCOs that are government entities, the MCO agrees to indemnify and save and hold the STATE, its agents and employees harmless from

all claims arising out of, resulting from, or in any manner attributable to any violation by the MCO of any provision of the laws listed in section 2.155 in connection with the performance of the MCO's duties and obligations under this Contract. This includes, but is not limited to, legal fees and disbursements paid or incurred to enforce the provisions of this Contract.

For MCOs that are government entities, each party shall be responsible for claims, losses, damages and expenses which are proximately caused by the wrongful or negligent acts or omissions of that party or its agents, employees or representatives acting within the scope of their duties from all claims arising out of, resulting from, or in any manner attributable to any violation by that party of any provision of the laws listed in section 2.106 in connection with the performance of its duties and obligations under this Contract. This includes, but is not limited to, legal fees and disbursements paid or incurred to enforce the provisions of this Contract. The liability of the STATE is provided for under the Tort Claims Act, Minnesota Statutes, § 3.736 and subject to the limitations therein. The liability of the MCO is provided for under the Municipal Tort Claims Act, Minnesota Statutes, §§ 466.01 to 466.15 and subject to the limitations therein. Nothing herein shall be construed to limit either party from asserting against third parties any defenses or immunities (including common law, statutory and constitutional) it may have or be construed to create a basis for a claim or suit when none would otherwise exist. This provision shall survive the termination of this Agreement.

ARTICLE. 14 ADVANCE DIRECTIVES COMPLIANCE.

Pursuant to 42 USC §1396a(a)(57) and (58), 42 CFR §§489.100 through 489.104, and 42 CFR §438.3(j) (referring to 42 CFR §422.128), the MCO agrees

14.1 ENROLLEE INFORMATION.

To provide all Enrollees at the time of enrollment a written description of applicable State law on Advance Directives and the following:

- 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, health care directive or other Advance Directive;
- Written policies of the MCO respecting the implementation of the right;
- 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
- Information that complaints concerning noncompliance with the Advance Directive requirements may be filed with the State survey and certification agency (Minnesota Department of Health). [42 CFR §422.128, as required in 42 CFR §438.(3)(j)]

14.2 PROVIDERS DOCUMENTATION.

To require MCO's Primary Care Providers; hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care (and for Medicaid purposes, providers of personal care services), and hospices to ensure that it has been documented in the Enrollee's medical records whether or not an Enrollee has executed an Advance Directive;

14.3 TREATMENT.

To not condition treatment or otherwise discriminate on the basis of whether an Enrollee has executed an Advance Directive;

14.4 Compliance with State Law.

To comply with State law, whether statutory or recognized by the courts of the State, on Advance Directives or health care directives, including Minnesota Statutes, Chapters 145B and 145C.

14.5 Education.

To provide, individually or with others, education for MCO staff, Providers and the community on Advance Directives.

ARTICLE. 15 EMERGENCY PERFORMANCE INTERRUPTION (EPI).

15.1 Business Continuity Plan.

The MCO shall have in place a written Business Continuity Plan (BCP) to be enacted in the event of an EPI. The BCP must:

15.1.1 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 notify the STATE immediately whenever there is a change in the MCO's EPRC and must include the contact information of its new appointed EPRC.

15.1.2 Outline Activation Procedures. Outline the procedures used for the activation of the BCP upon the occurrence of an EPI.

15.1.3 Ensure Priority Services. Ensure that MCO operations continue to produce and deliver Priority Services under this Contract. This includes, but is not limited to:

(1) Outlining the roles, command structure, decision making processes and emergency action procedures that will be implemented upon the occurrence of an EPI;

(2) Providing alternative operating plans for Priority Services;

(3) Providing procedures to assist the STATE to transition Enrollees to the FFS Medical Assistance program if the STATE determines such movement is necessary to properly provide service to the Enrollees; and

(4) Providing procedures to allow Enrollees to go to another clinic if their primary care clinic is not functioning.

15.1.4 Include Reversal Process. Include procedures to reverse the process once the external environment permits the MCO to re-enter normal operations.

15.1.5 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.

15.1.6 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.

15.2 EPI Occurrence.

If an EPI occurs, the MCO must:

15.2.1 Implement its BCP within two (2) days of such EPI. In the event that the MCO's BCP cannot or is not implemented in this timeframe, the STATE shall have one or more of the following courses of action and remedies:

(1) Require joint management of contract operations between MCO and STATE staff.

(2) Move some or all of the MCO's Enrollees to another MCO.

(3) Bring some or all of the MCO's contractual duties in-house within the STATE.

(4) Immediately terminate the Contract for the MCO's failure to provide the BCP services.

(5) Postpone Negotiations. If requested by the STATE immediately postpone any active or soon to be active negotiations with the STATE for the following year's contract until such time as normal operations can be resumed. If, as a result of the EPI, a contract is not executed for the following year prior to December 15th of the Contract Year, the current contract will be renewed in accordance with Article 5.

15.2.2 Provide Notice to the State. Use best efforts to provide notification to the STATE of any significant closures within the MCO or its network.

15.2.3 Affected Enrollee Access. Allow Enrollees whose Primary Care Provider(s) is significantly affected by the EPI to access other Primary Care Providers or, if found necessary by the STATE, be moved to the FFS Medical Assistance program.

15.2.4 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 contract services, the MCO must provide the STATE prompt written notices of such belief and request the STATE excuse it from those services. The notice and request must include specific details as to: 1) what services the MCO is requesting to be excused; and 2) what circumstances prevent the MCO from providing the services.

15.2.5 Burden for Excuse. If the MCO asserts that it can no longer provide any or all contract services as a result of the EPI, the MCO shall have the burden of proving that:

(1) Reasonable steps were taken (under the circumstances) to minimize delay or damages caused by foreseeable events;

(2) That all non-excused obligations will be substantially fulfilled; and

(3) That the STATE was timely notified of the likelihood or actual occurrence which would justify such an assertion, so that other prudent precautions could be contemplated. Failure by the MCO to prove any of these points may result in penalties for contract breach in accordance with Article 5.

15.2.6 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.

15.2.7 Return to Normal Operations. The MCO may suspend the performance of excused services under this Contract until any disruption resulting from the EPI has been resolved. However, the MCO shall make every effort to eliminate any obstacles resulting from the EPI so as to minimize to the greatest extent possible its adverse effects. Once the disruptions from the EPI are resolved to the point that the MCO can reasonably resume normal performance on one or more of the excused services, the MCO shall reverse the BCP process, resume normal operations for those services, and provide notice to the STATE of the same.

ARTICLE. 16 MISCELLANEOUS.

16.1 MODIFICATIONS.

Any material alteration, modification or variation in the terms of this Contract shall be reduced to writing as an amendment hereto and signed by the parties. The STATE reserves the right to issue unilateral amendments to this Contract to correct non-material errors, including scribe errors.

- The STATE may extend the due date of any report or deliverable by giving notice to the MCO.
- The STATE may unilaterally amend the rates pages attached as Appendix 2 to correct non-material errors, and to comply with the risk adjustment process described in section 4.5.
- In the event that that the STATE determines that an error should be corrected, the STATE shall provide a clear and complete written description of any such amendment prior to implementation. If requested by the MCO, the STATE shall meet with the MCO to discuss any dispute regarding the appropriateness of the amendment, other than the risk adjustment process described in section 4.5.
- This section is not intended to, and shall not be construed to, create or materially modify any of the obligations of the parties.

16.2 ENTIRE AGREEMENT.

The parties understand and agree that the entire agreement of the parties is contained herein and that this Contract supersedes all oral agreements and negotiations between the parties relating to this subject matter. All appendices, guidance, reference books including companion guides, technical specifications and webpages referred to in this Contract are incorporated or attached and deemed to be part of the Contract.

16.3 ORDER OF PRECEDENCE

In interpretation of this Contract and incorporated documents, the terms and conditions shall be construed whenever possible to be complementary. In the event complementary interpretation is not possible, the order of precedence shall be federal statutes and regulations, state laws and rules, general terms and conditions of this contract, other terms and conditions of this contract, and then any other material incorporated by reference. A provision of this Contract that is stricter than such laws, regulations or documents shall not be interpreted as a conflict.

16.4 FORMAT

Section headings throughout this Contract are for convenience and do not extend nor reduce the rights and obligations described in the following text.

16.5 ASSIGNMENT.

The MCO shall neither assign nor transfer any rights or obligations under this Contract without the prior written consent of the STATE.

16.6 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.

16.7 COMPLIANCE

The STATE makes no warranty or representation that compliance with any or all of this Contract by the MCO or its Subcontractors will be adequate for the MCO's own legal or compliance purposes.

The MCO is solely responsible for all decisions it and its Subcontractors make regarding compliance to laws affecting this Contract, including those relating to data protection.

16.8 WAIVER.

If a party fails to enforce any provision of this Contract, that failure does not waive the provision or that party's right to enforce the provision.

16.9 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.

16.10 EXECUTION IN COUNTERPARTS.

Each party agrees that this Contract may be executed in two or more counterparts, all of which shall be considered one and the same agreement, and which shall become effective if and when both counterparts have been signed and dated by each of the parties. It is understood that both parties need not sign the same counterpart.

ARTICLE. 17 GOVERNING LAW, JURISDICTION AND VENUE.

This Contract, and amendments and supplements thereto, will be governed by the laws of the State of Minnesota. Venue for all legal proceedings arising out of this Contract, or breach thereof, will be in the state or federal court with competent jurisdiction in Ramsey County, Minnesota.

ARTICLE. 18 SURVIVAL.

Notwithstanding the termination of this Contract for any reason, section 3.16 (Encounter Data), Article 4's sections regarding payments including withholds, section 4.9.7 above (CMS Approval), section 4.18 (Integrated Health Partnership Demonstration), sections 5.3 through 5.5 (Deficiencies and sanctions), section 7.2 (PIPs), section 7.12 (Financial Performance Incentives), sections of Article 8 sufficient to afford Enrollees' rights under state or federal law, section 9.5 (Maintenance, Retention, Inspection and Audit of Records), section 9.7 (Trade Secret Information), Article. 10 (Third Party Liability), Article. 11 (Reporting and Deliverables) and Article. 13 (Information Privacy and Security, including section 13.16 Indemnification) shall survive the termination of this Contract.

Signature page follows.

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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.

HENNEPIN COUNTY APPROVAL

The STATE, having signed this contract, and Hennepin County through its Hennepin Health, having duly approved this Contract on the **_____ day of _____, 2019,** and pursuant to such approval, the proper County officials having signed this contract, the parties hereto agree to be bound by the provisions herein set forth.

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

By:_____

Printed Name: Charles E. Johnson

Title: Deputy Commissioner

Date:_____

COUNTY OF HENNEPIN
STATE OF MINNESOTA

By:_____

Printed Name: _____

Title: CEO of Hennepin Health

Date:_____

and

By:_____

Printed Name:_____

Title: Hennepin County Administrator

Date:_____

Approved as to form and execution:
Assistant County Attorney

By:_____

Date:_____

This certifies that the signatories for the County have lawful authority, by virtue of Board Resolution, to bind the County to the term of this Agreement.

SWIFT # 0000197294

List of Appendices:

Appendix 1: Service Areas
Appendix 2: Rates

Appendix 1: Service Areas

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Appendix 2: Rates

SNBC County
Hennepin

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Table 1 Special Needs BasicCare January 2020 December 2020 Capitation Payment Rates Hennepin Health								
			Risk Adjustment Base Rate [1]	Plan Acute Risk Factor [2]	Plan RA Rate [1]	Plan RA Rate - Withhold [1]	NF Add-On	Plan Reimbursement Amount [1]
			1	2	3	4	5	6
Rate Regions			Exh 2A (A + B + D + E)		(1 x 2)	(3 x 0.92)	Exh 2A (C)	(4 + 5)
All Regions	Institutionalized	Dual	$643.60	1.0271	$661.04	$608.16	N/A	$608.16
		Non- Dual	4,709.38	1.0265	4,834.26	4,447.52	N/A	4,447.52
Metro	Non-Institutionalized	Dual	563.47	1.0692	602.45	554.25	$14.25	568.50
		Non- Dual	2,099.94	1.0910	2,291.14	2,107.85	26.95	2,134.80

[1] Includes 1.0% premium tax and 0.6% HMO surcharge.

[2] Risk scores are based on enrollment as of April 2019. These are a preliminary estimate of the final risk scores. The final risk scores for January 2020 – June 2020 will be based on enrollment as of October 2019, and the final risk scores for July 2020 – December 2020 will be based on enrollment as of April 2020.

This material assumes that the reader is familiar with Minnesota Medicaid programs, their benefits, eligibility, administration and other factors. The material was prepared solely to provide assistance to the State of Minnesota in setting rates for capitated programs. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

This exhibit should be viewed in conjunction with, and is subject to the same caveats and limitations outlined in, the September 19, 2019 report.