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

CONTRACT INDEX

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

THIS CONTRACT, which shall be interpreted pursuant to the laws of the State of Minnesota, is made and entered into by the State of Minnesota, acting through its Department of Human Services (hereinafter STATE), and _____ (hereinafter HEALTH PLAN);

WHEREAS, the STATE and the HEALTH PLAN have agreed to renew the Contract numbered M-99-_____, for the period of January 1, 2000 through December 31, 2000;

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

Article 1. Overview. This Agreement applies to the health benefits the HEALTH PLAN shall provide through the Prepaid Medical Assistance, Prepaid General Assistance Medical Care and MinnesotaCare programs to eligible Enrollees. The Medical Assistance, General Assistance Medical Care and MinnesotaCare Medical Care programs are public health benefits programs intended to provide Enrollees with access to cost-effective health care options.

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

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

Section 2.1. ***Abuse*** means the definition as set out in Minnesota Rules, Part 9505.2165, Subpart 2. Abuse shall also include substantial failure to provide Medically Necessary items and services that are required to be provided to an Enrollee under this Contract if the failure has adversely affected or has a substantial likelihood of adversely affecting the health of the Enrollee.

Section 2.2. ***Adult*** means an individual 21 years of age or older.

Section 2.3. ***Aged*** means a category of PMAP Enrollees used as a factor to determine the Rate Cell status of an individual Enrollee. The Aged category includes those PMAP Enrollees who are age 65 and older.

Section 2.4. ***Allowed*** refers to a claim from a provider that the HEALTH PLAN approved or authorized.

Section 2.5. ***Appeal*** means an Enrollee's written request for a hearing, filed with the STATE according to Minnesota Statutes, Section 256.045, related to the delivery of health services or

participation in the HEALTH PLAN, denial (full or partial) of a claim or service, or failure to make an initial determination in 30 days.

Section 2.6. ***Automatic Newborn*** means the basis of eligibility for MA, as defined in 42 C.F.R. 435 and implemented under State law, that is used to determine the Rate Cell of an Enrollee.

Section 2.7. ***Care Management*** means a method of providing health care in which the HEALTH PLAN coordinates the provision of health services to an Enrollee, including but not limited to: needs assessment, Prior Approval, care communication, and care coordination with social service and Local Agency Pre-Admission Screening/Elderly Waiver, mental health, developmental disability, and chemical dependency care managers, and pre-petition screeners.

Section 2.8. ***Child*** means, for MinnesotaCare, an individual under 21 years of age, including the unborn Child of a Pregnant Woman, an emancipated minor, and the emancipated minor's spouse (if under 21) pursuant to Minnesota Statutes, Section 256L.01, Subdivision 1(a). ***Child*** means, for MA and GAMC, an individual under 21 years of age pursuant to Minnesota Statutes, Section 256B.055.

Section 2.9. ***Common Carrier Transportation*** means the transport of an Enrollee by a bus, taxicab, or other commercial carrier or by private automobile.

Section 2.10. ***Complaint*** means any written or oral communication by an Enrollee or by a provider on behalf of an Enrollee, with the Enrollee's written consent, to the HEALTH PLAN expressing dissatisfaction with the provision of health services. The subject of the Complaint may include, but is not limited to, the scope of covered services, quality of care, or administrative operations. A written grievance is the same as a Complaint. An inquiry by an Enrollee is not a Complaint.

Section 2.11. ***Community Health Services Agency*** means a "local health agency" or a public or private nonprofit organization which enters into a contract with the Commissioner of Health pursuant to Minnesota Statutes, Sections 145.891 to 145.897.

Section 2.12. ***Cost Avoidance Procedure*** means the process by which a provider obtains payment from the identified third party resource before billing the HEALTH PLAN.

Section 2.13. ***Cut-Off Date*** means the last day on which enrollment information may be entered in MMIS in order to be effective the first day of the following month.

Section 2.14. ***EPSDT (or C&TC)*** means the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) Program required under 42 C.F.R. 441.50, known in Minnesota as the Child and Teen Checkup (C&TC) Program, that provides comprehensive health services for MA-eligible Children under age 21.

Section 2.15. ***Education Begin Date*** means the date on which the HEALTH PLAN will be presented by the Local Agency as an initial enrollment option to PMAP and PGAMC Recipients.

Section 2.16. ***Elderly Waiver*** means the federal Medicaid Home and Community Based Services waiver program required under Minnesota Statutes, Sections 256B.0911 and 256B.0915, and Minnesota Rules, Parts 9505.2390 to 9505.2500.

Section 2.17. ***Enrollee*** means a MA, GAMC, or MinnesotaCare eligible person whose enrollment in the HEALTH PLAN has been entered on MMIS.

Section 2.18. ***Family Planning Service*** means a family planning supply (related prescribed drug or contraceptive device) or health service, including screening, testing, and counseling for sexually transmitted diseases, such as HIV, when provided in conjunction with the voluntary planning of the conception and bearing of Children and related to an Enrollee's condition of fertility.

Section 2.19. ***Fraud*** means the definition set out in Minnesota Rules, Part 9505.2165, Subpart 4.

Section 2.20. ***General Assistance Medical Care or GAMC*** means the state medical program authorized under Minnesota Statutes, Chapter 256D.03.

Section 2.21. ***HCFA*** means the Health Care Financing Administration of the U.S. Department of Health and Human Services.

Section 2.22. ***Home Care Services*** includes nursing services, private duty nursing services, home health aide services, personal care services, nursing supervision of personal care services, physical therapy, occupational therapy, speech therapy, respiratory therapy, durable medical equipment, and supplies.

Section 2.23. ***Inpatient Hospitalization*** includes inpatient medical, mental health and chemical dependency services.

Section 2.24. ***Institutionalized*** means a category of Enrollees used as a factor to determine the Rate Cell of an individual who resides in a Nursing Facility or intermediate care facility for the mentally retarded (ICF/MR).

Section 2.25. ***Local Agency*** means a county or multi-county agency that is authorized under Minnesota Statutes, Sections 393.01, Subdivision 7 and 393.07, Subdivision 2, as the agency responsible for determining Recipient eligibility for the MA and GAMC programs.

Section 2.26. ***Material Modification of Provider Network*** means (1) a change which would result in an Enrollee having only three remaining choices of a Primary Care Provider within 30 miles or 30 minutes; or (2) a change which results in the discontinuation of a Primary Care

Provider who is responsible for the primary care physician services for 1/3 or more of the Enrollees in the applicable area (the same area from which the affected Enrollee chose their Primary Care Provider or sole source provider, prior to the Material Modification); or (3) a change that involves a termination of a sole source service provider where the termination is for cause. For purposes of this Section, termination of a provider for cause does not include the inability to reach agreement on contract terms.

Section 2.27. ***Medical Assistance, or MA*** means the federal/state Medicaid program authorized under Title XIX of the federal Social Security Act and Minnesota Statutes, Chapter 256B.

Section 2.28. ***MA Drug Formulary*** means prescription or over-the-counter drugs covered under the MA program as determined by the Commissioner of Human Services pursuant to Minnesota Statutes, Section 256B.0625.

Section 2.29. ***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: placing the physical or mental health of the individual (or, with respect to a Pregnant Woman, the health of the woman or her unborn Child) in serious jeopardy; continuation of severe pain; serious impairment to bodily functions; serious dysfunction of any bodily organ or part; or death. Labor and delivery is a Medical Emergency if it meets this definition.

Section 2.30. ***Medical Emergency Services*** means inpatient and outpatient services covered under this Contract that are furnished by a provider qualified to furnish emergency services and are needed to evaluate or stabilize an Enrollee's Medical Emergency.

Section 2.31. ***Medical Support*** means cash contributions by a Child's Parent for all or a portion of the Child's ongoing medical expenses in accordance with a court order or judgment, pursuant to Minnesota Statutes, Section 518.171.

Section 2.32. ***Medically Necessary or Medical Necessity*** means, pursuant to Minnesota Rules, Part 9505.0175, Subpart 25, a health service that is consistent with the Enrollee's diagnosis or condition and:

A. is recognized as the prevailing standard or current practice by the provider's peer group; and

B. is rendered in response to a life threatening condition or pain; or to treat an injury, illness or infection; or to treat a condition that could result in physical or mental disability; or to care for the mother through the maternity period; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition; or

C. is a preventive health service defined under Minnesota Rules, Part 9505.0355.

Section 2.33. ***Medically Needy*** means a category of PMAP Enrollees used as a factor to determine the Rate Cell of an individual Enrollee. The Medically Needy category includes those Enrollees who are under age 21, who would not be eligible for Statewide MFIP even if their income or assets were below the Statewide MFIP program standards.

Section 2.34. ***Metro Area*** means the following seven Minnesota counties: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington.

Section 2.35. ***MinnesotaCare*** means the program authorized in Minnesota Statutes, Chapter 256L, to promote access to appropriate covered health services to assure healthy Children and Adults.

Section 2.36. ***MinnesotaCare Enrollee*** means a non-pregnant Adult who meets MinnesotaCare eligibility requirements, has paid the required Premium (active) and is eligible to receive the MinnesotaCare health care service described in Section 6.3.2. of this Contract.

Section 2.37. ***MinnesotaCare/MA Enrollee*** means a Child or Pregnant Woman who meets MinnesotaCare/MA eligibility requirements, has paid the required Premium (active) and is eligible to receive the MinnesotaCare/MA health care services described in Section 6.3.1. of this Contract.

Section 2.38. ***MMIS*** means the Medicaid Management Information System.

Section 2.39. ***Nursing Facility (NF)*** means a long term care facility certified by the Minnesota Department of Health for services provided and reimbursed under Medicaid. For purposes of this Contract, except for Sections 4.6 and 9.2.21, NF also means an intermediate care facility for the mentally retarded (ICF/MR).

Section 2.40. ***Non-Institutionalized*** means a category of Enrollees used as a factor to determine the Rate Cell of an individual not permanently residing in a NF or ICF/MR.

Section 2.41. ***Out of Area*** refers to health care provided to an Enrollee by non-Participating Providers outside of the geographical area served by the HEALTH PLAN.

Section 2.42. ***Out of Plan*** refers to health care provided to an Enrollee by non-Participating Providers within the geographic area served by the HEALTH PLAN.

Section 2.43. ***Parent*** means, for MinnesotaCare, the legal guardian or birth, step, or adoptive mother or father of a Child.

Section 2.44. ***Participating Provider*** means a provider who is employed by or under contract with the HEALTH PLAN to provide health services to Enrollees.

Section 2.45. ***Person Master Index (PMI)*** means the STATE identification number assigned to an individual Recipient.

Section 2.46. ***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 HEALTH PLAN, as defined in 42 C.F.R. 417.479(c).

Section 2.47. ***Post-Payment Recovery Process*** means systematic and determined efforts by the HEALTH PLAN to collect all third party liability monies related to health service claims paid by the HEALTH PLAN to which the HEALTH PLAN is legitimately entitled resulting in financial recoveries.

Section 2.48. ***Post-Stabilization Care Services*** means Medically Necessary, non-emergency services needed to ensure that the Enrollee remains stabilized from the time that the treating hospital requests Prior Authorization from the HEALTH PLAN until: (i) the Enrollee is discharged; (ii) a HEALTH PLAN physician arrives and assumes responsibility for the Enrollee's case; or (iii) the treating physician and HEALTH PLAN agree to another arrangement.

Section 2.49. ***Premium Payment*** means, for MinnesotaCare, the payment made by a MinnesotaCare applicant or Enrollee and received by the STATE as required under Minnesota Statutes, Section 256L.06 and Minnesota Rules, Part 9506.0040.

Section 2.50. ***Pregnant Woman*** means a basis of eligibility for MA, as defined in 42 C.F.R. 435 and implemented under State law, that is used as a factor to determine the Rate Cell of an Enrollee.

Section 2.51. ***Prepaid General Assistance Medical Care Program, or PGAMC*** means the program authorized under Minnesota Statutes, Section 256D.03.

Section 2.52. ***Prepaid Medical Assistance Program, or PMAP*** means the program authorized under Minnesota Statutes, Section 256B.69 and Minnesota Rules, Parts 9500.1450 to 9500.1464.

Section 2.53. ***Primary Care Provider*** means a provider or licensed practitioner, pursuant to Minnesota Rules, Part 4685.0100, Subpart 12 a, or a nurse practitioner or physician assistant, pursuant to Minnesota Rules, Part 4685.0100, Subpart 12b, under contract with or employed by the HEALTH PLAN.

Section 2.54. ***Prior Approval or Prior Authorization*** means the process of approving Medical Necessity for a medical service previous to the delivery or payment of the service.

Section 2.55. ***Provider Manual*** means the official STATE publication, entitled "Minnesota Health Care Programs Provider Manual" dated March 1998 that is issued to enrolled providers

by the STATE to clarify policy, procedures, or definitions of covered services under the MA, GAMC and MinnesotaCare programs.

Section 2.56. ***Rate Cell*** means the category attributed to an Enrollee to determine the monthly prepaid capitation rate by the STATE to the HEALTH PLAN for health care coverage of that Enrollee. A Rate Cell is assigned based on Rate Cell determinants which may consist of all or a part of the following, consistent with MMIS requirements: age, sex, county of service, major program, eligibility type, living arrangement, Medicare status, and product ID.

Section 2.57. ***Recipient*** means a person who has been determined by the Local Agency to be eligible for the Medical Assistance or General Assistance Medical Care Program or by the STATE to be eligible and active for the MinnesotaCare Program.

Section 2.58. ***Service Area*** means the Counties of Minnesota in which the HEALTH PLAN agrees to offer health coverage under this Contract. See Appendix D: Service Area.

Section 2.59. ***Spenddown*** means the process by which a person who has income in excess of the MA or GAMC income standard, allowed in Minnesota Statutes, Section 256D.03, Subdivision 3, and Section 256B.056, Subdivision 5, becomes eligible for MA or GAMC by incurring medical expenses that are not covered by a liable third party, and that reduce the excess income to zero.

Section 2.60. ***STATE*** means the Minnesota Department of Human Services or its agents and the Commissioner of Human Services.

Section 2.61. ***Statewide MFIP*** (Minnesota Family Investment Program) means a category of PMAP Enrollees used as a factor to determine the Rate Cell of an individual Enrollee, pursuant to Minnesota Statutes, Chapter 256J.

Section 2.62. ***Swing Bed Days*** means 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.

Section 2.63. ***Telemedicine Consultations*** means physician services made via two-way interactive video or store-and-forward technology. The Enrollee record must include a written opinion from the consulting physician providing the Telemedicine Consultation. A communication between two physicians that consists solely of a telephone conversation is not a Telemedicine Consultation.

Section 2.64. ***Urgent Care*** means acute, episodic medical services available on a 24-hour basis that are required in order to prevent a serious deterioration of the health of an Enrollee.

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

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

Section 3.1.1. ***Eligibility.***

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

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

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

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

2.) Children under the age of 21 years receiving MA who are in foster care placement, unless they enroll in PMAP on a voluntary basis.

3.) MA Recipients receiving MA through an adoption subsidy.

4.) MA and GAMC Recipients receiving the Refugee Assistance Program pursuant to 8 U.S.C. 1522(e).

5.) MA and GAMC Recipients who are residents of state institutions, unless the placement has been approved by the HEALTH PLAN.

6.) MA and GAMC Recipients with private health care coverage through a HMO licensed under Minnesota Statutes, Chapter 62D. Such Recipients may enroll in PMAP and PGAMC on a voluntary basis if the private HMO is the same as the health plan the person will select under PMAP or PGAMC. (Also see D(4) in this section).

7.) MA and GAMC Recipients who are terminally ill as defined in Minnesota Rules, Part 9505.0297, Subpart 2(N) and who, at the time enrollment in PMAP would occur, have an established relationship with a primary physician who is not part of a PMAP health plan.

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

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

10.) Non-documented alien Recipients who only receive emergency MA under Minnesota Statutes, Section 256B.06, Subdivision 4 or emergency GAMC under Minnesota Statutes, Section 256D.03, Subdivision (3).

11.) Recipients receiving MA or GAMC on a non-institutional Spenddown basis.

12.) Recipients, who at the time of notification of mandatory enrollment in PMAP or PGAMC have a communicable disease whose prognosis is terminal and whose primary physician is not a Participating Provider in the HEALTH PLAN, 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.

13.) Children who prior to enrollment in PMAP are determined to be in need of protection and are receiving MA services through a provider who is not a Participating Provider in PMAP. These Children are eligible to enroll in PMAP on a voluntary basis.

14.) American Indians who are receiving MA or GAMC and who are living on the Indian reservation, if the tribal government of that reservation chooses to exclude these persons. After receiving federal approval, the STATE in consultation with tribal governments will enroll these Recipients in PMAP or PGAMC. However, American Indian MA and GAMC Recipients, living on or off a reservation, will have direct out-of-network access to Indian Health Service facilities and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, Sections 450f to 450n, or title III of the Indian Self-Determination Act, Public Law Number 93-638, for services that would otherwise be covered under Minnesota Statutes, Section 256B.0625. "American Indian" under this paragraph describes those persons for whom services may be provided pursuant to 42 C.F.R. Section 36.12. The STATE will begin enrollment 120 days after notification to the HEALTH PLAN that HCFA has provided federal approval.

15.) Children who prior to enrollment in a health plan are identified to be severely emotionally disturbed (SED), pursuant to Minnesota Statutes, Section 245.487 , are receiving mental health case management services, and are under the primary care of a mental health professional as defined in

Minnesota Statutes, Section 245.4871, Subdivision 27, who is not a Participating Provider in PMAP. These Children are eligible to enroll in PMAP on a voluntary basis.

16.) Special Income Standards (SIS) Elderly Waiver Recipients with a waiver obligation. These individuals are eligible to enroll in PMAP on a voluntary basis.

D. The following MA and/or GAMC populations are excluded on the effective date of this Contract, but may become eligible for mandatory enrollment (or voluntary enrollment for the population described in paragraph 5) during the term of this Contract. Upon receipt of notice from HCFA approving enrollment of these populations, the STATE will provide the HEALTH PLAN 60 days notice prior to beginning enrollment.

1.) Children receiving MA who are in foster care placement.

2.) Children receiving MA through an adoption subsidy.

3.) Children who prior to enrollment in PMAP are determined to be in need of protection and are receiving MA services through a provider who is not a Participating Provider in PMAP.

4.) MA and GAMC Recipients who have private health care coverage through an HMO licensed under Minnesota Statutes, Chapter 62D.

5.) Non-institutionalized Recipients who are eligible for MA and GAMC on a monthly Spenddown basis may voluntarily enroll in PMAP or PGAMC.

E. The following MA and GAMC populations are not excluded on the effective date of this Contract, but may become excluded during the term of this Contract. Upon receipt of notice from HCFA that these exclusions are approved, the STATE will provide the HEALTH PLAN 60 days notice prior to implementation of these exclusions.

1.) Adults who are identified by the STATE to be seriously and persistently mentally ill (SPMI). These Recipients remain eligible to enroll in PMAP or PGAMC on a voluntary basis throughout the term of this Contract, even if the STATE implements the exclusion.

2.) Children who are identified to be severely emotionally disturbed (SED) pursuant to Minnesota Statutes, Section 245.487 These Recipients remain eligible to enroll in PMAP or PGAMC on a voluntary basis throughout the term of this Contract, even if the STATE implements the exclusion.

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

Section 3.1.2. ***Enrollment.***

A. ***Nondiscrimination.*** The HEALTH PLAN will accept all eligible Recipients who select or are assigned to the HEALTH PLAN without regard to physical or mental condition, age, sex, national origin, health status, race or religion.

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

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

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

E. ***Enrollee Change of Health Plan.*** Enrollees may change to a different health plan during the open enrollment period, and as required under Minnesota Rules, Part 9500.1453, Subparts 5 and 7. Also see Section 3.4.1.(C) and (G).

F. ***Open Enrollment.*** The HEALTH PLAN shall enroll any eligible Recipients during any open enrollment period required by the STATE.

G. ***Notice to Student Enrollees.*** HEALTH PLANS meeting the definition of a closed panel health plan, as defined in Minnesota Statutes, Section 62Q.43, Subdivision 1, shall at least annually notify full-time student Enrollees under the age of 25 of their right to change their designated clinics or physicians at least once per month, providing that the HEALTH PLAN may require from the student at least 15 days notice of intent to change his/her designated clinic or physician, and as long as the clinic or physician is part of the HEALTH PLAN'S statewide clinic or physician network.

H. ***Effective Date of Coverage***. HEALTH PLAN coverage of Enrollees shall commence at the following times:

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

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

3.) HEALTH PLAN coverage of Recipients who are hospitalized in an acute care facility at the time coverage otherwise would become effective under 1) and 2) above of this Section shall commence:

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

b) for MA, GAMC and MinnesotaCare or MinnesotaCare/MA Enrollees not included in 3(a), on the first day of the month following the month of discharge from the hospital, except for eligible newborns who may be enrolled in the plan effective the first day of the month of birth, even if hospitalized.

I. ***Capability to Receive Electronically.*** The HEALTH PLAN shall have the capability to receive enrollment data electronically via a medium prescribed by the STATE. If there is a disruption of the STATE's electronic capabilities, the HEALTH PLAN has the time period specified in Section 3.2.3.A. to disseminate enrollment information to its Enrollees.

The HEALTH PLAN shall provide valid enrollment data to providers for Enrollee coverage verification by the first day of the month and within two working days of receipt at the time of reinstatement, pursuant to Section 3.4.3. This shall include pharmacy verifications. The HEALTH PLAN may require its providers to use the STATE's Electronic Verification System (EVS) to meet this requirement.

Section 3.2. ***Health Plan and Enrollee Communication.***

Section 3.2.1. ***Direct Marketing.*** Except through mailings as set forth below, the HEALTH PLAN, which includes any of its subcontractors, agents, independent contractors, employees and providers, is restricted from direct marketing and promotion to Recipients who are not enrolled in the HEALTH PLAN, including, but not limited to: telephone marketing, face-to-face marketing, promotion, cold-calling, or direct mail marketing. Such mailings shall not contain false or materially misleading information.

A. ***Mailings to Recipients.*** The HEALTH PLAN may make no more than two mailings per contract term to all MA, GAMC, and MinnesotaCare Recipients who are Enrollees of a health plan under contract with the STATE or are eligible to become Enrollees of a health plan under contract with the STATE, who reside in the Service Area, at HEALTH PLAN expense, using a mailing list provided by the STATE supplied in a format as determined by the STATE. All mailings must be sent to all Recipients within a specified region (such region shall be approved by the STATE) who are in the same program who are Enrollees of a health plan or are eligible to become Enrollees of a health plan in the Service Area receiving the mailing.

B. ***Prior Approval of Materials.*** The HEALTH PLAN shall present to the STATE for approval information and materials on all marketing activities targeting Recipients that the HEALTH PLAN, or its subcontractors, plan to undertake during the contract period, prior to the HEALTH PLAN's use of such information and materials. If the marketing materials target American Indian Recipients, the STATE shall consult with tribal governments within a reasonable period of time before approval. Such approval by the STATE shall not be unreasonably withheld.

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

Section 3.2.2. ***Indirect Marketing.*** The HEALTH PLAN, acting indirectly through the publications and other material distributed by the Local Agency or the STATE, or through mass media advertising (including the Internet), may inform MA, GAMC and MinnesotaCare Recipients who reside in the Service Area of the availability of medical coverage through the HEALTH PLAN, the location and hours of service and other plan characteristics, subject to Section 3.2.2.A. The HEALTH PLAN may also distribute brochures and display posters at physician offices and clinics, informing patients that the clinic or physician is part of the HEALTH PLAN's provider network.

A. ***Prior Approval by STATE.*** All posters, brochures and provider network-related materials must be prior approved by the STATE. If such materials target American Indian Recipients, the STATE shall consult with relevant tribal governments before approval. The STATE shall respond in writing to the HEALTH PLAN within 30 calendar days from the date the HEALTH PLAN submits such materials for approval. If the STATE does not respond within 30 calendar days, the materials shall be considered to be approved by the STATE.

Section 3.2.3. ***Enrollment Materials.***

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

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

a) a description of the HEALTH PLAN's medical and remedial care program, including specific information on benefits, limitations, and exclusions, and a description of how Enrollee Complaints are resolved, including the telephone number of the department or person handling Complaints;

b) notification of the free choice of Family Planning Services;

c) information about providing coverage for prescriptions that are dispensed as written (DAW);

d) a statement informing Enrollees that upon request an Enrollee can obtain a COC in Spanish, Hmong, Laotian, Russian, Somali, Vietnamese or Cambodian. Upon request, the HEALTH PLAN shall provide the Enrollee with a COC in the specified language of preference. Until such time as the translation and printing of the COC is complete, the HEALTH PLAN may use a reasonable method of complying with this section, e.g., a photocopy of the translated model, or an oral interpreter translating requested sections. If the HEALTH PLAN makes changes to the translated model COC, and the HEALTH PLAN chooses to use a vendor other than the vendor used by the STATE, the HEALTH PLAN shall pay the expenses of the STATE in verifying that the translation is correct.

e) when the STATE begins enrollment of American Indian MA and GAMC Recipients under Section 3.1.1.C.(14), a description of how American Indian Enrollees may directly access Indian Health Service and certain tribal providers and how such Enrollees shall obtain referral services. In prior approving this portion of the COC, the STATE shall consult with tribal governments.

f) a description of how Enrollees may access services to which they are entitled under Medical Assistance, or for all programs, such as abortion services, but that the HEALTH PLAN does not provide under this Contract.

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

2.) A membership card which identifies the Recipient as a HEALTH PLAN Enrollee, and that contains a HEALTH PLAN telephone number to call regarding

coverage, procedures, and Complaints. The membership card shall demonstrate that the Enrollee is a Recipient of Minnesota Health Care Programs, either by printing the Enrollee's STATE PMI number on the card, or by other reasonable means. The HEALTH PLAN shall submit a plan to the STATE by January 31, 2000, describing how the HEALTH PLAN will ensure that Enrollees and providers know the different benefit sets that exist for MinnesotaCare and how to identify which copays apply.

3.) A description of how the Enrollee may obtain services, including hours of service, appointment procedures, a list of Participating Providers, including clinics, physicians, hospitals, dentists and other HEALTH PLAN affiliated providers and their addresses and telephone numbers, Prior Approval requirements and procedures, and procedures for obtaining Medical Emergency care, Urgent Care, and Out of Plan care, including a 24-hour telephone number for Medical Emergency Services. If the HEALTH PLAN does not allow direct access to all primary care physician specialties, the HEALTH PLAN must inform Enrollees the circumstances under which a referral may be made to such providers.

4.) A toll-free telephone number that the Enrollee may call regarding HEALTH PLAN coverage or procedures.

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

6.) A description of all Complaint and Appeal rights and procedures available to Enrollees, including the HEALTH PLAN's internal grievance procedures, the availability of arbitration to Appeal an internal grievance decision (through April 1, 2000), the ability of internal and STATE appeals to run concurrently, and the availability of a second opinion within the HEALTH PLAN.

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

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

9.) A description of the Enrollee's right to request information about Physician Incentive Plans from the HEALTH PLAN, including whether the prepaid plan

uses a Physician Incentive Plan that affects the use of referral services, the type of incentive arrangement, whether stop-loss protection is provided, and a summary of survey results.

10.) A description of the Enrollee's right to request the results of an external quality review study. See Section 4705(a) of the Balanced Budget Act of 1997.

B. ***Advance Approval.*** The STATE must approve all new enrollment materials sent to Enrollees prior to their use. The HEALTH PLAN must revise its Certificate of Coverage for all substantial changes in its Complaint and Appeals procedures, and its health care delivery systems, including changes in procedures to obtain access to or approval for health care services. All revisions to the Certificate of Coverage must be approved in writing by the STATE in accordance with this Section and issued to Enrollees prior to implementation of the change. Approvals by the STATE for these materials shall not be unreasonably withheld. The STATE agrees to inform the HEALTH PLAN of its approval or denial of these documents within 30 days of receipt of these documents from the HEALTH PLAN.

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

1.) ***Primary Care Network List Specifications.*** The HEALTH PLAN must supply all Local Agencies within its Service Area, and the STATE for MinnesotaCare, with copies of a standardized document (known as a " Primary Care Network List, or PCNL") that provides information about the HEALTH PLAN's provider network and that includes a description of the essential components of the HEALTH PLAN, to be used by the Local Agencies to educate consumers. This document must be prior approved by the STATE in accordance with Section 3.2.2.A. The document must be printed on a grade of paper which is equivalent to bond paper which is not less than twenty (20) pound but not greater than 28 pound bond. If the PCNL has a cover, the grade of paper must be on uncoated offset paper not less than 50 pound, but not greater than 60 pound. The paper must be 8 ½" x 11" or 17" x 11"; and the 17" x 11" document must fold to 8½" x 11". The document must contain the following information:

a) A list of Participating Providers from which the Enrollee must make an advance selection and their addresses, including clinics, physicians, hospitals, dentists, mental health and chemical dependency providers, and any provider category from which the Enrollee must make an advance selection. The HEALTH PLAN may list other affiliated providers and their addresses, at the HEALTH PLAN'S discretion. All Primary Care Providers, and dental providers for whom the Enrollee must select a primary dental provider, must be numbered using a numeric code of up to seven digits.

b) A toll-free HEALTH PLAN telephone number that the Recipient may contact regarding HEALTH PLAN coverage or procedures.

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

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

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

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

If the MDH determines that new language needs to be included, the HEALTH PLAN will incorporate it into the next available, either monthly or quarterly, printing of the PCNL.

f) A misrepresentation of providers on the HEALTH PLAN's PCNLs may be determined by the STATE to be an intentional misrepresentation in order to induce Recipients to select the HEALTH PLAN.

2.) ***Primary Care Network List.*** When the HEALTH PLAN is new to a Service Area, the HEALTH PLAN must supply the Local Agency, and the STATE for MinnesotaCare, with a supply of the final, printed and approved Primary Care Network List 10 calendar days in advance of the Education Begin Date and on or before the first day of each calendar quarter thereafter, in quantities sufficient to meet the Local Agency or STATE need for a calendar quarter. If the HEALTH PLAN's Service Area expands for MinnesotaCare, additional Primary Care Network Lists must be supplied to the STATE 60 days prior to the effective date of the expanded Service Area. The HEALTH PLAN must update the Primary Care Network List as necessary to maintain accuracy, particularly with regard to the list of Participating Providers. The Primary Care Network List and all revisions to the Primary Care Network List must be approved in writing by the STATE before copies are provided to the Local Agency. Such approval by the STATE shall not be unreasonably withheld.

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

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

D. ***Recipient Education.***

1.) The STATE or the Local Agency will inform Recipients who reside in the Service Area of the options available in health care coverage. The STATE or Local Agency shall describe through presentations and/or written materials the various health plans available to Recipients in a particular geographic area and complete enrollment of Recipients by obtaining the signature of Recipients or their lawful representatives on the enrollment form or release of information form. For Recipients who are assigned to a HEALTH PLAN, a signature will not be obtained. Tribal governments may assist the STATE or Local Agency in presenting or developing materials describing the various health plan options for their members. If the tribal government revises any HEALTH PLAN materials, the HEALTH PLAN may review them prior to distribution. If the HEALTH PLAN deems the revisions to be substantial, the HEALTH PLAN shall have 30 days to respond to the tribal government and no HEALTH PLAN materials will be distributed until there is mutual agreement on the revisions.

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

E. The HEALTH PLAN, or its subcontractors, is not prohibited from providing information to Recipients who are enrolled in the HEALTH PLAN for the purpose of

educating Enrollees about provider choices available through the HEALTH PLAN, subject to the limitations in this Contract.

F. ***Readability Test.*** The HEALTH PLAN's marketing and education practices will conform to the provisions of Minnesota Statutes, Section 62D.22, Subdivision 8, and applicable rules and regulations promulgated by the Commissioners of Commerce and Health. All marketing materials, new Enrollee information, Complaint and Appeal information and other written information which are disseminated to Enrollees in the English language must be understandable to a person who reads at the seventh grade level, using the Flesch scale analysis readability score as determined under Minnesota Statutes, Section 72C.09. The results of the Flesch score must be submitted at the time all documents specified in this Section are submitted to the STATE for approval. All materials sent to Enrollees must be in at least a 10-point type size. All materials must comply with the Americans with Disabilities Act requirements. All membership materials must include the following statement: "If you ask, we will give you this information in another form, such as Braille, large print, or on audio tape."

Section 3.2.4. ***Significant Events.*** HEALTH PLAN must notify STATE as soon as possible of significant events affecting the level of service either by HEALTH PLAN or its providers or subcontractors. Such events include:

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

1.) ***Notice to STATE***. The HEALTH PLAN must notify the STATE of a possible Material Modification in its Provider Network within 10 working days from the date the HEALTH PLAN has been notified that a Material Modification is likely to occur. A Material Modification shall be reported to the STATE no less than 120 days prior to the effective date. A HEALTH PLAN may terminate a sub-contract without 120 days notice in those situations where the termination is for cause. For the purposes of this Section, termination of a provider for cause does not include the inability to reach agreement on contract terms.

2.) ***Notice to Enrollees.*** The HEALTH PLAN shall provide prior written notification to Enrollees who will be affected by a Material Modification. Such prior written notice shall be approved by the STATE. The notice must inform each affected Enrollee that: one of the Primary Care Providers they have used in the past are no longer available and that they must choose a new Primary Care Provider from the HEALTH PLAN's remaining choices OR that the Enrollee has been reassigned from a terminated sole source provider, AND in either case the Enrollee has the opportunity to disenroll and change health plans up to 120 days from the date of notification, unless open enrollment occurs within 120 days of the date of notification. The HEALTH PLAN shall fully cooperate with the STATE and Local Agency to facilitate a change of health plan for Enrollees affected by the provider termination.

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

C. ***Network Stability.*** The HEALTH PLAN shall provide the same network of providers for all Enrollees covered under this contract.

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

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

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

A. The Enrollee becomes ineligible for MA, GAMC or MinnesotaCare.

B. The Enrollee moves out of the HEALTH PLAN's Service Area after an absence of two calendar months, with the intent of a permanent move, except in the case where the Enrollee is in an inpatient facility.

C. The Enrollee is permitted to change health plans pursuant to Minnesota Rules, Part 9500.1453 because of problems with access or service delivery, or other good cause.

D. The Enrollee no longer meets the enrollment criteria in Section 3.1.1.

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

F. Pursuant to Minnesota Rules, Part 9500.1453, Subpart 5, the Enrollee elects to change health plans once during the first year of initial enrollment in the HEALTH PLAN or during the first 60 days after a change in enrollment from a health plan that no longer participates in PMAP, PGAMC or MinnesotaCare.

G. Pursuant to Minnesota Rules, Part 9500.1453, Subparts 7 or 8, the Enrollee elects to change health plans due to substantial travel time or Local Agency error.

H. The Enrollee elects to change health plans during the annual open enrollment period.

I. The Enrollee elects to change health plans within 120 days following notice of a Material Modification of the HEALTH PLAN's Provider Network under Section 3.2.4.A.2.

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

Section 3.4.2. ***Notification and Termination of Coverage.*** Notification and termination of HEALTH PLAN coverage shall become effective at the following times.

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

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

C. When termination takes place due to ineligibility for MA, GAMC or MinnesotaCare, or for participation in the prepaid MA or GAMC program, and the Enrollee is hospitalized in an acute care facility on the effective date of ineligibility, HEALTH PLAN coverage shall cease at midnight, Minnesota time, on the first day following discharge from the hospital. The STATE will not pay to the HEALTH PLAN a capitation payment for any month after the month in which the Enrollee's eligibility for MA, GAMC, MinnesotaCare, prepaid MA or prepaid GAMC was terminated.

D. When termination takes place for any reason other than those set forth in this Section, including the termination or expiration of this Contract, while the Enrollee is hospitalized in an acute care facility, HEALTH PLAN coverage shall cease at midnight, Minnesota time, on the first day of the month following the month of discharge from the hospital.

Section 3.4.3. ***Reinstatement.*** An Enrollee whose termination from the HEALTH PLAN has been entered into MMIS on or before the monthly Cut-Off Date may be reinstated for the following month with no lapse in coverage if the Enrollee re-establishes his/her eligibility and such eligibility is entered into MMIS by the last business day of the month.

An Enrollee whose termination from the HEALTH PLAN has been entered into MMIS on or before the monthly Cut-Off Date and who fails to re-establish his/her eligibility and have it entered into MMIS by the last business day of the month shall be disenrolled from the HEALTH PLAN for the following month unless a continuity of care issue arises and it is mutually agreed by all parties that the Enrollee will be reinstated in the HEALTH PLAN for that following month and subsequent months. The STATE shall pay according to Article 4 for the month of coverage in which the Enrollee was reinstated.

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

Section 3.5.1. ***Encounter Data.***

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

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

1.) Individual Enrollee specific, claim-level encounter data for services provided by the HEALTH PLAN to Enrollees detailing all medical and dental diagnostic and treatment encounters, all pharmaceuticals, supplies and medical equipment dispensed to Enrollees, and all Nursing Facility services for which the HEALTH PLAN is financially responsible.

2.) Claim-level data must be reported to the STATE using the following claim formats: HCFA 1500 form for physician and professional services; UB92 form for inpatient and outpatient hospital services, and Nursing Facility services that are the responsibility of the HEALTH PLAN; NCPDP form for pharmacy or non-durable medical supplies; and ADA (American Dental Association) form for dental services, as detailed in the Billing Policy Chapter of the Provider Manual.

3.) All encounter claims with dates of service prior to January 1, 1999 must be submitted electronically and must comply with the STATE requirements as outlined in the EDI (Electronic Data Interchange) Specifications Guide dated March 1996 for the HCFA 1500, dental, and pharmacy claims, and as amended with the September 1996 LTC/UB-92 specifications for the UB-92 claims. For encounter claims with dates of service on or after January 1, 1999, all encounter claims must be submitted electronically and must comply with STATE requirements, including the requirements to submit charge data and to use the standard formats and procedures, as outlined in the EDI Specifications Guide dated 1998. 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.

4.) The HEALTH PLAN shall submit to the STATE, in a format provided by the STATE, a file of all the providers serving these Enrollees maintained on their reference system, so that the STATE can issue a STATE approved provider identification number to be submitted as required on encounter claims. The HEALTH PLAN may substitute the pseudo provider numbers provided by the STATE within the 3% tolerance level. There is a 3% tolerance level for treating providers and an additional 3% tolerance level for pay-to providers. This may include but is not limited to Out-of-Plan providers of Medical Emergency Services.

5.) The HEALTH PLAN must update the provider identification numbers issued by the STATE by submitting, at least quarterly:

a) For providers already on file, new affiliation and demographic information about the provider which is current and complete. The HEALTH PLAN shall take all reasonable steps to ensure that it does not resubmit information about providers when there is no change.

b) For new providers, affiliation and demographic information about the provider which is current and complete.

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

7.) All encounter data for Nursing Facility and Skilled Nursing Facility services must be submitted according to procedures as prescribed by the STATE in the Minnesota Health Programs Encounter UB92/LTC Electronic Billing Instructions, dated September 1998. The HEALTH PLAN shall be responsible for submitting claim-level encounter data that distinguishes between the Skilled Nursing Facility (SNF) and Nursing Facility (NF) days used by the Enrollee.

C. For encounter claims with dates of service on or after January 1, 1999, the HEALTH PLAN shall submit encounter claims with all of the required data elements to the STATE no later than 90 days after date the HEALTH PLAN Allowed the claim.

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

E. For all encounter claims, when the STATE returns or rejects a file of providers, the HEALTH PLAN shall have 60 days from the date the HEALTH PLAN receives the file to resubmit the file with all of the required data elements in the correct file format.

F. For encounter claims with dates of service prior to January 1, 1999 that have not been submitted to the STATE or have not been re-submitted after they were returned or rejected, the HEALTH PLAN shall submit accurate encounter claims according to a schedule determined by the STATE.

G. For encounter claims with dates of service on or after January 1, 1998, the HEALTH PLAN may submit replacement claims or re-submit denied claims at any time.

H. The STATE will provide remittance advice for all submitted encounter claims, including replacement claims.

I. For dates of service after December 31, 1999, the HEALTH PLAN shall collect and report to the STATE individual Enrollee specific, claim level encounter data that identifies the Enrollee's treating provider (the provider that actually provided the service), when the provider is part of a group practices that bills on the HCFA 1500 or Dental Claim form. The treating provider is not required when there is an individual practice office, i.e., a sole treating provider, because in those cases it will be identical to the pay-to provider. Group practice provider categories that bill on the HCFA 1500 or Dental Claim form and will require a treating provider include:

1.) Community Mental Health Clinics;

2.) Physician Clinics;

3.) Dental Clinics;

4.) County Contracted Mental Health Providers;

5.) Indian Health Service;

6.) Federally Qualified Health Centers;

7.) Rural Health Clinics; and

8.) Chiropractic Clinics.

No treating provider is required for the following claims: Day Treatment; Pathologists; Radiology; Laboratories; Anesthesiologists; and Home Health Agency providers. Additional provider types which could be excluded from the treating

provider requirement should be submitted by the HEALTH PLAN for approval by the STATE.

J. ***Distinguishable Claim-Level Encounter Data.*** The HEALTH PLAN shall be responsible for submitting claim-level encounter data that distinguishes between the Skilled Nursing Facility (SNF) and Nursing Facility (NF) days used by the Enrollee.

K. Coding Requirements.

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

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

b) Levels I, II and III procedural codes from the Health Care Financing Administration Common Procedure Coding System (HCPCS) Manual. Level 1 is the Physician's Current Procedural Terminology (CPT). The STATE shall distribute the HCPCS manual to the HEALTH PLAN once per year. The STATE shall provide additional Level III STATE-related codes in respective service chapters of the Provider Manual which are incorporated herein by reference.

c) American Dental Association (ADA) codes.

d) National Drug Codes.

e) Codes identified by the STATE in the EDI Specifications Guide for Nursing Facility services.

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

3.) Neither the HEALTH PLAN nor its subcontractors may redefine or substitute these required codes.

4.) Codes must be submitted on encounter data.

5.) Unlisted codes for procedures, medical equipment and supplies may be submitted only when a specific code that defines the procedure, equipment or supply is not available. Unlisted codes may not be redefined.

6.) The STATE will define "filler" codes that may be used to allow encounter data to enter the STATE's data system.

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

Capitation Payment Dates	Final Encounter Data Due Dates	Assessment Periods
January 2000-March 2000	October 22, 1999	April 1, 1998-March 31, 1999
April 2000-June 2000	February 1, 2000	July 1, 1998-June 30, 1999
July 2000-September 2000	May 1, 2000	October 1, 1998-September 30, 1999
October 2000-December 2000	August 1, 2000	January 1, 1999-December 31, 1999
January 2001-March 2001	November 1, 2000	April 1, 1999-March 31, 2000

Section 3.5.2. ***Other Reporting Requirements***. The HEALTH PLAN must provide the STATE with the following information in a format and timeframe determined by the STATE.

A. The HEALTH PLAN shall report to the Local Agency on a form approved by the STATE for all counties the birth of any Child to a MA or GAMC Enrollee, and to the STATE on a form approved by the STATE the birth of any Child to a MinnesotaCare Enrollee, within 30 days after the birth of the Child. For births where the delivery is performed by a non-Participating Provider, the HEALTH PLAN shall report the birth to the county or the STATE as soon as reasonably possible after the HEALTH PLAN knows of the birth.

B. Enrollment and marketing materials described in Section 3.2. of this Contract.

C. Any substantive changes in the service delivery plan previously submitted shall be provided by the HEALTH PLAN to the STATE within 30 days of the effective date of this Contract and prior to any subsequent changes made by the HEALTH PLAN. The STATE must approve all changes to the HEALTH PLAN's service delivery plan.

D. Financial statements and other information as specified by the STATE to determine the HEALTH PLAN's financial and risk capability.

E. Information as specified in Article 7 regarding quality assurance and improvement.

F. Information regarding Complaints and Denial, Termination, or Reduction (DTR) of services as required under Sections 8.1.6 and 8.2.5.

G. Information relating to HEALTH PLAN administration and subcontracting arrangements, as specified by the STATE and HCFA.

H. A copy of the "Prepaid Health Plans - Chemical Dependency Services Client Assessment/Placement" form (STATE-3079) for each Enrollee who is assessed for chemical dependency (CD) services. This form must be submitted directly to the STATE's Chemical Dependency Division within 30 days of the assessment. The STATE shall comply with the confidentiality requirements for CD service pursuant to 42 C.F.R. Part 2 and Section 1902(a)(27) of the Social Security Act, 42 U.S.C. 1396(a)(27).

I. The HEALTH PLAN shall submit to the STATE by April 1, 2000 the HEALTH PLAN's Common Carrier Transportation services policy and procedures for MA and GAMC Enrollees, or any changes to such policy or procedures since their last submission to the STATE.

J. The HEALTH PLAN shall report prenatal risk assessments and EPSDT/C&TC information as specified in this Contract.

K. The HEALTH PLAN shall submit provider network data within 60 days of request by the STATE, but not to exceed twice per year, pursuant to the following specifications:

1.) All data must be submitted from a standard database program, using a '.DBF' extension.

2.) A detailed statement of the parameters and specifications necessary to interpret the data must be submitted, including: the software used; the software version; any data compression utilities used; and any other unique characteristics of the formatting.

3.) Data must be submitted on IBM-compatible 3.5 inch diskettes, labeled with the health plan name, date and file names.

4.) The HEALTH PLAN must submit only the names of providers in Minnesota, or within 60 miles of Minnesota with whom it contracts or has binding agreements.

5.) The HEALTH PLAN shall use the three-digit codes listed in Appendix B of the 1996 PMAP RFP, or equivalent codes along with a key to the coding system. Providers who meet criteria for more than one type of provider should be listed in all provider types that apply.

L. Pursuant to Section 12.2.2., the HEALTH PLAN shall report to the STATE any additional third party resources in a format provided by the STATE.

M. Pursuant to Section 12.4.1., the HEALTH PLAN shall report all recovery/cost avoided amounts on the encounter claim as third party payments.

N. Pursuant to Section 12.4.3., the HEALTH PLAN shall, on a quarterly basis, disclose to the STATE all cost avoided and recovered amounts.

O. The HEALTH PLAN shall report all abortions received by Enrollees as an additional or alternative service under Sections 6.4. and 6.5., including those performed outside of Minnesota.

Section 3.5.3. ***Consumer Involvement in Mental Health.*** A written report, due to the STATE on July 1, 2000, detailing the HEALTH PLAN's efforts to increase mental health consumers' involvement in the management of mental health services, which includes but is not limited to, consumer input on coverage issues related to the delivery of mental health services.

Section 3.5.4. ***Electronic Reporting Data Capability.*** The HEALTH PLAN shall be capable of receiving data electronically from the STATE, which are: price files, remittance advices, enrollment data, and rates files.

Section 3.6. ***Year 2000 Compliance.***

Section 3.6.1. ***By the HEALTH PLAN.*** The HEALTH PLAN shall take all reasonable steps to ensure that hardware and software used by the HEALTH PLAN before, during, and after the turn of the century shall not experience abnormal ending and/or produce invalid or incorrect results in the operation and administration of the PMAP, PGAMC, and MinnesotaCare programs, and that the accuracy and integrity of the data exchanges in this Contract will not be adversely affected. In the event of any recognition, calculation, or indication of century problems related to the Year 2000 in databases utilized by the HEALTH PLAN, the HEALTH PLAN agrees that it will, to the extent permitted by law, make all code adjustments necessary at no cost to the STATE in order to ensure that the code and databases used by the HEALTH PLAN are "Year 2000 Compliant"as described in Section 3.6.7. The assurance shall be in effect throughout the term of and survive this Contract. The HEALTH PLAN shall develop contingency plans to minimize the impact of Year 2000 problems on Enrollees where necessary.

Section 3.6.2. ***By the STATE.*** The STATE shall take all reasonable steps to ensure that hardware and software used by the STATE before, during, and after the turn of the century shall not experience abnormal ending and/or produce invalid or incorrect results in the operation and administration of the PMAP, PGAMC, and MinnesotaCare programs, and that the accuracy and integrity of the data exchanges in this Contract will not be adversely affected. In the event of any recognition, calculation, or indication of century problems

related to the Year 2000 in databases utilized by the STATE, the STATE agrees that it will, to the extent permitted by law, make all code adjustments necessary at no cost to the HEALTH PLAN in order to ensure that the code and databases used by the STATE are "Year 2000 Compliant"as described in Section 3.6.5. The assurance shall be in effect throughout the term of and survive this Contract.

Section 3.6.3. ***By the HEALTH PLAN's Subcontractors.*** The HEALTH PLAN shall include the requirements in 3.6.1. in all of its subcontracts for services under this Contract.

Section 3.6.4. ***Bridging of Interfaces.*** The STATE and the HEALTH PLAN will work together to ensure that the interfaces critical to business function are changed synchronously. The STATE and the HEALTH PLAN agree to work together to develop timelines for testing data.

Section 3.6.5. ***"Year 2000 Compliant"*** means that information resources meet the following criteria and/or perform as described below:

A. Data structures (databases, data files, etc.) provide 4-digit date century recognition when critical to business function. For the purposes of this Contract, 4-digit date century recognition means that all dates are clearly relatable to a specific century.

B. Stored data contains date century recognition when critical to business function, including (but not limited to) data stored in databases and hardware/device internal system dates.

C. Calculations and program logic accommodate both same century and multi-century formulas and data values. Calculations and logic include, but are not limited to: sort algorithms, calendar generations, event recognition, and all processing actions that use or produce data values.

D. Interfaces to and from other systems or organizations prevent non-compliant dates and data from entering or exiting any STATE system.

E. Files and data accurately show 4-digit years, if critical to business functions.

F. Year 2000 is correctly treated as a leap year within all calculation and calendar logic.

Section 3.7. ***Conflicts of Interest.*** Pursuant to Section 4724(c) of the Balanced Budget Act of 1997, and Laws of Minnesota 1999, Article 4, Section 60, the HEALTH PLAN shall have in effect conflict of interest rules at least as effective as those in 41 U.S.C. 423.

Article 4. Payments to HEALTH PLAN.

Section 4.1. ***Prepaid Capitation Rate.*** On or before the 10th day of each month during the term of this Contract, the STATE agrees to prepay the HEALTH PLAN the following rates as

specified in Appendix A of this Contract (except as provided under Section 7.6.), per month, per Recipient enrolled with the HEALTH PLAN, as full compensation for medical goods and services provided hereunder in that month. For the capitation payment for those Enrollees who have been reinstated, the STATE agrees to pay the HEALTH PLAN on the next available warrant.

Section 4.1.1. ***Capitation Payments.*** The STATE will pay to the HEALTH PLAN a capitation payment for each Enrollee in accordance with Article 4 for the month in which coverage becomes effective and thereafter until termination of Enrollee coverage pursuant to Section 3.4. becomes effective.

Section 4.1.2. ***Newborns.*** The STATE will pay to the HEALTH PLAN a capitation payment for the birth month of an eligible newborn Enrollee if the mother was enrolled in the HEALTH PLAN during the month of the Child's birth and eligibility is established for the Child.

Section 4.1.3. ***Pregnant Women.*** The rate paid for women in this Rate Cell category is based on an adjustment that reflects the reported average time period in this Rate Cell for a Pregnant Woman as compared to the expected average time period of nine months. As reported to the STATE by the HEALTH PLAN, the average time period in this Rate Cell for a Pregnant Woman is 4.5 months for MinnesotaCare and 3.8 months for MA per Pregnant Woman. The STATE shall monitor the average length of stay in this Rate Cell and shall adjust rates prospectively if there is a variance of at least one month. For this purpose the variance will be derived from an average change occurring over at least two months.

Section 4.1.4. ***Medical Education and Research Trust Fund Money (MERC).*** Appendix A includes:

A. A set of capitation rates with HEALTH PLAN specific MERC and Disproportionate Population Adjustment (DPA) funding in the rates;

B. A set of capitation rates with HEALTH PLAN specific MERC funding out of the rates; and

C. A set of capitiation rates with HEALTH PLAN specific MERC and DPA funding out of the rates.

D. The dollar difference between A and B, which is the amount of payment made by the STATE directly to the MERC Trust Fund on behalf of the HEALTH PLAN.

E. The dollar difference between B. and C., which is the HEALTH PLAN's specific DPA rate.

The STATE shall begin making payments to the MERC Trust Fund on behalf of the HEALTH PLAN and reduce the payment to the HEALTH PLAN by the amount in D.,

above, on the first capitation warrant date which is at least thirty days after the STATE has received a waiver from HCFA allowing the establishment of the trust fund and distribution of Medical Education and Research funds through the trust. The STATE shall reflect on the remittance advice the total reimbursement amount and the reduction of this total reimbursement amount due to the removal of MERC funds as described in B., above.

Section 4.1.5. ***Risk Adjusted Payments.*** Appendix B includes:

A. The HEALTH PLAN's risk factors for the first quarter of 2000 (Column 3).

   New risk factors will be calculated by the STATE on a quarterly basis based on encounter data submitted by the HEALTH PLAN pursuant to Section 3.5.1. of this Contract. The STATE shall calculate these risk factors as follows: (1) the STATE will calculate for the HEALTH PLAN an annual risk factor for each eligibility group by putting each Enrollee into a relative weight category as outlined in Appendix C, and multiplying each Enrollee's relative weight by that Enrollee's total number of Enrollee-months; (2) then, the results derived from (1) for each HEALTH PLAN Enrollee will be summed and divided by the total number of Enrollee-months.

   For the payment period January 2000 through March 2000, the HEALTH PLAN's specific risk factor will be based on the HEALTH PLAN's Enrollees' experiences during the period of April 1998 through March 1999. The STATE shall base the risk factor for each subsequent quarter of payment on the HEALTH PLAN specific risk factor for an annual period that is advanced by one quarter of capitation and used to calculate the risk adjusted payments to the HEALTH PLAN.

B. The statewide capitation base rates that are used to calculate the risk adjusted payments to the HEALTH PLAN (Column 4).

Section 4.1.6. ***Risk Adjustment Appeals.*** The HEALTH PLAN may appeal to the STATE the following quarter's risk factor. Any appeal of risk factors must be filed with the STATE within two weeks of notification of the new risk factors. The basis for any appeal by the HEALTH PLAN under this Section shall be limited to whether or not the STATE correctly calculated the HEALTH PLAN's risk factor based on encounter data submitted in a timely manner as required by Section 3.5.1.

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

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

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

Section 4.2. ***Capitation Payment Rates.*** Payments for all Enrollees, except dual eligible Enrollees 65 and over, shall be the sum of payments under A. and B. below, which have an actuarial basis and which shall not exceed the payments limits set forth in 42 C.F.R. 447.361. Dual eligible Enrollees 65 and over shall be paid under A only, but at 100% instead of 95%. The HEALTH PLAN shall receive for each Enrollee the rate of the county of service.

A. Until the date specified in Section 4.1.4., monthly payments paid by the STATE to the HEALTH PLAN shall be paid at 95% of the rates in Appendix A, Column (3), plus the MERC and DPA rates in Appendix A, Columns (4) and (5) ; This amount is shown in Appendix B, Column (1). After the date specified in Section 4.1.4., the amount is shown in Appendix B, Column (2).

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

The sum of (A) and (B) is the total capitation payment to the HEALTH PLAN and is identified in Appendix B, Column (6).

Section 4.2.1. Assignment of Rate Cells shall be made based on information on the STATE MMIS and information provided by the HEALTH PLAN to the STATE.

Section 4.2.2. The STATE will periodically review information in MMIS related to the assignment of Rate Cells to verify that appropriate rates are being paid.

Section 4.2.3. The HEALTH PLAN shall promptly pay all valid claims, whether provided within or outside the Service Area of this Contract consistent with Sections 1816(c)(2) (42 U.S.C. 1395(h)(c)(2)), 1842(c)(2) (42 U.S.C. 1395u(c)(2)) and 1902(a)(37)(a) (42 U.S.C. 1396 (a)) of the Social Security Act and Minnesota Statutes, Section 16A.124.

Section 4.2.4. The prepaid capitation rates for Recipients enrolled in the HEALTH PLAN shall be subject to renegotiation not more than annually unless required by State or federal law or regulation, or necessary due to changes in eligibility and benefits.

Section 4.2.5. The capitation rate shall not include payment for recoupment of losses incurred by the HEALTH PLAN from prior years or under previous contracts.

Section 4.3. ***Premiums and Copayments.***

Section 4.3.1. The STATE shall collect any insurance premiums from Enrollees.

Section 4.3.2. The HEALTH PLAN agrees that no copayments or deductibles shall be charged to MinnesotaCare/MA Enrollees for covered services or services provided as alternatives to covered services as part of the HEALTH PLAN's case management plan.

Section 4.3.3. MinnesotaCare Enrollees must make copayments to the provider of the following services:

A. prescription drugs ($3 per prescription),

B. eyeglasses ($25 per pair) and

C. Inpatient Hospitalization (10% of paid charges subject to an annual calendar year maximum of $1,000 per individual and $3,000 per family). This co-payment does not apply to Parents and Adult caretakers whose income does not exceed 175% of the Federal Poverty Guidelines.

D. Nonpregnant Adults whose income does not exceed 175% of the Federal Poverty Guidelines will have a 50% copay based on the MinnesotaCare fee schedule of the restorative dental services (not including orthodontia).

E. The HEALTH PLAN may delegate to the providers of these services the responsibility to collect the copayment. The HEALTH PLAN may not reduce or waive the copayment as an inducement to MinnesotaCare Enrollees to enroll or continue membership in the HEALTH PLAN.

Section 4.4. ***Payment Error in Excess of $500,000.*** If the STATE determines that there has been an error in its payment to the HEALTH PLAN 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 HEALTH PLAN or the Enrollee, the STATE or the HEALTH PLAN may make a claim under this Section.

Section 4.4.1. ***Independent Audit.*** The STATE or the HEALTH PLAN may request an independent audit of the payment error prior to recovery or offset by the STATE of the overpayment or underpayment amount.

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

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

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

D. The STATE shall not be obligated to honor the HEALTH PLAN'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 HEALTH PLAN from obtaining an independent audit at its own expense, however, the HEALTH PLAN must give reasonable notice of the audit to the STATE and must provide the STATE with a copy of any final audit results.

Section 4.4.2. ***Mutually Develop Procedures.*** The STATE and the HEALTH PLAN shall work together to develop reasonable procedures for the inspection of STATE documentation to determine the accuracy of payment amounts pursuant to this Section.

Section 4.4.3. ***Two Year Limit to Assert Claim.***

A. The STATE shall not assert any claim for or seek the payment of or make any adjustment for any alleged overpayment made by the STATE to the HEALTH PLAN pursuant to Section 4.2. of this contract, more than two years after the date such payment was actually received by the HEALTH PLAN from the STATE.

B. The HEALTH PLAN shall not assert any claim for or seek the payment of or make any adjustment for any alleged underpayment made by the STATE to the HEALTH PLAN pursuant to Section 4.2. of this contract, more than two years after the date such payment was actually received by the HEALTH PLAN from the STATE.

Section 4.4.4. ***Payment Offset.*** When possible, a recovery for an overpayment or payment due because of an underpayment shall be offset against or added to future payment made according to Section 4.2. of this contract.

Section 4.4.5. ***Survival.*** Section 4.4. in its entirety survives the termination or cancellation of this agreement.

Section 4.4.6. ***Notice.*** The parties shall notify each other in writing of an intent to assert a claim under Section 4.5.

Section 4.5. ***Other Payment Errors.*** If the STATE determines there has been an error or errors in its payment to the HEALTH PLAN pursuant to Section 4.2. that resulted in overpayment or underpayment to the HEALTH PLAN 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 HEALTH PLAN or the Enrollee, the STATE or the HEALTH PLAN may make a claim under this Section.

Section 4.5.1. ***One Year Limit to Assert Claim.***

A. The STATE shall not assert any claim for or seek the payment of or make any adjustment for any alleged overpayment made by the STATE to the HEALTH PLAN

under Section 4.6. more than one year after the date such payment was actually received by the HEALTH PLAN from the STATE, except for duplicate payments because of multiple identification numbers for the same Enrollee, and payments for months after the death of the Enrollee.

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

Section 4.5.2. ***Notice.*** The parties shall notify each other in writing of an intent to assert a claim under this Section.

Section 4.6. ***Skilled Nursing Facility/Nursing Facility Liability***.

Section 4.6.1. ***90-Day SNF/NF Liability Period.***

A. Beginning March 1, 2000, if federal approval is received by November 30, 1999; or July 1, 2000, if federal approval is received by March 31, 2000; or October 1, 2000, if federal approval is received by June 30, 2000; for any Recipient who is age 65 or older, is Non-Institutionalized and who is currently enrolled or enrolls in the HEALTH PLAN's MA product while in a community setting, the HEALTH PLAN shall have financial responsibility for Nursing Facility services for 90 days. The 90 days begin at the time of the Enrollee's date of admission to a Skilled Nursing Facility (SNF) or Nursing Facility (NF) or the effective date of enrollment, whichever is later. Both MA and Medicare covered days shall be counted toward the 90-day liability period. The 90 days shall be counted cumulatively. The HEALTH PLAN shall be responsible for paying any coinsurance for Medicare covered days during the 90-day liability period. The 90-day liability 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 4.7.4.

B. The HEALTH PLAN may accrue the following types of days toward the cumulative 90-day liability period:

1.) Medicare SNF days.

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

3.) Medicaid NF days. These may include paid Medicaid leave days. Leave days must be for hospital or therapeutic leave of an Enrollee who has not been discharged from a long term care facility. According to current MA standards,

payments for hospital leave days are limited to 18 consecutive days for each separate and distinct episode of Medically Necessary hospitalization, and payments for therapeutic leave days are limited to 36 leave days per calendar year.

4.) Days accrued in the hospice setting do not count toward the 90-day SNF/NF liability period.

C. The HEALTH PLAN will remain liable for the 90-day SNF/NF liability across contract years unless the Enrollee disenrolls from PMAP at the same time as the contract year changes in which case the PMAP Disenrollment Fee policy shall be applied to the HEALTH PLAN as specified in Section 4.6.7.

Section 4.6.2. ***Pre-admission Screening*****.** The HEALTH PLAN must determine the Enrollee's risk of Nursing Facility admission or current need for Nursing Facility care to ensure that each Enrollee eligible to receive Nursing Facility benefits under section 4.6.1 of this contract is screened in accordance with Minnesota Statutes, Section 256B.0911. The HEALTH PLAN may choose either to delegate all of its pre-admission responsibilities to a Local Agency or work in cooperation with the Local Agency to carry out its pre-admission screening responsibilities. All other Pre-admission Screening functions shall remain the responsibility of the Local Agency.

A. The HEALTH PLAN may delegate to a Local Agency the pre-admission screening responsibilities referenced in this section. If the HEALTH PLAN chooses to delegate these responsibilities to a Local Agency, it must abide by all level of care determinations made by that Local Agency. It must also inform all Enrollees prior to Nursing Facility placement that they may qualify for services under the STATE's Elderly Waiver program. The HEALTH PLAN shall not be financially responsible for costs of pre-admission screening.

B. The HEALTH PLAN may work in cooperation with a Local Agency to carry out the pre-admission screening responsibilities referenced in this section. If the HEALTH PLAN chooses to work in cooperation with a Local Agency, it shall conduct the pre-admission screening process as follows:

1.) The HEALTH PLAN must conduct screenings for hospital discharges and emergency placements using the most current Pre-Admission Screening (PAS) process and convey any information obtained during the screenings to the Local Agency.

2.) The HEALTH PLAN must conduct OBRA Level 1 screenings and convey any information obtained during the screenings to the Local Agency.

3.) The HEALTH PLAN must allow the Local Agency to conduct OBRA Level II evaluations when indicated, provide the Nursing Facility with documentation of

the OBRA Level II evaluations, enter long term care screening document information, and generate Quality Assurance and Review (QA&R) or case mix forms.

4.) For Enrollees living in the community and entering a Nursing Facility, the HEALTH PLAN must conduct an in-person, pre-admission screening using the most current PAS tool and level of care criteria.

C. The HEALTH PLAN shall notify the STATE of those counties where it intends to be involved in the PAS process, pursuant to B., above, no later than thirty (30) days after the STATE has given the HEALTH PLAN notice of federal approval to implement this coverage, pursuant to Section 4.6.1.

Section 4.6.3. ***Responsibility for Payment of Medicaid NF Days After the 90-Day Liability Period.*** After the 90-day liability period is expended, the STATE shall assume responsibility for MA Nursing Facility Days.

Section 4.6.4. ***Responsibility for Payment of Medicare SNF Days After the 90-Day Liability Period.*** PMAP Enrollees who are eligible for Medicare Part A will receive coverage for Medicare SNF days paid for either on a Fee-for-Service basis or through a Medicare + Choice contractor according to Medicare SNF coverage criteria.

Section 4.6.5. ***Responsibility for Tracking 90-Day Liability.*** The HEALTH PLAN shall be responsible for tracking accrual of days toward the 90-day SNF/NF liability period for PMAP Enrollees to whom the liability applies. During the 90-day liability period, reimbursement for NF services provided by a Nursing Facility can only be made through the HEALTH PLAN and not through the MA fee-for-service claims system. Before Medicaid NF claims can be paid by the STATE, either the HEALTH PLAN or a Nursing Facility must notify the STATE that the HEALTH PLAN has met its 90 days of SNF/NF liability. Acceptable notification shall include but is not limited to the following:

A. The HEALTH PLAN or a Nursing Facility may provide documentation to the STATE demonstrating that the HEALTH PLAN has been liable for 90 days of SNF/NF services. Acceptable documentation may include, but is not limited to: 1) provider claims submitted to the HEALTH PLAN for Nursing Facility services, 2) coinsurance claims for Medicare-covered days, 3) internal patient account summaries, 4) Prior Authorizations if used by the HEALTH PLAN and 5) claim denials for any days billed after the HEALTH PLAN's 90-day liability period has ended. The HEALTH PLAN shall also submit a "PMAP 90 DAY NF Liability Cover Form" supplied by the STATE.

Section 4.6.6. ***180-Day Separation Period.***

A. If the HEALTH PLAN has not previously had NF liability for an Enrollee, the 180-Day Separation Period is defined as 180 consecutive institutional (defined in B.,

below) or community days after the Enrollee moves from a Nursing Facility to a community setting. If the HEALTH PLAN has already been liable for 90 days of SNF/NF services, then the 180-Day Separation Period is defined as 180 consecutive institutional (defined in B., below) or community days after the HEALTH PLAN has already been liable for 90 days of SNF/NF services. In either case, after this separation period has expired, the HEALTH PLAN shall be liable for a new, distinct 90-day SNF/NF liability period for any Enrollee who is community-based on the last day of the separation period. The new liability span shall begin on the first day of the next available month following the 180th day of the separation period.

B. If an Enrollee is hospitalized and/or placed in a Nursing Facility during the 180-day Separation Period for 30 consecutive days or less, the Enrollee shall be still be considered to be residing in the community and these days shall be counted toward the 180-day Separation Period. If the Enrollee spends more than 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.

C. The STATE shall have the responsibility for tracking the 180-day Separation Period. The HEALTH PLAN shall cooperate with the STATE in verifying the 180-day Separation Period.

D. The STATE enrollment data will contain information indicating the HEALTH PLAN's Nursing Facility liability.

Section 4.6.7. ***PMAP Disenrollment Fee.***

A. A disenrollment fee shall be paid to the STATE by the HEALTH PLAN when an Institutionalized PMAP Enrollee disenrolls during the 90-day liability period, and liability for continuing Nursing Facility costs reverts to the STATE. The disenrollment fee shall be applied to the Enrollees who have been Institutionalized for at least 30 consecutive days on the effective disenrollment date.

B. The disenrollment fee that must be paid by the HEALTH PLAN to the STATE shall be based on the following formula:

PMAP-Hennepin = 71 days x $106.49 x (90 - Accrued Days)/90 days
PMAP-Other Metro = 71 days x $103.60 x (90 - Accrued Days)/90 days
PMAP-Non Metro = 73 days x $91.45 x (90 - Accrued Days)/90 days

C. Within 90 days of the effective date of disenrollment, the HEALTH PLAN must provide documentation to the STATE showing the number of days of the PMAP 90-day SNF/NF liability that the HEALTH PLAN accrued prior to the effective date of disenrollment for each Enrollee who has disenrolled from the HEALTH PLAN. The STATE reserves the right to verify the HEALTH PLAN's documentation regarding the number of days of the SNF/NF liability that the HEALTH PLAN accrued.

Section 4.6.8. ***Change in Living Arrangement Prior to Capitation Cut-off.*** If an Enrollee enters the Nursing Facility prior to Capitation Cut-off, the STATE shall retroactively change the eligibility span for the Enrollee so the HEALTH PLAN will not have liability for Nursing Facility days for the Enrollee, unless the conditions for a new Nursing Facility liability period are met.

Section 4.6.9. ***Transfer of Assets.*** The STATE will notify the HEALTH PLAN when an Enrollee has made a transfer of assets or income that results in a penalty for Medicaid payment of long term care services. As long as the Enrollee remains enrolled in PMAP, the HEALTH PLAN shall be required to reassume financial responsibility for all Nursing Facility Services covered under PMAP after the ineligibility period has passed. The STATE and the HEALTH PLAN will mutually develop a methodology to ensure compliance with this section.

Article 5. Term, Termination and Partial Breach.

Section 5.1. ***Term.*** The term of this Contract shall be from January 1, 2000, and shall remain in effect until December 31, 2000, and will renew for an additional one year term, unless the HEALTH PLAN or the STATE provides notice of termination in accordance with Article 5, Section 5.2.: Contract Termination Provisions. Except for Section 5.2.1. and for all obligations set forth in this Contract that have not been satisfactorily fulfilled, this Contract shall remain in effect until the end of the Contract term or until terminated, whichever occurs earlier.

Coverage will begin at 12:00 a.m. on January 1, 2000 and end at 11:59:59 p.m on December 31, 2000. (Central Standard Time).

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

Section 5.1.2. ***Notice.*** The HEALTH PLAN shall provide the STATE with 120 days written notice prior to the end of the contract term if the HEALTH PLAN chooses not to renew or extend this Contract at the end of the contract term. If the STATE has not provided rates to the HEALTH PLAN prior to the 120th day before the end of the contract term, and the HEALTH PLAN chooses not to renew or extend this Contract after receipt of the rates, the HEALTH PLAN shall immediately give 120 days written notice. The STATE and the HEALTH PLAN agree to extend this agreement until the end of the notice period.

Section 5.1.3. ***Notice of County Based Purchasing.*** After receiving federal approval for County Based Purchasing, the STATE shall provide the HEALTH PLAN with no less than 120 days written notice of intent to remove any counties from the HEALTH PLAN's Service Area.

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

Section 5.2.1. ***Survival.*** Notwithstanding the termination of this Contract for any reason, Article 14 (Indemnification), Section 9.7. (confidentiality), Sections 3.5. and 9.3. (reporting and access to records), Sections 4.4. and 4.5. (payment error), Section 3.6. (Year 2000 Compliance), Section 6.20.2. (Payment for IHS and Tribal Services), and Section 7.6. (Financial Performance Incentives) shall survive the termination of this Contract.

Section 5.2.2. ***Termination Without Cause.*** This Contract may be terminated by the STATE at any time without cause, upon a 120 calendar day written notice to the HEALTH PLAN.

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

A. By the Health Plan. This Contract may be terminated by the HEALTH PLAN, except as provided in Section 5.1.1. related to renewal of this Contract, in the event of the STATE's material breach of this Contract, upon a 120 calendar day advance written notice to the STATE. In the event of such termination, the HEALTH PLAN shall be entitled to payment, determined on a pro rata basis, for work or services satisfactorily performed through the effective date of cancellation or termination.

B. By the STATE. The STATE may terminate this Contract for any material breach by the HEALTH PLAN after 120 days from the date the STATE provides the HEALTH PLAN notice of termination. In the event the material breach consists of fraudulent or criminal action by the HEALTH PLAN, termination may occur after 30 days from the date the STATE provides notice. The HEALTH PLAN may request, and must receive if requested, a hearing before the mediation panel described in Section 5.3.3. prior to termination.

C. Legislative Appropriation. Continuation of this Contract is contingent upon continued legislative appropriation of funds for the purpose of this Contract. If these funds are not appropriated, the STATE will immediately notify the HEALTH PLAN in writing and the Contract will terminate on June 30 of that year.

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

A. Both parties shall cooperate in notifying all HEALTH PLAN Enrollees covered under this Contract in writing of the date of termination and the process by which those Enrollees will continue to receive medical care, at least 60 calendar days in advance of the termination. Such notice must be approved by the STATE. Such notice must include a description of alternatives available for obtaining services after contract termination.

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

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

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

E. Written notices shall be sent by U.S. Postal Service certified mail, return receipt requested. The required notice periods set forth in Section 5 of this Contract shall be calendar days measured from the date the receipt is signed.

F. Termination under Section 5 of this Contract shall be effective on the last day of the calendar month in which the notice becomes effective. Payment shall continue and services shall continue to be provided during that calendar month.

Section 5.3. ***Partial Breach*****.** The STATE and the HEALTH PLAN agree that if the HEALTH PLAN does not perform any of the duties in this Contract, the STATE may, in lieu of terminating this Contract, enforce one of the remedies listed in Section 5.3.4., at the STATE's option. Enforcing one of the remedies shall not be construed to bar other legal or equitable remedies which may be available to the STATE, including, but not limited to, criminal prosecution. Concurrent breaches of the same administrative functions may be construed as more than a single breach.

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

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

B. The effect, if any, of the breach on Enrollees' or Recipients' health and access to health services;

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

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

E. The economic benefits, if any, derived by the HEALTH PLAN by virtue of the breach.

Section 5.3.2. ***Opportunity to Cure.*** The STATE shall give the HEALTH PLAN reasonable written notice of a breach by the HEALTH PLAN prior to imposing a remedy under this Section. The HEALTH PLAN shall have a period of time not to exceed 60 calendar days from the date it receives the notice of breach, unless a longer period to cure the breach is mutually agreed upon, to cure the breach if the breach can be cured. In urgent situations, as determined by the STATE, the STATE may establish a shorter time period to cure the breach. If the STATE determines that the HEALTH PLAN failed to cure the breach within the specified time period, the STATE may enforce a remedy or remedies under this Section.

Section 5.3.3. ***Mediation Panel.*** If the STATE enforces a remedy under this Section, the STATE shall provide the HEALTH PLAN written notice of the remedy to be imposed. The HEALTH PLAN may request the recommendation of a three-person mediation panel within three working days of receiving notice of a remedy from the STATE. The Commissioner of the Department of Human Services shall resolve all disputes after taking into account the recommendations of the mediation panel and within three days after receiving the recommendation of the mediation panel. The panel shall be composed of one designee of the Minnesota Council of Health Plans, one designee of the Commissioner of Human Services, and one designee of the Commissioner of Health. The mediation panel shall meet, accept both written and oral argument as requested, and make its recommendation within fifteen days of receiving the request for recommendation unless the parties mutually agree to a longer time period.

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

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

B. Monetary payments from the HEALTH PLAN to the STATE in the amount of up to One Thousand Dollars ($1,000) per day, offset against payments due the HEALTH PLAN by the STATE, until such time as the problem is corrected to the satisfaction of the STATE.

C. Monetary payments from the HEALTH PLAN to the STATE in the amount of up to One Thousand Dollars ($1,000) per day, offset against capitation payments, from the time the notification by the HEALTH PLAN should have occurred or the time the correction should have been made until the time when notification by the HEALTH PLAN is actually made or the correction is made. This paragraph allows the STATE to enforce a remedy against the HEALTH PLAN for actions which have been corrected prior to coming to the attention of the STATE.

D. Withhold the capitation payment for the first month of life of a newborn Enrollee whose birth was not reported by the HEALTH PLAN to the Local Agency or the STATE within 30 days after the HEALTH PLAN was notified of the birth.

E. Require an independent financial audit of all Common Carrier Transpiration services provided by the HEALTH PLAN during the contract term, at HEALTH PLAN expense.

F. Not offer the HEALTH PLAN as an enrollment choice for Recipients in the affected county until 30 days after the Local Agency or the STATE receives the required marketing and enrollment materials.

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

Section 6.1. ***MA and MinnesotaCare/MA Covered Services.*** The HEALTH PLAN shall provide, or arrange to have provided to MA and MinnesotaCare/MA Enrollees comprehensive preventive, diagnostic, therapeutic and rehabilitative health care services as defined in Minnesota Statutes, Section 256B.0625 and Minnesota Rules, Parts 9505.0170 to 9505.0475. Except for Sections 6.1.24. and 6.1.28., these services shall be provided to the extent that the above law and rules were in effect on the effective day of this Contract. These services shall include but are not limited to, the following.

Section 6.1.1. ***Care Management Services.*** The HEALTH PLAN shall be responsible for the Care Management of all Enrollees. The HEALTH PLAN'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. At a minimum, the HEALTH PLAN's Care Management system must incorporate the following elements.

A. Procedures for the provision of an individual needs assessment, diagnostic assessment, the development of an individual treatment plan as necessary based on the needs assessment, the establishment of treatment objectives, the monitoring of outcomes, and a process to ensure that treatment plans are revised as necessary. These procedures must be designed to accommodate the specific cultural and linguistic needs of the HEALTH PLAN's Enrollees.

B. A strategy to ensure that all Enrollees and/or authorized family members or guardians are involved in treatment planning and consent to the medical treatment.

C. A method for coordinating the medical needs of an Enrollee with his/her social service needs. This may involve working with county social service staff or with the various community resources in the county. Coordination with the county social service staff will be required when the Enrollee is in need of the following services: case management for serious and persistent mental illness or seriously emotionally disturbed Children, prepetition screening, preadmission screening or Elderly Waiver services, extended care or halfway house services covered by the Consolidated Chemical Dependency Treatment Fund, child protection, court ordered treatment,

developmental disabilities, or a STATE medical review team or social security disability determination. It may also involve working with county social service staff or county attorney staff for Enrollees who are the victims or perpetrators in criminal cases.

D. Procedures and criteria for making referrals to specialists and subspecialists.

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

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

G. Procedures for coordinating care for American Indian Enrollees.

Section 6.1.2. ***Chemical Dependency (CD) Treatment Services.*** CD treatment services does not include detoxification (unless it is required for medical treatment), halfway house care, extended care and transitional care. Notwithstanding Section 6.21.2., CD services shall be provided in accordance with Minnesota Rules, Part 9530.6600 to 9530.6660 and by programs and facilities licensed under Minnesota Rules, Part 9530.5000 to 9530.6400, and Part 9530.4100 to 9530.4450.

Section 6.1.3. ***Child and Teen Checkup.*** The Health Plan agrees to provide, or arrange to provide Child and Teen Checkup (C&TC) screenings to each Enrollee under age 21, as follows, and shall be subject to 42 U.S.C. Section 1396d(r):

A. The following C&TC components are currently required and must be performed in accordance with C&TC program standards and according to the periodicity schedule as specified in the C&TC Chapter of the Provider Manual, which is herein incorporated by reference:

1.) Assessment of physical growth.
2.) Vision screening.
3.) Hearing screening.
4.) Health history.
5.) Developmental and behavioral assessment.
6.) Physical examination.

7.) Nutritional assessment.
8.) Immunization and review.
9.) Laboratory tests.
10.) Health education and anticipatory guidance.
11.) An initial examination by a dentist is required for each Enrollee beginning at age three.

B. The HEALTH PLAN must report to the STATE on a monthly basis appropriate C&TC encounters, including all screening components, submitted electronically in the ASCII file format as required by the STATE. The report for each month must be according to the specifications which have been provided by the STATE and is due to the STATE between the 1st and 10th day after the last day of the month. The HEALTH PLAN must report data of all health services provided to Enrollees under age 21 pursuant to Section 3.5.1. The HEALTH PLAN shall submit C&TC encounters to the STATE no later than two months after the date the HEALTH PLAN Allowed the claim. For all C&TC encounters, when the STATE rejects the file, the HEALTH PLAN shall have 15 days from the date of return to resubmit an accurate file.

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

D. The HEALTH PLAN must:
1.) notify Enrollees under the age of 21 of the availability of C&TC screening at least annually;
2.) provide all of the required screening components according to the C&TC standards and periodicity schedule (although the HEALTH PLAN may offer additional preventive services beyond these minimal standards); and
3.) provide all Medically Necessary health care, diagnostic services, treatments and other measures, to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, which are mandatory or optional MA-covered services under 42 U.S.C. Section 1396d(a). See 42 U.S.C. Section 1396d(r)(5).

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

F. The STATE agrees to work with the HEALTH PLAN on policy issues and process improvements regarding C&TC during the Contract year.

Section 6.1.4. ***Chiropractic Services.***

Section 6.1.5. ***Clinic Services.***

Section 6.1.6. ***Dental Services***. Dental services includes dentures. Replacement of dental prosthesis may be limited to one replacement every five years unless the HEALTH PLAN gives Prior Approval to a replacement within the five-year period.

Section 6.1.7. ***Family Planning Services.***

A. The HEALTH PLAN must comply with the sterilization consent procedures required by the federal government and must ensure free choice of Family Planning Services.

B. The HEALTH PLAN may not restrict the choice of an Enrollee as to where the Enrollee receives the following services, pursuant to Minnesota Statutes, Section 62Q.14:

1.) voluntary planning of the conception and bearing of Children, provided that this clause does not refer to abortion issues;
2.) diagnosis of infertility, including counseling and services related to the diagnosis (i.e., provider visit(s) and test(s) necessary to make a diagnosis of infertility and to inform the Enrollee of the results);
3.) testing and treatment of a sexually-transmitted disease; and
4.) testing for AIDS and other HIV-related conditions.

C. The HEALTH PLAN may require family planning agencies and other providers to refer patients back to the HEALTH PLAN under the following circumstances for other services, diagnosis, treatment and follow-up:

1.) abnormal pap smear/colposcopy;
2.) infertility treatment;
3.) non-Family Planning Services;
4.) genetic testing; and
5.) HIV treatment.

Section 6.1.8. ***Home Care Services.***

A. Home Care Services include:

1.) Nursing services provided by a certified Home Health Care Agency, up to the service limit described in Minnesota Statutes, Section 256B.0627, Subd. 5(e)(1).

2.) Home Health Aide services provided by a certified Home Health Care Agency, up to the service limit described in Minnesota Statutes, Section 256B.0627, Subd. 5(e)(1).

3.) Personal Care Services, up to the service limits established in Minnesota Statutes, Section 256B.0627, Subd. 4 and Subd. 5(e)(2). The HEALTH PLAN must ensure that an explanation of any changes in service levels is documented.

4.) Nursing supervision of Personal Care services, up to the service limits established in Minnesota Statutes, Section 256B.0627, Subd. 4(a) and Subd. 5(e)(2).

5.) Private Duty Nursing Services, up to the limits established in Minnesota Statutes, Section 256B.0627, Subd. 5(e)(3).

6.) Therapy Services, including physical therapy, occupational therapy, speech therapy and respiratory therapy, up to the limits established in Minnesota Rules, Part 9505.0220(V).

7.) Medical Equipment and Supplies, pursuant to Section 6.1.14.

B. For Enrollees who are ventilator-dependent, the limits described in 1-6 above, do not apply; the limits for these Enrollees are as described in Minnesota Statutes, Section 256B.0627, Subd. 5(e)4.

C. If the HEALTH PLAN prior authorizes Home Care Services, it shall comply with Section 6.21. of this Contract.

D. The HEALTH PLAN shall use the criteria established in Minnesota Statutes, Section 256B.0627, Subd. 4(b)(10) to determine whether or not to grant a hardship waiver to an Enrollee's relative.

E. Enrollees over age 65 who require more than the Home Care Services covered under Minnesota Statutes, Section 256B.0627, Subdivision 2 or who require services provided under the Elderly Waiver program in addition to Home Care Services, shall be referred to the Elderly Waiver program.

Section 6.1.9. ***Hospice Services.*** Services provided by a Medicare certified hospice agency or, when a Medicare certified hospice agency is not available, services that are equivalent to those provided in a Medicare certified hospice agency. For purposes of this Section, "equivalent" means that the Enrollee:

A. will be provided with a hospice election process that is similar to the hospice election process used by a Medicare certified hospice agency; and

B. will be provided with the same choice and amount of services that would be available from a Medicare certified hospice agency.

Section 6.1.10. ***Inpatient Hospital Services.*** Coverage for Inpatient Hospital services shall not exceed the actual semi-private room rate, unless a private room is determined to be Medically Necessary by the HEALTH PLAN.

Section 6.1.11. ***Interpreter Services.*** The HEALTH PLAN shall provide sign and spoken language interpreter services that assist Enrollees in obtaining their program's covered health services, to the extent that interpreter services are available to the HEALTH PLAN or its subcontractor when services are delivered. The intent of the limitation, above, is that the HEALTH PLAN 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 HEALTH PLAN from using all diligent efforts to make interpreter services available.

Section 6.1.12. ***Laboratory, Diagnostic and Radiological Services.***

Section 6.1.13. ***Medical Emergency, Post-Stabilization Care, and Urgent Care Services*****.** Medical Emergency Services, Post-Stabilization Care Services and Urgent Care services must be available 24 hours per day, seven days per week, including a 24-hour per day number for Enrollees to call in case of a Medical Emergency. The HEALTH PLAN shall not require Prior Authorization as a condition of providing a Medical Emergency Service. Nor shall the HEALTH PLAN require an Enrollee to receive a Medical Emergency or Post-Stabilization Care Service within the HEALTH PLAN's network. See Section 6.22.1.

Section 6.1.14. ***Medical Supplies and Equipment.*** Replacement of lost, stolen or irreparably damaged hearing aids for an Enrollee who is 21 years of age or older may be limited to two replacements in a five-year period.

Section 6.1.15. ***Medical Transportation Services.*** Also see Section 6.6. for Common Carrier Transportation Services. Medical transportation services includes:

A. Ambulance services required for Medical Emergency care;

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

C. Transportation to service delivery sites for Nursing Facility and elderly high rise residents when in-home or on-site services are not available (which are not covered for MinnesotaCare Enrollees).

Section 6.1.16. ***Mental Health Services.*** In approving and providing mental health services, the HEALTH PLAN shall use a definition of Medical Necessity that is no more restrictive than the definition of Medical Necessity found in Minnesota Statutes, Section 62Q.53 or described in Section 2.32.

A. ***General Mental Health Services.*** Mental health services must be provided in accordance with Minnesota Rules, Part 9505.0323 (MA payment for outpatient mental health services). Mental health services should be directed at rehabilitation of the client in the least restrictive clinically appropriate setting. The HEALTH PLAN must ensure that the following services are available to its Enrollees:

1.) Diagnostic assessment, psychological testing, and explanation of findings to establish or rule out the appropriate MI diagnosis and develop the individual treatment plan. A psychiatric assessment must include the direct assessment of the Enrollee.
2.) Crisis intervention (phone and walk-in).
3.) Day treatment, partial hospitalization, and in-home family based mental health services.
4.) Individual, family, and group therapy and multiple family group psychotherapy, including counseling related to adjustment to physical disabilities or chronic illness.
5.) Inpatient and outpatient treatment.
6.) Assessment of Enrollees whose health care seeking behavior and/or mental functioning suggests underlying mental health problems.
7.) Neuropsychological assessment.
8.) Neuropsychological rehabilitation and/or cognitive remediation training for Enrollees with a diagnosed neurological disorder who can benefit from cognitive rehabilitation services.
9.) Medication management.
10.) Therapeutic Support of Foster Care.
11.) Family Community Support Services.

B. ***Court-Ordered Treatment.*** The following procedures apply to mental health services that are court-ordered.

1.) When a person is ordered held or other care or treatment is ordered, pursuant to Minnesota Statutes, Section 253B.05, Subdivision 1 and 2 and 253B.07, Subdivision 2b, by a court for a MA Recipient who is enrolled in the HEALTH PLAN, the HEALTH PLAN must do an assessment to determine Medical Necessity. Pursuant to Minnesota Statutes, Section 253B.11, Subdivision 2, when the confinement of an Enrollee is provided at a STATE regional treatment center, the HEALTH PLAN shall be responsible for the Enrollee's Medically Necessary hospitalization.

2.) The HEALTH PLAN must provide a 24-hour telephone number answered in-person that a County may call to get an expeditious response to situations involving the HEALTH PLAN'S Enrollees where court ordered treatment and disability certification are involved.

3.) County social workers or probation officers who are involved in making a recommendation to the court regarding a treatment plan for a HEALTH PLAN Enrollee must obtain the approval of the HEALTH PLAN prior to initiating a diagnostic evaluation, recommendation, or referral for treatment, in order to get paid by the HEALTH PLAN. If the County social workers or probation officers can document that the HEALTH PLAN has been contacted in a manner mutually agreed upon by the HEALTH PLAN and the county, and there has been no response from the HEALTH PLAN within 48 hours of receipt of the request for approval of the treatment plan, the treatment plan shall be deemed approved by the HEALTH PLAN.

4.) When the HEALTH PLAN is made aware of the court ordered treatment, but only after an assessment or evaluation by an Out of Plan provider has been performed, the plan must review the assessment/evaluation and if it disagrees with the results, it must conduct its own assessment. If, after performing its own assessment/evaluation, the HEALTH PLAN determines that the services are not Medically Necessary, the HEALTH PLAN will not be responsible for providing the services. The HEALTH PLAN must provide its Enrollees with a notice indicating that the services have been denied and the specific reason for the denial.

5.) When an organization outside of the HEALTH PLAN does the assessment/evaluation and the HEALTH PLAN reviews and agrees with the recommended treatment, the HEALTH PLAN is then responsible for providing the treatment through its provider network, or at its option, it may authorize a referral for the Out of Plan provision of the services. The HEALTH PLAN shall communicate its treatment plan and discharge plans with the county social workers and probation officers.

6.) Pursuant to Minnesota Statutes, Section 256B.19, Subdivision 1, when the HEALTH PLAN has not been consulted in court ordered treatment and Out of Plan treatment is recommended, the HEALTH PLAN is not responsible for payment of the court ordered treatment, the county will bear the full financial responsibility in such cases. If the County social workers or probation officers can document that the HEALTH PLAN has been contacted in a manner mutually agreed upon by the HEALTH PLAN and the county, and there has been no response from the HEALTH PLAN within 48 hours of receipt of the request for approval of the treatment plan, the treatment plan shall be deemed approved by the HEALTH PLAN.

Section 6.1.17. ***Nurse Practitioner Services.*** Nurse Practitioner services are services provided by a certified pediatric, adult, geriatric, family, obstetric/gynecological (OB/GYN), or neonatal nurse practitioner.

Section 6.1.18. ***Nursing Facility Services.*** Beginning the date specified in Section 4.6.1., the HEALTH PLAN shall provide Nursing Facility services for those MA Enrollees age 65 and over who are not residing in a Nursing Facility at the time of enrollment into PMAP. The HEALTH PLAN may limit coverage of Nursing Facility services to 90 days. The HEALTH PLAN is not responsible for covering Nursing Facility services, except as described in this Section and Section 4.6.

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

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

B. ***Prenatal Care Services.*** The HEALTH PLAN must perform the following tasks:

1.) All pregnant Enrollees must be screened during their initial prenatal care office visit. The purpose of the screening is to determine the Enrollee's risk of poor pregnancy outcome as well as to establish an appropriate treatment plan, including enhanced health services if the Enrollee is an at-risk Pregnant Woman as defined in Minnesota Rules, Part 9505.0353. A referral to the Women, Infants, Children Supplemental Food and Nutrition Program (WIC) must be made when WIC assessment standards are met.

2.) The HEALTH PLAN must ensure that DHS Form # 3294, also known as the Minnesota Pregnancy Risk Assessment Form ("MPAF"), is completed at the initial prenatal visit and at the office visit nearest the 28th week of pregnancy. This form must be retained in the Enrollee's medical record. The HEALTH PLAN shall submit to the STATE completed forms electronically in a format determined by the STATE no later than 30 days after each quarter for the prenatal visits described above that the HEALTH PLAN received during the quarter.

3.) Those women who are identified as at-risk, according to an approved STATE assessment form, must be offered enhanced perinatal services. Enhanced perinatal services include: at-risk antepartum management, care coordination, prenatal health education, prenatal nutrition education, and a postpartum home visit.

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

Section 6.1.21. ***Personal Care Attendant (PCA) Services.***

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

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

Section 6.1.24. ***Prescriptions Drugs and Over-the-Counter Drugs.*** Covered prescription and over-the-counter drugs prescribed by a provider who is licensed to prescribe drugs within the scope of his/her profession and dispensed by a provider who is licensed to dispense drugs within the scope of his/her profession, which are contained in the MA Drug Formulary or that are the therapeutic equivalent to MA formulary drugs. If the prescription indicates "brand necessary" or to dispense as written (DAW), the HEALTH PLAN must provide the drug as written, even if there is a generically equivalent drug and even if the drug has a therapeutic equivalent in the HEALTH PLAN's formulary.

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

Section 6.1.26. ***Public Health Services.*** Public health clinic services and public health nursing clinic services as they are described in Chapter 8 of the Provider Manual which is incorporated herein by reference. Also see Section 9.2.8.

Section 6.1.27. ***Rehabilitation and Therapeutic Services.*** Rehabilitation and therapeutic services (related to evaluation and treatment) include:

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

B. speech therapy (including specialized maintenance therapy;

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

D. audiology; and

E. respiratory therapy.

Section 6.1.28. ***Transplants.*** Covered organ and tissue transplants: heart, liver, bone marrow, stem cell, kidney, lung, heart-lung, cornea, pancreas, intestine, pancreatic islet cell, and other Transplants or diagnoses that Medicare covers or the STATE accepts upon recommendation of the Transplant Advisory Committee, and upon 60 days notice by the STATE. Coverage shall be limited to the conditions as covered under Minnesota Statutes, Sections 256B.0625 and 256B.0629, as Medicare covers them, and as the STATE accepts the recommendations of the Transplant Advisory Committee.

Section 6.1.29. ***Tuberculosis-Related Services.*** Tuberculosis related services includes Care Management and direct observation of the intake of drugs prescribed to treat tuberculosis. The HEALTH PLAN shall use the Local Agency's public health nursing as a preferred provider for direct observation of the intake of drugs prescribed to treat tuberculosis. The HEALTH PLAN shall communicate to medical care providers that non-compliant tuberculosis patients should be referred to the Local Agency's public health agency for direct observed therapy. The HEALTH PLAN agrees to work with the PMAP Public Health Goals Workgroup regarding communication between providers, the HEALTH PLAN and public health agencies about non-compliant tuberculosis patients.

Section 6.1.30. ***Vaccines and Immunizations.*** Covered vaccines and immunizations include, but are not limited to recommendations by the Minnesota Department of Health.

Section 6.1.31. ***Vision Care Services.*** Vision care services includes vision examinations, eyeglasses, and optician, optometrist and ophthalmologist services. Eyeglasses, sunglasses and contact lenses shall be provided only if prescribed by or through the HEALTH PLAN participating physicians or participating optometrists. The HEALTH PLAN must make available a reasonable selection of eyeglass frames, but is not required to make available an unlimited selection. Replacement of lost, stolen or irreparably damaged eyeglasses, sunglasses, and contact lenses may be covered upon a showing of Medical Necessity and may be limited to the replacement of the same frames.

Section 6.2. ***GAMC Covered Services.*** The HEALTH PLAN shall provide, or arrange to have provided to Enrollees comprehensive preventive, diagnostic, therapeutic and rehabilitative health care services as defined in Minnesota Statutes, Section 256D.03. Except for Section 6.2.16, these services shall be provided to the extent that this law was in effect on the effective day of this contract. These services shall include, but are not limited to, the following.

Section 6.2.1. ***Care Management***, as specified in Section 6.1.1.

Section 6.2.2. ***Chemical Dependency Treatment Services***, as specified in Section 6.1.2.

Section 6.2.3. ***Chiropractic Services***.

Section 6.2.4. ***Dental Services,*** as specified in Section 6.1.6.

Section 6.2.5. ***Family Planning Services***, as specified in Section 6.1.7.

Section 6.2.6. ***Hearing Aids, Prosthetic and Orthotic Devices***. Replacement of lost, stolen or irreparably damaged hearing aids for an Enrollee who is 21 years of age or older may be limited to two replacements in a five-year period.

Section 6.2.7. ***Inpatient and Outpatient Hospital Services.*** Coverage for Inpatient Hospital services shall not exceed the actual semi-private room rate, unless a private room is determined to be Medically Necessary by the HEALTH PLAN.

Section 6.2.8. ***Interpreter Services***, as specified in Section 6.1.11.

Section 6.2.9. ***Laboratory, Diagnostic and Radiological Services***.

Section 6.2.10. ***Medical Emergency, Post-Stabilization Care and Urgent Care Services***, as specified in Section 6.1.13.

Section 6.2.11. ***Medical Supplies and Equipment***, including those necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar levels.

Section 6.2.12. ***Medical Transportation*** services, as specified in Section 6.1.15, except that 6.1.15.B is covered only for Enrollees who reside in an IMD.

Section 6.2.13. ***Mental Health Services***, as specified in Section 6.1.16.

Section 6.2.14. ***Nurse Practitioner Services.*** Services provided by a certified family, adult, geriatric, pediatric, obstetrical/gynecological (OB/GYN) or neonatal nurse practitioner.

Section 6.2.15. ***Physician, Clinic and Community Health Clinic Services,*** including Telemedicine Consultations. Coverage of Telemedicine Consultations is limited to three Telemedicine Consultations per Enrollee per week.

Section 6.2.16. ***Prescription Drugs and Over-the-Counter Drugs.*** Covered prescription and over-the-counter drugs prescribed by a provider licensed in Minnesota to prescribe drugs within the scope of his or her profession and dispensed by a provider who is licensed in Minnesota to dispense drugs within the scope of his or her profession, which are contained in the Medical Assistance Drug Formulary or are the therapeutic equivalent of MA formulary drugs, with the exception of Silfenadil (Viagra). If the physician indicates "brand necessary" or to dispense as written (DAW), the HEALTH PLAN must provide the drug as written, even if there is a generically equivalent drug and even if the drug has a therapeutic equivalent in the HEALTH PLAN's formulary.

Section 6.2.17. ***Public Health Nursing Clinic Services.*** Services of a certified public health nurse or a registered nurse practicing in a Public Health Nursing Clinic as they are described in Chapter 8 of the Provider Manual which is incorporated herein by reference.

Section 6.2.18. ***Rehabilitative Services*** by a Medicare-certified agency.

Section 6.2.19. ***Vision Care Services***, specified in Section 6.1.32.

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

Section 6.3.1. ***MinnesotaCare/MA Enrollees***. The HEALTH PLAN shall provide, or arrange to have provided to MinnesotaCare/MA Enrollees comprehensive preventive,

diagnostic, therapeutic and rehabilitative health care services as defined in Minnesota Statutes, Section 256B.0625 and Minnesota Rules, Parts 9505.0170 to 9505.0475. Except for Sections 6.1.24. and 6.1.28., these services shall be provided to the extent that the above law and rules were in effect on the effective day of this Contract.

Section 6.3.2. ***MinnesotaCare Enrollees.*** The HEALTH PLAN shall provide, or arrange to have provided to MinnesotaCare Enrollees the same services described in Section 6.1. above with the following modifications. Co-pays apply to some covered services as specified in section 4.3.3.

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

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

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

B. Dental services covered for preventive services only.

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

D. Outpatient mental health services covered are limited to diagnostic assessments, psychological testing, explanation of findings, medication management by a physician, day treatment, partial hospitalization, and individual, family, and group psychotherapy.

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

F. Non-emergency medical transportation is not covered.

G. Nursing Facility services are not covered.

Section 6.4. ***Alternative Services Permitted.*** To the extent consistent with Minnesota Statutes, Chapter 256B and Sections 256L.03, et seq., and 256D.03, Subdivision 4(b), the HEALTH PLAN shall have the right, in its discretion, to pay for or provide alternative health services if such services are, in the judgement of the HEALTH PLAN, medically appropriate and cost-effective; provided, however, that it is understood that the provision of any such services shall not affect the calculation of capitation rates pursuant to Article 4.

Section 6.5. ***Additional Services Permitted.*** The HEALTH PLAN may provide or arrange to have provided services in addition to the services described in Article 6, Sections 6.1., 6.2., and 6.3., as permitted through waivers granted by the U.S. Department of Health and Human Services-Health Care Financing Administration under Title XI, Section 1115 of the Social Security Act, for Enrollees for whom, in the judgment of the HEALTH PLAN's Care Management staff, the provision of such services is Medically Necessary; provided, however, that it is understood that the provision of any such services shall not affect the calculation of capitation rates pursuant to Article 4.

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

Section 6.6.1. ***General.*** In addition to the medical transportation services described in Section 6.1.15., and except for the services described in Section 6.6.2., the HEALTH PLAN shall provide Common Carrier Transpiration to its MA and GAMC Enrollees for the purpose of obtaining health care services. The STATE will provide Common Carrier Transpiration services to MinnesotaCare/MA Enrollees.

Section 6.6.2. ***Common Carrier Transportation Which is Not the Responsibility of the HEALTH PLAN.*** The Local Agency shall remain responsible for reimbursing the Enrollee or the Enrollee's driver for mileage to non-emergency covered services, and meals and lodging as necessary. The HEALTH PLAN shall not be responsible for providing Common Carrier Transpiration in any situation where the Enrollee has access to private automobile transportation to a non-emergency service covered under this Contract. The Local Agency shall remain responsible for providing non-emergency transportation to medical services located outside of Minnesota that have been approved by the HEALTH PLAN.

Section 6.6.3. ***Metro Area Transportation.*** The STATE shall reimburse the HEALTH PLAN on a capitation basis for transporting an Enrollee to or from the site of a non-emergency service covered under this Contract in the metropolitan counties, pursuant to Minnesota Statutes, Section 256B.691.

Section 6.6.4. ***Non-Metro Area Transportation.*** Non-Metro Area transportation is transportation to receive non-emergency medical and dental services covered under this Contract. Payment for non-Metro Area transportation is not included in the capitation payments in Article 4.

A. ***Payment.***

1.) ***Only Public Transportation Available***. For transportation services provided in a non-Metro Area where there is only Common Carrier Transpiration available to the general public, the STATE will pay no more than that charged by the common carrier to the public for similar services.

2.) ***Only Non-Profit Community Service Transportation Available***. For transportation services provided in a non-Metro Area where there is no available Common Carrier Transpiration that is available to the general public, but where there is Common Carrier Transpiration available from a non-profit community service entity which provides the service to the public, the STATE will pay the HEALTH PLAN no more than that charged by the non-profit entity to the public for the similar services.

3.) ***Both Public and Non-Profit Services Available.*** For transportation services provided in a non-Metro Area where both public transportation and non-profit community service transportation are available, the STATE will pay the lower of the two rates. In situations where the lower cost form of transportation is inappropriate for an Enrollee's needs, or is unavailable at the time the Enrollee needs the transportation, the STATE will pay the higher rate.

B. ***Billings.*** The HEALTH PLAN must submit monthly invoices in a format prescribed by the STATE. The HEALTH PLAN will not submit bills to the STATE which exceed the payment rates above. The HEALTH PLAN shall submit to the STATE all costs for a month in a single invoice submission. The STATE will make a warrant request within 30 days of receipt of all necessary documentation from the HEALTH PLAN. All required documentation must be submitted monthly within three calendar months of the month the transportation trip is provided. No payment will be made by the STATE if documentation submission exceeds this time line.

1.) ***Review and Reconciliation.*** The HEALTH PLAN shall submit to the STATE 120 days after the end of the contract year an annual independent review by an accounting firm using agreed-upon procedures. Such review shall not be completed by HEALTH PLAN employees. Such requirement does not prohibit the HEALTH PLAN from compiling the required documentation prior to submitting it for the independent review. Such review shall consist of a reconciliation of the invoice detail submitted for reimbursement by the HEALTH PLAN to the STATE with the invoice totals paid to transportation providers by the HEALTH PLAN for transportation trips for its Enrollees. The review shall include a random sample of 10% of the total transportation trips or 100 transportation trips, whichever is less, that were provided over the contract year for which client health plan membership and health care service delivery are verified for the date of the trip. The STATE, at its option, may require reasonable additional supporting documentation from the HEALTH PLAN related to the annual independent review.

2.) ***Recovery of Payment Upon Review.*** The STATE shall make a warrant request within 30 days of receipt of the independent review for any payment due the HEALTH PLAN as indicated by the findings. The STATE shall offset any overpayment to the HEALTH PLAN indicated by the findings against the next payment due the HEALTH PLAN by the STATE.

Section 6.7. ***Deficiencies.***

Section 6.7.1. ***Quality of Services.*** If the STATE or HCFA finds that the quality of services offered by the HEALTH PLAN is materially deficient, the STATE has the right to terminate this Contract pursuant to Section 5.2.3.B. or to enforce remedies pursuant to Section 5.3.

Section 6.7.2. ***Failure to Provide Services.*** The HEALTH PLAN shall be subject to one of the remedies listed in Section 5.3.4. if the HEALTH PLAN fails substantially to provide Medically Necessary items and services that are required to be provided to an individual covered under this Contract, if the failure has adversely affected or has a substantial likelihood of adversely affecting the individual.

Section 6.8. ***Vaccines for Children.*** The HEALTH PLAN agrees to participate in the Vaccines for Children (VFC) immunization program, pursuant to 42 U.S.C., Section 1396s. The HEALTH PLAN will collaborate as reasonably requested with public health agencies to ensure childhood immunizations to all enrolled families with Children, pursuant to Minnesota Statutes, Section 256L.12, Subdivision 10.

Section 6.9. ***Limitations on Health Plan Services.***

Section 6.9.1. ***Medical Necessity.*** Unless otherwise provided in this Contract, the HEALTH PLAN shall be responsible for the provision and cost of health care services as described in Section 6 only when such services are deemed to be Medically Necessary by the HEALTH PLAN.

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

Section 6.9.3. ***Nursing Facility Per Diem Services.*** Nursing Facility Per Diem services which are not a covered service under 6.1.18. or authorized by a HEALTH PLAN are not a covered service.

Section 6.10. ***Special Education Services.*** The HEALTH PLAN may not deny the provision of or payment for medically necessary medical services for which the HEALTH PLAN is otherwise responsible under this contract, solely because, pursuant to Section 6.11.8., those services are or could be included in a Child's individualized education program, or an infant's or toddler's individualized family service plan, adopted pursuant to parts B and H of the Individuals with Disabilities Education Act, Public Law No. 105-17 (June 4, 1997), amending 20 U.S.C. 1400 et seq. (1996).

Section 6.11. ***Services Not Covered By This Contract.*** Although the HEALTH PLAN may provide the following services, the prepaid capitation rate does not include payment for the following services, and therefore the HEALTH PLAN is not required to provide them.

Section 6.11.1. ***Federal and State Institutions.*** All claims arising from services provided by institutions operated or owned by the federal government, a STATE regional treatment center, a state-owned long term care facility, or an institution for mental disease (IMD) unless the services are approved by the HEALTH PLAN.

Section 6.11.2. ***Cosmetic Procedures or Treatment.*** Cosmetic procedures or treatment are not covered, except that the following services are not considered cosmetic and therefore must be covered: services necessary as the result of injury, illness or disease, or for the treatment or repair of birth anomalies.

Section 6.11.3. ***Incidental Services.*** Incidental services are not covered, including but not limited to rental of television or telephone, barber and beauty services, and guest services that are not Medically Necessary.

Section 6.11.4. ***Mental Health Case Management.*** Mental health case management services for persons with serious and persistent mental illness, according to Minnesota Rules, Parts 9520.0900 to 9520.0926, and mental health case management for Children with severe emotional disturbances according to Minnesota Rules, Part 9505.0322 are not covered.

Section 6.11.5. ***Waivered Services.*** Waivered services provided under home-based and community-based waivers authorized under 42 U.S.C., Section 1396 are not covered, except as provided in Section 6.1.8.

Section 6.11.6. ***Fertility Drugs and Procedures.*** Fertility Drugs are not covered when specifically used to enhance fertility. The following procedures also are not covered: in vitro fertilization, artificial insemination, and reversal of a voluntary sterilization.

Section 6.11.7. ***Gender Reassignment Surgery.*** Gender reassignment surgery and other gender reassignment medical procedures including drug therapy are not covered unless the Enrollee began receiving such services prior to July 1, 1998. Such services are not covered for PGAMC Enrollees unless the Enrollee began receiving them prior to July 1, 1995.

Section 6.11.8. ***IEP and IFSP Services***. Medically Necessary MA services that would otherwise be covered by this contract, identified in an Enrollee's Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) and provided by school districts are not covered.

Section 6.11.9. ***Other.*** All other exclusions set forth in Minnesota Statutes, Section 256B.0625, Minnesota Statutes, Section 256B.69, Minnesota Rules, Part 9505.0170 to 9505.0475, and Minnesota Rules, Part 9500.1450 to 9500.1464 are not covered.

Section 6.12. ***Enrollee Liability.*** The HEALTH PLAN, and its subcontractor, agrees that, except for Section 4.3.3., the Enrollee shall not be billed or be held responsible in any way for any charges, including copayments or deductibles, for Medically Necessary covered services or services provided as alternatives to covered services as part of the HEALTH PLAN's Care Management plan. Also see Section 9.2.11. If the HEALTH PLAN or its subcontractor violates 42 U.S.C. Section 1320a-7b(d)(1), the HEALTH PLAN and subcontractor may be subject to criminal penalties. In addition, the HEALTH PLAN shall not make payment to an Enrollee in reimbursement for a service provided under this Contract where the provider of the service refuses to accept assignment. See 42 CFR 447.25.

Section 6.13. ***Fair Access to Care.*** The HEALTH PLAN agrees that the health care services listed in Article 6 will be available to Enrollees during normal business hours to the same extent available to the general population.

Section 6.14. ***Around-the-Clock Access to Care.*** The HEALTH PLAN shall make available to Enrollees access to Medical Emergency Services, Post-Stabilization Care Services and Urgent Care on a 24-hour, seven-day-per-week basis. The HEALTH PLAN must provide a 24-hour, seven day per week HEALTH PLAN telephone number that is answered in-person by the HEALTH PLAN or an agent of the HEALTH PLAN; this telephone number must be provided to the STATE. The HEALTH PLAN is not required to have a dedicated telephone line.

Section 6.15. ***Serving Minority and Special Needs Populations*****.** The HEALTH PLAN must offer appropriate services for the following special needs groups. Services must be available within the HEALTH PLAN or through contractual arrangements with providers to the extent that the service is a covered service pursuant to this Article.

Section 6.15.1. ***Seriously and Persistently Mentally Ill (SPMI)***: ongoing medications review and monitoring, day treatment, and other alternatives to conventional therapy, and coordination with the individual's case management service provider to assure appropriate utilization of all needed psychosocial services.

Section 6.15.2. ***Elderly, Physically Handicapped and Chronically Ill:*** in-home services, neurological assessments.

Section 6.15.3. ***Abused Children and Adults, Abusive Individuals:*** comprehensive assessment and diagnostic services and specialized treatment techniques for victims and perpetrators of maltreatment (physical, sexual, emotional).

Section 6.15.4. ***Enrollees With Language Barriers:*** interpreter services, bilingual staff, culturally appropriate assessment and treatment. When an individual is enrolled in PMAP, the enrollment form will indicate whether the Enrollee needs the services of an interpreter and what language she/he speaks. Upon receipt of enrollment information indicating interpreter services are needed, the HEALTH PLAN shall contact the MA, GAMC or MinnesotaCare/MA Enrollee by phone or mail in the appropriate language to inform the

Enrollee how to obtain primary care services. In addition, whenever an Enrollee requests an interpreter in order to obtain health care services, the HEALTH PLAN must provide the Enrollee with access to an interpreter, pursuant to Section 6.1.11.

Section 6.15.5. ***Cultural and Racial Minorities:*** culturally appropriate services rendered by providers with special expertise in the delivery of health care services to the various cultural and racial minority groups.

Section 6.15.6. ***Dual MI/Developmentally Disabled (DD) or MI/CD clients:*** comprehensive assessment, diagnostic and treatment services provided by staff who are trained to work with clients with multiple disabilities and complex needs.

Section 6.15.7. ***Lesbians and Gay Men:*** sensitivity to critical social and family issues unique to lesbians and gay men.

Section 6.15.8. ***Hearing Impaired:*** access to TDD and hearing impaired interpreter services.

Section 6.15.9. ***Enrollees in Need of Gender Specific Mental Health and/or Chemical Dependency Treatment:*** The HEALTH PLAN must provide its Enrollees with an opportunity to receive mental health and/or chemical dependency services from the same sex therapist and the option of participating in an all male/all female group therapy program.

Section 6.15.10. ***Children and Adolescents. Including Severely and Emotionally Disturbed (SED) Children and Children Involved in the Child Protection System:*** services specific to the needs of these groups, including day treatment, home-based mental health services, and inpatient services. The services which the HEALTH PLAN delivers must be provided in the least restrictive clinical setting, individualized to meet the specific needs of each Child, and designed to provide early identification and treatment of mental illness. The HEALTH PLAN must coordinate services with the Child's county case management service provider(s).

Section 6.15.11. ***Developmentally Disabled (DD):*** specialized mental health and rehabilitative services and other appropriate services covered by MA. Such services may include: Family Planning Services adapted to the special needs of the developmentally disabled population, behavior management, rehabilitative and therapeutic services, pain management, or genetic counseling. After an initial assessment, a written treatment plan must be developed for the Enrollee when appropriate. As required, the treatment plans should provide access to a coordinated outpatient rehabilitation team, independent living skills training, , and services designed to maintain or increase function and prevent further deterioration or dependency. The treatment plan should be coordinated with available community resources and support systems, including the Enrollee's county DD case management service provider. The treatment plan must identify the persons responsible for providing services and a case management service provider. For those Enrollees with multiple handicaps, a multi-disciplinary provider consultation should be arranged. Although

continuity of care should be a major consideration in the treatment planning process, referrals to specialists and sub-specialists must be made when medically indicated.

Section 6.15.12. ***Visually Impaired:*** all membership materials must include the following statement: "If you ask, we will give you this information in another form, such as Braille, large print, or on audio tape".

Section 6.15.13. ***American Indians:*** culturally appropriate services rendered by providers with special expertise in the delivery of health care services to the various tribes.

Section 6.16. ***Client Education.*** The HEALTH PLAN will advise Recipients enrolled in its health care plan of the appropriate use of health care and the contributions they can make to the maintenance of their own health.

Section 6.17. ***Primary Care Provider.*** The HEALTH PLAN will reasonably provide each Enrollee with a choice of a primary care health professional who will coordinate the Enrollee's care.

Section 6.18. ***Geographic Accessibility of Providers.*** In accordance with Minnesota Rules, Part 4685.1010, Subpart 3, the HEALTH PLAN must demonstrate that its provider network is geographically accessible to Enrollees in its Service Area. For purposes of this Section, "geographically accessible" means, for Primary Care Providers, Mental Health providers, and general hospitals, no more than 30 miles travel distance or 30 minutes travel time between provider location and Enrollee residence, and, for all other ancillary providers and specialty hospitals, no more than 60 miles travel distance and 60 minutes travel time between provider location and Enrollee residence. The HEALTH PLAN will be in compliance with this Section if it has received a waiver from the Minnesota Department of Health in areas where it cannot meet this standard.

Section 6.19. ***Direct Access to Obstetricians and Gynecologists.*** Pursuant to Minnesota Statutes, Section 62Q.52, the HEALTH PLAN shall provide Enrollees direct access without a referral or Prior Approval to the following obstetric and gynecologic services: annual preventive health examinations and any subsequent obstetric or gynecologic visits determined to be Medically Necessary by the examining obstetrician or gynecologist; maternity care; and evaluation and necessary treatment for acute gynecologic conditions or emergencies. Direct access shall apply to obstetric and gynecologic providers within the Enrollee's network or care system, including any providers with whom the HEALTH PLAN has established referral patterns.

Section 6.20. ***Services Received at Indian Health Service and Tribal Providers.*** This Section applies when the STATE begins enrollment of American Indians under Section 3.1.1.C.(14). American Indian PMAP and PGAMC Enrollees -- living on or off a reservation -- shall have direct access to services provided at Indian Health Service (IHS) facilities and facilities (also known as 638 facilities or providers) operated by a tribe or tribal organization under funding authorized by United States Code, title 25, Sections 450f to 450n, or title III of the Indian Self-

Determination Act, Public Law Number 93-638, even if such facilities are not Participating Providers, for services which are otherwise covered under Minnesota Statutes, Section 256B.0625. The HEALTH PLAN shall not require any Prior Approval or impose any condition for an American Indian to access services at such facilities. "American Indian" under this Section describes those persons for whom services may be provided pursuant to 42 C.F.R. Section 36.12.

Section 6.20.1. ***Referrals from IHS and 638 Providers.*** When a physician in a facility described in Section 6.20. refers an American Indian PMAP or PGAMC Enrollee to a Participating Provider for services covered under this Contract, the HEALTH PLAN shall not require the Enrollee to see a Primary Care Provider prior to the referral. The Participating Provider to whom the IHS or 638 physician refers the Enrollee may determine that services are not Medically Necessary or not covered .

Section 6.20.2. ***Payment for IHS and Tribal Services.*** Except for facilities with which the HEALTH PLAN has a contract, the STATE shall pay facilities described in Section 6.20. directly on a fee-for-service basis for services provided to American Indian PMAP and PGAMC Enrollees. The STATE shall obtain reimbursement from the HEALTH PLAN, on an annual basis and through reasonable means, for payments to IHS and 638 facilities for services provided to Enrollees that would be covered under this Contract, however the financial liability of the HEALTH PLAN for these services, in aggregate for all Enrollees who utilized the facilities described in 6.20. during the Contract Year, shall be limited to 40% of the aggregate annual capitated payment amount for these Enrollees. The HEALTH PLAN retains liability for all services for Enrollees who do not utilize the services in Section 6.20. The STATE shall provide the HEALTH PLAN with a statement of encounters by Enrollees, which shall describe the date of service, the Recipient, and the diagnosis code, prior to any payment by the HEALTH PLAN to the STATE.

Section 6.21. ***Prior Authorization.***

Section 6.21.1. ***General Exemption.*** The HEALTH PLAN is exempt from STATE Prior Authorization and second surgical opinion procedures at Minnesota Rules, Part 9505.5000 to 9505.5105, and from certification for admission requirements at Minnesota Rules, Part 9505.0500 to 9505.0540.

Section 6.21.2. ***Medical Necessity Standard.*** The HEALTH PLAN may prior authorize services, except for Medical Emergency Services and services as described in Section 6.20. Authorization shall be based on Medical Necessity, pursuant to Section 2.32., and, in the case of mental health services, shall also be based on Minnesota Statutes, Section 62Q.53.

Section 6.22. ***Out of Network and Transition Services.***

Section 6.22.1. ***Out of Network Services.*** The HEALTH PLAN shall cover Medically Necessary Out of Plan or Out of Area services received by an Enrollee when one of the following occurs.

A. The Enrollee requires Medical Emergency Services.

B. The Enrollee requires Post-Stabilization Care Services, and (i) the HEALTH PLAN prior authorized the services; (ii) the HEALTH PLAN did not prior authorize the services because it did not respond to the request by the provider of Post-Stabilization Care Services for Prior Authorization within 1 hour after the HEALTH PLAN was asked to prior authorize care; or (iii) the HEALTH PLAN could not be contacted to prior authorize services. Coverage shall extend until the HEALTH PLAN has contacted the provider of post-stabilization care to arrange a discharge or transfer.

C. The Enrollee is Out of Area and requires Urgent Care.

D. The Enrollee is Out of Area and in need of non-emergency medical services that are or have been prescribed, recommended or are currently being provided by a Participating Provider. The HEALTH PLAN may require Prior Authorization.

E. The Enrollee moves Out of Area and this change is entered on MMIS after the Cut-Off Date, and a payment has been or will be made to the HEALTH PLAN for coverage for the Enrollee for that same or next month. The HEALTH PLAN shall reimburse at no less than the MA or GAMC fee-for-service rate any services provided by non-Participating Providers to the Enrollee during the balance of the month or the month after which the Enrollee has moved. The HEALTH PLAN may condition reimbursement of these Out of Plan services on the Enrollee's requesting HEALTH PLAN approval or Prior Authorization to receive such services except for services needed to respond to a Medical Emergency.

F. Pregnancy-related services received in connection with an abortion.

Section 6.22.2. ***Transition Services.*** The HEALTH PLAN is responsible for care in the following situations.

A. Services Previously Prior Authorized. The HEALTH PLAN shall provide Enrollees Medically Necessary covered services that an Out of Plan provider, another health plan, or the STATE had prior authorized before enrollment in the HEALTH PLAN. The HEALTH PLAN may require the Enrollee to receive the services by a HEALTH PLAN provider, if such a transfer would not create undue hardship on the Enrollee, and is clinically appropriate. Transition services relating to orthodontia care, mental health services, at-risk pregnancy services, and chemical dependency services are covered as described in the below paragraphs of this Section.

B. Orthodontia Care. The HEALTH PLAN shall provide, for MA, GAMC, or MinnesotaCare/MA Enrollees, orthodontia care if (i) an Out of Plan provider or the

STATE has prior authorized such care, (ii) the care falls under an established plan of care, and (iii) the care plan has a definitive end date. Payment to the prior provider must be at least equivalent to the STATE MA fee-for-service rate for orthodontia care. In the alternative, the HEALTH PLAN may transfer the Enrollee to a HEALTH PLAN provider, if such a transfer would not create undue hardship on the Enrollee, and is clinically appropriate.

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

D. ***CD Services.*** Services that have been authorized by the Consolidated Chemical Dependency Treatment Fund (CCDTF) prior to the Recipient's enrollment in PMAP will continue to be reimbursed by the CCDTF through the duration of the period authorized. After the authorization period expires, the HEALTH PLAN will be responsible for providing all Medically Necessary services. For Enrollees who are in an inpatient hospital or a Rule 35 facility (i.e. extended care, halfway house or free-standing residential CD treatment facility [IMD]) at the time of enrollment in the HEALTH PLAN, the effective date of the enrollment will be delayed until the month following the Enrollee's discharge from the CD facility.

E. ***Mental Health Services.*** At the time of initial enrollment in PMAP, the HEALTH PLAN shall consider the individual Enrollee's prior use of mental health services and to develop a transitional plan to assist the Enrollee in changing mental health providers, should this be necessary, and to develop a plan to assure the need for continuity of care for any individual or family who is receiving ongoing mental health services. The HEALTH PLAN shall also develop a transitional plan for Children who have previously been excluded from PMAP because they have been involved in the Child protection system, placed in foster care or diagnosed as severely and emotionally disturbed. While excluded from PMAP, a treatment regimen may be initiated for those Children who are assessed as having behavioral or other mental health problems. However, because the duration of the exclusion from PMAP will vary from one Child to the next, some of these Children may be enrolled in the HEALTH PLAN before their treatment program is completed. As part of this

transition plan, the HEALTH PLAN should have a process to assure proper communication and coordination between the county social services agency and the HEALTH PLAN regarding the specific needs of each Child.

F. ***Enrollee Change of Major Program.*** The Enrollee was enrolled with the HEALTH PLAN in the same county, but under a different major program under this Contract; the HEALTH PLAN products do not have the same Participating Providers; and the Enrollee chooses to receive services from the Participating Providers from the prior enrollment with the HEALTH PLAN. The HEALTH PLAN must notify any affected Enrollee of his/her right to choose to remain with their original Participating Providers.

Section 6.22.3. ***Reimbursement Rate.*** When the HEALTH PLAN or a Participating Provider authorizes Out of Plan care or Out of Area care, the HEALTH PLAN shall reimburse the non-Participating Provider for the Out of Plan care or Out of Area care. The HEALTH PLAN is not obligated to reimburse the non-Participating Provider more than the comparable MA, GAMC or MinnesotaCare fee-for-service rate, unless another rate is required by law.

Section 6.23. ***Residents of Nursing Facilities***. If a medical service eligible for coverage under this Contract has been ordered by a participating physician or dentist for an Enrollee residing in a Nursing Facility, the HEALTH PLAN is responsible for providing the service and covering the cost of the service required by the physician's or dentist's order.

Section 6.24. ***Timeframe to Evaluate Requests for Services.***

Section 6.24.1. ***General Request for Services.*** The HEALTH PLAN must evaluate all requests for services, either by Participating Providers or Enrollees within 30 working days of receipt of all required information. The HEALTH PLAN must communicate its decision on all requests for services to the Enrollee or his or her authorized representative and the appropriate provider within three working days or sooner after a decision is made

Section 6.24.2. ***Request for Urgent Services.*** If the need for services is urgent or required to prevent institutionalization, the HEALTH PLAN must evaluate the request for services and communicate its decision to the Enrollee or authorized representative and the provider within an expedited time frame appropriate to the type of service and the need for service that has been requested by the Enrollee or requested on the Enrollee's behalf.

Section 6.24.3. ***Request for Mental Health and/or Chemical Dependency Services.*** The HEALTH PLAN must provide Mental Health and/or Chemical Dependency services in a timely manner. Enrollees requiring chemical dependency or mental health crisis intervention services should be seen immediately. Other Enrollees in need of mental health and chemical dependency services should have an appropriate assessment performed within two weeks.

Section 6.25. ***Public Health Goals.*** The HEALTH PLAN shall engage in the following public health activities, toward the achievement of public health goals.

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

1.) ***Response to Violence.*** By compiling and analyzing data from Minnesota Pregnancy Assessment Forms (MPAF) to determine the exposure of pregnant women to violence, the HEALTH PLAN will report its progress toward the goal of having 100% of participating medical clinics include assessments for family violence in their protocols, and the HEALTH PLAN's progress toward having participating medical clinics create care plans that connect clients to community resources.

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

a) The HEALTH PLAN will encourage medical clinics to enter into agreements with administrative entities for participation in the metropolitan immunization registry.

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

3.) ***Tobacco Use Prevention and Control.*** By undertaking the following activities the HEALTH PLAN will work toward the goal of a 30% reduction in tobacco use among young people (0-21 years) by the year 2005:

a) The HEALTH PLAN will work with local public health agencies to prepare and implement coordinated community-based tobacco use prevention plans, and to prepare and implement proposals for use of the tobacco prevention endowment funding.

b) The HEALTH PLAN will compile and analyze data from Minnesota Pregnancy Assessment Forms (MPAF) to assess the exposure of pregnant women to cigarette smoke.

B. For the Non-Metro Area, The HEALTH PLAN agrees to meet with the Local Agency to develop and discuss mutual objectives related to public health priorities.

Article 7. Quality Improvement.

Section 7.1. ***Internal System.*** The HEALTH PLAN shall provide for an internal quality assurance (QA) system consistent with federal requirements under Title XIX of the Social Security Act, and as required pursuant to Minnesota Statutes, Chapters 62D, 62M, 62N, and 256B.692 and related rules, including Minnesota Rules, Part 4685.1100 to 4685.1130. The HEALTH PLAN's system shall provide for review by appropriate health professionals of the process followed in the provision of health services, utilize a system for data collection of performance and patient results, provide interpretation of such data to the practitioners and provide for instituting needed changes with identified practitioners. The HEALTH PLAN shall utilize a Continuous Quality Improvement (CQI) model in supporting practitioner changes in practice patterns and administrative process. The HEALTH PLAN's QA system shall include documentation and appropriate review and/or conduct of:

Section 7.1.1. A randomly selected sample of all cases to identify problems or potential problem areas;

Section 7.1.2. Utilization of services, including but not limited to utilization of inpatient, outpatient and long term care services, including both institutional and non-institutional services, and emergency services;

Section 7.1.3. Sentinel events (e.g. birth and deaths);

Section 7.1.4. Unauthorized use of Out of Plan services;

Section 7.1.5. Medical records audits;

Section 7.1.6. Appropriate corrective actions;

Section 7.1.7. Focus studies; and

Section 7.1.8. Enrollee satisfaction surveys, measured by an annual Enrollee survey that meets STATE approval. The HEALTH PLAN shall conduct a satisfaction survey of Enrollees who received services from the HEALTH PLAN in 1999. The STATE recommends that the HEALTH PLAN use the Consumer Assessment of Health Plan Survey (CAHPS) instrument to conduct this survey. The HEALTH PLAN must provide the STATE with these survey results, as well as the framing of the questions and sampling techniques used to conduct the survey. The HEALTH PLAN shall participate in surveys conducted by the STATE, or its designee, in the manner required by Minnesota Statutes, Chapter 62J, and such participation shall meet the requirements of this Section. The HEALTH PLAN shall cooperate with the STATE or its designee in data collection activities as directed by the STATE.

Section 7.2. ***Inspection.*** The HEALTH PLAN shall provide that the STATE and HCFA or their agents may evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under this contract.

Section 7.3. ***External Quality Review Organization Study.*** The HEALTH PLAN shall cooperate with the entity as arranged for by the STATE in an annual independent, external review of the quality of services furnished under this Contract, as required under 42 U.S.C. Section 1396a(a)(30); such cooperation shall include, but is not limited to providing requested medical records, data in the requested format, a copy of the sample selection logic used to frame the sample or obtain the administrative data, and other records and/or data necessary for the external review.

Section 7.3.1. ***Review of Study Report Prior to Publication.*** The STATE shall provide a draft copy of an external quality review study report completed under this Section to the HEALTH PLAN for review prior to the date of publication. The HEALTH PLAN shall provide the STATE any written comments about the study report, including comment on its scientific soundness or statistical validity, within 30 days of receipt of the study report. The STATE shall include a summary of the HEALTH PLAN's written comments in the final publication of the study report.

Section 7.4. ***HEDIS Measures***. The HEALTH PLAN shall report Health Plan Employer Data Information Set (HEDIS 2000) use of service and effectiveness of care measures based on 1999 data to the Minnesota Department of Health (MDH) for Enrollees, on a date that is consistent with the Minnesota Department of Health's 2000 reporting requirement. For those effectiveness of care measures that allow a choice of administrative or hybrid specifications, the HEALTH PLAN will indicate to the STATE the choice utilized.

Section 7.5. ***Performance Improvement.*** The HEALTH PLAN shall provide the following:

Section 7.5.1. An annual report, due to the STATE before April 15, 2000, detailing the HEALTH PLAN's progress toward meeting the federal EPSDT (Child and Teen Check-ups) requirement of 80% participation for well-Child visits, as it pertains to the Enrollees covered by this Contract during 1999.

Section 7.5.2. A final report due to the STATE by August 31, 2000, detailing the HEALTH PLAN's performance improvement efforts and results in the area of access to mental health services by Children and Adults, and in the area of preventive dental visits for Children, as they relate to the Enrollees covered by this Contract. The HEALTH PLAN shall follow the guidelines and specifications developed by the STATE for the report.

Section 7.6. ***Financial Performance Incentives.*** The HEALTH PLAN will be eligible for a financial performance incentive payment in an amount based on the HEALTH PLAN's reported participation rate for C&TC/EPSDT screenings as reported in encounter data under Section 3.5.1.

Section 7.6.1. ***Withhold.*** The STATE shall withhold one percent of those MA and MinnesotaCare capitation rates paid to the HEALTH PLAN under this Contract, which are identified in Appendix A and B as Rate Cells that include families, Children, and Pregnant Women.

Section 7.6.2. ***Repayment of Withhold.*** The STATE shall disburse to the HEALTH PLAN payment from the capitation amounts withheld under Section 7.6.1., pursuant to the criteria in the table below for determining the amount of the disbursement. Participation rates shall be based on encounter data submitted by the HEALTH PLAN no later than May 31, 2001 for screenings with dates of service in 2000. The STATE shall repay the HEALTH PLAN the withhold payment, if any, within 30 days after the finalization of the encounter data submissions.

C&TC Screening Participation Rate	Percent of Withheld Funds Disbursed
45-100%	100
40- 44%	75
30-39%	50
30%	0

Section 7.6.3. ***Incentive Payment.*** If the HEALTH PLAN exceeds the 50% threshold, in addition to receiving a repayment of the withhold in 7.6.2., the STATE shall disburse to the HEALTH PLAN an incentive payment. The value of the incentive payment shall not exceed the amount withheld under 7.6.1. The total potential incentive payment shall be an amount equal to the amount of the withhold described in 7.6.1. The STATE shall follow the criteria in the table below in determining the amount of the incentive payment, as a percentage of the total potential incentive payment. Participation rates shall be based on encounter data submitted by the HEALTH PLAN no later than May 31, 2001 for screenings with dates of service in 2000. The STATE shall pay the HEALTH PLAN the incentive payment, if any, within 30 days after the finalization of the encounter data submissions.

C&TC Screening Participation Rate	Percent of Incentive Payment Earned
$80	100
76-79	90
71-75	75
66-70	60
61-65	45
56-60	30

50-55	15
<50	0

Section 7.7. ***Documentation of Care Management.*** The HEALTH PLAN shall maintain documentation sufficient to support its Care Management responsibilities set forth in Section 6.1.1. Upon the reasonable request of the STATE, the HEALTH PLAN shall make available to the STATE, or the STATE's designated review agency, access to a sample of Enrollee Care Management plans.

Section 7.8. ***Quality Improvement System for Managed Care (QISMC).*** The HEALTH PLAN agrees to operate an ongoing quality assurance program that incorporates the Quality Improvement System for Managed Care (QISMC) standards and guidelines outlined in HCFA's Interim Final Rules dated September 28, 1998, with modifications as defined by the STATE.

Section 7.8.1. The HEALTH PLAN shall initiate one performance improvement project in 2000 on the topic of immunizations. This performance improvement project must cover all age groups represented by the HEALTH PLAN's PMAP, GAMC and MinnesotaCare populations.

Section 7.8.2. On July 1, 2000, the HEALTH PLAN shall submit to the STATE for review and approval, a written description of the performance improvement project it proposes under this section 7.8. and the plan for conducting the performance improvement project. This written description shall follow guidelines and specifications developed by the STATE and must include: 1) a definition of the HEALTH PLAN's proposed intervention(s); 2) an established based line measurement; 3) the goals of the performance improvement project; 4) the methods used to measure the effectiveness of the intervention(s); and 5) any implementation protocol internal time lines and evaluation criteria. The written description must address children, adolescents and the adult elderly.

Section 7.9. ***Technical Assistance***. The STATE agrees to provide the HEALTH PLAN with technical assistance related to designing an appropriate performance improvement project for implementation under this section.

Section 7.10. ***Future Implementation of QISMC.*** The STATE intends to implement the requirements of this section as an interim step toward full implementation of QISMC. During 2000 the STATE will delay implementation of the following QISMC interim final standards in Domains 1 and 3:

Section 7.10.1. Minimum performance level: QISMC 1.1.1, 1.2.2, and 1.2.3;

Section 7.10.2. Adopting and disseminating practice guidelines, QISMC 3.4.1; and

Section 7.10.3. Initial assessment of new Enrollees: QISMC 3.6.1

Section 7.11. ***Annual Quality Assurance Work Plan.*** On or before February 1, 2000, the HEALTH PLAN shall provide the STATE an annual written work plan that details the HEALTH PLAN's proposed quality assurance and performance improvement projects for the year. This report shall follow the guidelines and specifications contained in Minnesota Rules, Part 4865.1130, subpart 2. If the HEALTH PLAN chooses to amend, modify or update its work plan at anytime during the year, it shall provide the STATE with any amendments, modifications or updates in a timely manner. As an alternative, the HEALTH PLAN may submit on or before February 1, 2000, the HEALTH PLAN approved final annual 1999 quality written workplan, followed by the year 2000 annual written workplan on or before May 1, 2000.

Section 7.12. ***Annual Meeting.*** At least once per year, the HEALTH PLAN and the STATE shall meet to discuss the HEALTH PLAN'S quality improvement activities. The HEALTH PLAN shall provide the STATE with an overview of all of their quality improvement activities relating to PMAP, GAMC and MinnesotaCare Enrollees. The STATE and the HEALTH PLAN shall discuss mutual efforts in quality improvement, challenges and future directions for the program.

Section 7.13. ***Committee Participation***. The HEALTH PLAN shall appoint a representative to participate in the STATE's quality improvement committee(s) to provide input on quality management and improvement issues, external quality review studies and consumer satisfaction surveys.

Article 8. Enrollee Complaint and Appeal Procedures.

Section 8.1. ***Internal Complaint Process.*** The HEALTH PLAN shall establish and maintain procedures for the fair, prompt and informal adjudication of Complaints raised by Enrollees pursuant to Minnesota Statutes, Section 256.045, Subdivision 3a and Minnesota Statutes, Section 62D.11. The Complaint process shall comply with applicable state and federal law and regulation and shall be subject to the approval of the STATE. According to Section 4704(a) of the Balanced Budget Act of 1997, the internal Complaint process shall include adjudication of Complaints made by providers on behalf of Enrollees, with the Enrollee's written consent.

Section 8.1.1. ***Required Procedures.*** The HEALTH PLAN Complaint procedures must consist of an informal system (e.g. telephone or face-to-face) with a determination to be made within 10 calendar days from the date of receipt of initial Complaints, and a formal structure (e.g. written Complaint, formal hearing, arbitration) with a determination to be made within 30 calendar days from the date of receipt of the formal Complaint. The HEALTH PLAN may not require the submission of a written Complaint as a condition of the HEALTH PLAN taking action on the Enrollee's Complaint. The HEALTH PLAN's Complaint procedures must also include the opportunity to receive an expedited determination.

Section 8.1.2. ***Notice to STATE.*** The HEALTH PLAN must notify the STATE ombudsman in writing within three working days after any written Complaint is filed with the HEALTH

PLAN by an Enrollee or by a provider on behalf of an Enrollee. Notification must include a copy of the Complaint.

Section 8.1.3. ***Response to Investigation.*** Pursuant to Minnesota Statutes, Section 256B.69, Subdivision 3a, the HEALTH PLAN must respond directly to county advocates, established under Minnesota Statutes, Section 256B.69, Subdivision 21, and the STATE ombudsmen, established under Minnesota Statutes, Section 256B.69, Subdivision 20, regarding service delivery.

Section 8.1.4. ***Notice of Denial, Termination or Reduction to Enrollees.*** Pursuant to Section 3.2.3.A.(6) of this Contract, the HEALTH PLAN shall inform all Enrollees in writing that is understandable to a person who reads at the seventh grade level and when possible, orally, of all Complaint and Appeal procedures available to them, including the right of an Enrollee to seek arbitration to Appeal an adverse internal decision (through April 1, 2000) and the right to seek an expedited determination. Such written materials are subject to STATE approval. In response to any written Complaint or an oral Complaint where there is a decision regarding the denial, termination or reduction of a service or payment and which is adverse to the Enrollee, the HEALTH PLAN must provide written notice to the Enrollee (and to a provider where the provider files a Complaint on behalf of the Enrollee) that contains a clear and detailed description in plain language of the final decision and its basis, and of the rights of the Enrollee to pursue further relief. This notice should comply with the provisions of 8.2. The HEALTH PLAN agrees to participate in a workgroup with the STATE and other health plans to identify the most efficient and effective method of informing Enrollees of their rights when a drug substitution is made based on the HEALTH PLAN's formulary.

Section 8.1.5. ***Changes to Procedure.*** Any change in the HEALTH PLAN's Complaint procedure shall be consistent with the provisions of Article 8 and is subject to STATE approval. The HEALTH PLAN shall inform Enrollees of all changes in Complaint procedures at least two weeks prior to implementation.

Section 8.1.6. ***Reporting.*** The HEALTH plan shall report the following information regarding Complaints.

A. Summaries of all written Complaints received by the HEALTH PLAN under this Contract, actions taken to resolve such Complaints and information on Complaint procedures pursuant to Minnesota Rules, Part 9500.1463, Subpart 8 shall be reported on a semi-annual basis. The HEALTH PLAN must attach to the written Complaint summary the HEALTH PLAN's responses to reported Complaints.

B. In addition, the HEALTH PLAN shall report monthly in an electronic format determined by the STATE summary information relating to written Complaints as specified by the STATE. The HEALTH PLAN shall maintain a log of written and oral Complaints.

C. The HEALTH PLAN shall submit a written report on a monthly basis, which summarizes the oral complaints the HEALTH PLAN has received. Details of this report shall be mutually determined through the DTR Workgroup.

Section 8.2. ***Denial, Termination, or Reduction of Services (DTR) Notice.***

Section 8.2.1. ***Notice Requirements.*** If the HEALTH PLAN denies, reduces or terminates services or claims that are: 1) requested by an Enrollee, 2) ordered by a Participating Provider, 3) ordered by an approved, non-Participating Provider, 4) ordered by a care manager, or 5) ordered by a court, the HEALTH PLAN must notify the Enrollee in writing of the following:

A. A statement of what action the HEALTH PLAN intends to take;

B. The type of service or claim that is denied, terminated or reduced, including Common Carrier Transportation oral and written denials;

C. The reason(s) for the intended action;

D. The specific federal or state regulations and HEALTH PLAN policies that support or require the action;

E. An explanation of the Enrollee's right to: 1) file a Complaint and/or request an evidentiary hearing with the HEALTH PLAN within 30 days of receipt of the DTR notice, 2) request an evidentiary hearing with the STATE pursuant to Minnesota Statutes, Section 256.045, Subdivision 3a without first exhausting the HEALTH PLAN Complaint procedure or 30 days after the HEALTH PLAN's final determination of the formal Complaint, 3) request a second opinion as required under Section 8.7., and (4) request an expedited determination; and

F. The circumstances under which the medical service will be continued if a hearing is requested.

Section 8.2.2. ***Form.*** Notification under Section 8.2.1. must be made by a denial/termination/reduction (DTR) notification form that has been approved in writing by the STATE. The notification form must contain a clear and detailed description in plain language of the basis for the denial, termination, or reduction and of the Enrollee's rights. In addition, the notification form must contain a language block in Spanish, Hmong, Laotian, Russian, Somali, Vietnamese, and Cambodian in a format determined by the STATE. It shall also include the telephone number(s) at the HEALTH PLAN where Enrollees may call to obtain information about the DTR, including about how to receive a translation of the notice into Spanish, Hmong, Laotian, Russian, Somali, Vietnamese, or Cambodian.

Section 8.2.3. ***Confidentiality.*** The HEALTH PLAN must maintain the confidentiality for Family Planning Services. The HEALTH PLAN must ensure that all information related to family planning is provided only to the Enrollee in a confidential manner.

Section 8.2.4. ***Notice to Enrollee.*** The HEALTH PLAN is required to send the DTR notification form to the Enrollee. The HEALTH PLAN may have its subcontractor send the DTR to the Enrollee if the HEALTH PLAN has received prior written approval from the STATE. If the HEALTH PLAN authorizes its subcontractor to send the DTR form, the HEALTH PLAN must submit in advance for STATE approval a sample DTR notification form that will be used by its subcontractor and also a sample written explanation notice of the HEALTH PLAN and STATE Complaint and Appeal processes. STATE approval under this Section shall be granted only for major HEALTH PLAN subcontractors, as determined by the STATE, who provide a single type of health service.

Section 8.2.5. ***Reporting Requirements.*** The HEALTH PLAN must submit to the STATE a monthly detailed DTR compilation report in ASCII format with specific data elements as determined by the STATE, including the STATE PMI number and major program covering the Enrollee. The STATE must approve a sample monthly DTR compilation report prior to submittal of the actual compilation report. If the HEALTH PLAN denies, terminates or reduces court-ordered mental health services, the HEALTH PLAN must submit a detailed written explanation to the STATE that supports the HEALTH PLAN's denial, termination or reduction.

Section 8.2.6. ***10 Day Notice Requirement for Ongoing Services.*** If the HEALTH PLAN proposes to reduce or terminate an Enrollee's ongoing medical service that has been ordered by a participating or treating physician, dentist, mental health professional, chiropractor or osteopath, and the service could be eligible for payment according to Minnesota Statutes, Section 256B.0625 and Minnesota Rules, Part 9505.0170 to 9505.0475 assuming all procedural requirements are met, the written notice required by Section 8.2.1. must be provided at least 10 calendar days prior to the proposed action. Advance notice and continuation of service are not required if the provider who orders the service is not a HEALTH PLAN Participating Provider.

A. ***Continuation of Benefits Pending Decision.*** If the Enrollee makes a formal written Complaint with the HEALTH PLAN before the date of the proposed action, the HEALTH PLAN may not reduce or terminate the service until 10 days after a written decision is issued in response to that formal Complaint.

B. ***Notice of Decision.*** The written decision notice must contain: 1) the reason for the decision, 2) an explanation of the Enrollee's right to request an evidentiary hearing with the STATE and the right to seek arbitration (through April 1, 2000), and 3) the circumstances under which the service will be continued if a STATE hearing or arbitration is requested.

Section 8.3. ***Sanctions for Enrollee Misconduct.***

Section 8.3.1. The HEALTH PLAN may impose administrative sanctions against Enrollees for the conduct described in Minnesota Rules, Part 9505.2160 to 9505.2245. The HEALTH PLAN must notify Enrollees in writing of any sanctions to be imposed and shall explain to the Enrollee in writing that this notification will not result in loss of eligibility for MA, GAMC or MinnesotaCare or removal from the HEALTH PLAN. The notice must be sent at least 10 days prior to the imposition of the proposed sanction. The HEALTH PLAN must send a copy of the Enrollee notice to the STATE. The notice to the Enrollee also must state:

A. The factual basis of the allegations against the Enrollee;

B. What actions the HEALTH PLAN intends to take;

C. The Enrollee's right to dispute the HEALTH PLAN's factual allegations; and

D. An explanation of the Enrollee's right to request an evidentiary hearing with the HEALTH PLAN and the STATE and the right to Appeal to the STATE without first exhausting the HEALTH PLAN Complaint procedure.

Section 8.3.2. The HEALTH PLAN may place restrictions on the use of medical services paid for by MA, GAMC or MinnesotaCare for such an Enrollee or impose any of the sanctions in Minnesota Rules, Part 9505.2210.

Section 8.3.3. An Enrollee may Appeal any sanction proposed by the HEALTH PLAN. If the Enrollee Appeals prior to the date of the proposed sanction, the HEALTH PLAN may not impose the sanction until the Appeal is resolved in the HEALTH PLAN's favor.

Section 8.3.4. The HEALTH PLAN must report to the STATE the names of all Enrollees placed on restrictions on a quarterly basis, and the nature of the restriction, the Enrollee's PMI, and the duration of the restriction.

Section 8.4. ***Appeal to STATE.***

Section 8.4.1. ***Continuation of Benefits Pending Appeal.*** If the Enrollee files a written request for Appeal with the STATE pursuant to Minnesota Statutes, Section 256.045, Subdivision 3a before the date of the proposed action in either the HEALTH PLAN's DTR notice or the HEALTH PLAN's formal Complaint decision, the HEALTH PLAN may not reduce or terminate the service until the STATE issues a written decision on the Appeal. In the case of a reduction or termination of ongoing services under Section 8.2.6., assuming all other requirements of the Section have been met, services must be continued pending outcome of all Internal Complaint Process and Administrative Appeal hearings if: (1) there is an existing order for services by the treating and Participating Provider, or (2) the treating and Participating Provider orders discontinuation of services and another Participating Provider orders the service, but only if that provider is authorized by his/her contract with the

HEALTH PLAN to order such services. The notice required by Section 8.2.6. shall include this right.

Section 8.4.2. ***Recovery of Payment for Services.*** If the HEALTH PLAN's action is sustained by the STATE hearing decision, the HEALTH PLAN may institute procedures to recover from the Enrollee the cost of medical services furnished solely by reason of Section 8.4.1. of this Contract.

Section 8.4.3. ***Costs of Appeal.*** The HEALTH PLAN shall provide reimbursement for transportation, Child care, photocopying, medical assessment, witness fee, and other necessary and reasonable costs incurred by the Enrollee or former Enrollee in connection with a STATE Appeal. Necessary and reasonable costs shall not include the Enrollee's legal fees and costs, or other consulting fees and costs incurred by the Enrollee.

Section 8.4.4. ***Compliance with STATE Decision.*** The HEALTH PLAN must comply with a STATE ruling made pursuant to Minnesota Statutes, Section 256B.69, Subdivision 11 and Section 256.045, pending judicial review.

Section 8.5. ***Representation of HEALTH PLAN Determinations.*** The HEALTH PLAN agrees that it is the responsibility of the HEALTH PLAN to represent and defend all HEALTH PLAN determinations at the STATE Appeals hearing and at any subsequent judicial reviews involving that determination. The HEALTH PLAN 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 HEALTH PLAN in a timely manner of any STATE Appeals hearings that involve the HEALTH PLAN.

Section 8.6. ***Judicial Review.*** If the Enrollee disagrees with the determination of the STATE resulting from the STATE Appeals hearing, the Enrollee may seek judicial review in the district court of the county of service.

Section 8.7. ***Second Opinions.***

Section 8.7.1. The HEALTH PLAN shall provide for a second medical opinion within the plan, at the Enrollee's request and shall comply with any order of the STATE pursuant to Minnesota Statutes, Section 256B.69, Subdivision 11 and Minnesota Rules, Part 9500.1462.

Section 8.7.2. The HEALTH PLAN shall provide for a second medical opinion for mental health conditions pursuant to Minnesota Statutes, Section 62D.103.

Section 8.7.3. The HEALTH PLAN shall provide for a second opinion for chemical dependency services as provided for in Minnesota Statutes, Section 62D.103 and Minnesota Rules, Part 9530.6655. The HEALTH PLAN shall inform the Enrollee in writing of the Enrollee's right to make a written request for a second assessment at the time the Enrollee is assessed for a program placement.

Section 8.8. ***Enrollees as Third-Party Beneficiaries.*** Enrollees are the intended third-party beneficiaries of Article 6 of this Contract, and of any HEALTH PLAN subcontracts for the delivery of covered services described in Article 6 of this Contract. As intended third-party beneficiaries, Enrollees are entitled to the remedies accorded to third-party beneficiaries under the law. This provision is not intended to provide any cause of action against the STATE beyond any that may exist under State or Federal law.

Article 9. Required Provisions.

Section 9.1. ***Licensing and Certification.*** HEALTH PLAN 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. HEALTH PLAN further warrants that HEALTH PLAN has obtained any and all necessary permits, licenses, or certificates to conduct business in the State. The HEALTH PLAN shall be properly licensed or certified for the performance of any services pursuant to this Contract. Loss of the appropriate certificate of authority for health maintenance organization (HMO) or community integrated service network (CISN), under Minnesota Statutes Chapters 62D and 62N respectively, shall be cause for termination of this Contract pursuant to Section 5.2.3 and 5.2.4. In the event any certificate is canceled, revoked, suspended or expires during the term of this Contract, the HEALTH PLAN agrees to so inform the STATE immediately. The HEALTH PLAN and its subcontractors shall comply with all applicable federal and state statutes and regulations, as well as local ordinances and rules now in effect and hereinafter adopted, including but not limited to Minnesota Statutes, Sections 62J.695 to 62J.76 (Patient Protection Act), Minnesota Statutes, Section 62Q.47 (mental health parity), Minnesota Statutes, Section 62Q.53 (mental health Medical Necessity), and Minnesota Statutes, Section 62Q.19 (essential community providers).

Section 9.2. ***Subcontractors.***

Section 9.2.1. All subcontracts must be in writing. All subcontracts are subject to STATE and HCFA review and approval, upon request by the STATE and/or HCFA.

Section 9.2.2. The HEALTH PLAN shall submit to the STATE, in a format provided by the STATE, a file of all the providers maintained on their reference system, pursuant to Section 3.5.1.

Section 9.2.3. The HEALTH PLAN must submit, upon STATE request, proof of subcontractor status prior to submission of Primary Care Network List.

Section 9.2.4. The HEALTH PLAN shall require that all subcontractors shall provide HCFA, the Comptroller General, or their designees, and the STATE with the right to inspect, evaluate, and audit any pertinent books, documents, papers, and records of any subcontractor involving transactions related to this Contract. The right under this Section to information for any particular contract period will exist for a period equivalent to that specified in Section 9.3.5. of this Contract.

Section 9.2.5. All subcontracts shall comply with 42 C.F.R. Part 434.6.

Section 9.2.6. Notwithstanding Section 9.2.1., the HEALTH PLAN may contract with providers of health care services to provide services to Enrollees of the HEALTH PLAN. Subcontracts with other providers of health care services shall not abrogate or alter the HEALTH PLAN's primary responsibility for performance under this Contract.

Section 9.2.7. ***FQHCs and RHCs Contracting Requirements.*** If the HEALTH PLAN negotiates a provider agreement or subcontract with a federally qualified health center (FQHC) as defined in Section 1905(l)(2)(B) of the Social Security Act, 42 U.S.C. Section 1396d(l)(2)(B), or a rural health clinic (RHC) as defined in 42 C.F.R. 440.20, the negotiated payment rates must be comparable to the rates negotiated with other subcontractors who provide similar health services. The STATE may require the HEALTH PLAN to offer to contract with any FQHC or RHC in the HEALTH PLAN's Service Area. The HEALTH PLAN is not required to pay any settle-up payments in addition to the negotiated payment rate.

Section 9.2.8. ***Community Clinic, Community Mental Health Centers, and Community Health Services Agencies Subcontracting Requirements.*** The HEALTH PLAN shall contract with nonprofit community clinics (community health clinic), community mental health centers, or community health services agencies 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 HEALTH PLAN providers for the same or similar services, pursuant to Minnesota Statutes, Section 256B.69, Subdivision 22. The HEALTH PLAN may reasonably require a community clinic, community mental health center, or community health services agency to comply with the same or similar contract terms that the HEALTH PLAN requires of the HEALTH PLAN's other Participating Providers, except that the HEALTH PLAN cannot exclude coverage for a covered service provided by a clinic or agency in a subcontract with a clinic or agency. The STATE will provide the HEALTH PLAN with a list of all nonprofit community clinics, community mental health centers, and community health services agencies within the Service Area within one week of the effective date of the Contract unless the STATE has already provided an updated list as part of the most recent PMAP RFP process or as part of the RFP for this Contract. The HEALTH PLAN must submit a written invitation to contract to each nonprofit community health clinic, community mental health center or community health services agency within the Service Area within 30 days of the effective date of this Contract. If the HEALTH PLAN invites providers within a community clinic, community mental health center, and/or community mental health services agency to contract with the HEALTH PLAN, it must offer to contract with all like providers within the community clinic, community mental health center, and/or community health services agency, so long as those providers meet the HEALTH PLAN's credentialing criteria. Within 90 days of the effective date of this Contract, the HEALTH PLAN shall submit to the STATE one of the following for each nonprofit community clinic, community mental health center or community health services agency within the HEALTH PLAN's Service Area: (a) the signature page from an

executed contract, or (b) a letter from the nonprofit community clinic, community mental health center or community health services agency stating that they are declining the HEALTH PLAN's contract offer, or (c) a progress report on the status of negotiations with the community clinic, community mental health center or community health services agency. This progress report shall be updated in writing on a quarterly basis, until (a) or (b) are achieved.

Section 9.2.9. ***Home Visiting Services***. The HEALTH PLAN shall contract with programs receiving grants under Minnesota Statutes, Section 145A.16: Universally Offered Home Visiting Programs for Infant Care, for covered home visiting services. The HEALTH PLAN may reasonably require a home visiting program to comply with the same or similar contract terms that the HEALTH PLAN requires of the HEALTH PLAN's other Participating Providers. The STATE will provide the HEALTH PLAN with a list of all existing home visiting programs receiving grants within the Service Area within one week of the effective date of the Contract, and as soon as possible after establishment of any home visiting programs.

Section 9.2.10. ***Children's Mental Health Collaborative.*** The HEALTH PLAN must subcontract with a children's mental health collaborative organized under Minnesota Statutes, Sections 245.491-245.496 that has an integrated services system approved by the Children's Cabinet, has entered into an agreement with the STATE to provide MA, GAMC or MinnesotaCare services, is capable of providing inpatient and outpatient mental health services in return for an actuarial based capitated payment from the HEALTH PLAN to be determined by the STATE and requests to become a subcontractor. The HEALTH PLAN must provide Enrollees that meet the membership requirements of the collaborative the choice to receive mental health services through either the collaborative or the HEALTH PLAN. The HEALTH PLAN must work cooperatively with a collaborative to assure the integration of physical and mental health services to enrollees of the collaborative. The collaborative must be willing to hold the HEALTH PLAN harmless from all liability of any kind associated with the collaborative's performance. The HEALTH PLAN may reasonably require in its contract with a collaborative the same or similar contract terms that the HEALTH PLAN requires of its other subcontractors. See Minnesota Statutes, Section 245.494, Subdivision 3.

Section 9.2.11. Except for MinnesotaCare copays pursuant to Section 4.3.3., the HEALTH PLAN shall ensure that the Enrollee is not held responsible for any fees associated with the Enrollee's medical care received from the HEALTH PLAN subcontractor or an out-of-plan provider with whom the HEALTH PLAN has negotiated a rate for providing the Enrollee services covered under this Contract. Where an Enrollee receives Medical Emergency Services, Post-Stabilization Care Services or Urgent Care Out of Area or Out of Plan, the HEALTH PLAN shall pay the Out of Area or Out of Plan provider on the condition that the provider hold the Enrollee harmless for any financial liability.

Section 9.2.12. The HEALTH PLAN shall inquire of a provider prior to entering into or renewing an agreement whether the provider: (i) has been sanctioned for fraudulent use of

federal or state funds by the U.S. Department of Health and Human Services, pursuant to 42 U.S.C. Section 1320 a-7(a) or by the State of Minnesota; or (ii) is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines interpreting such order, or who is an affiliate of such a provider. The HEALTH PLAN shall not knowingly contract with such a provider.

Section 9.2.13. The HEALTH PLAN shall not have a person described in Section 9.2.12. as a director, officer, partner, or person with beneficial ownership of more than 5 percent of the HEALTH PLAN's equity, nor have an employment, consulting, or other agreement with a person in Section 9.2.12. for the provision of items and services that are significant and material to the HEALTH PLAN's obligation under this Contract.

Section 9.2.14. The HEALTH PLAN shall not have any agents, management staff, or persons with ownership or control interests who have been convicted of criminal offenses related to their involvement in Medicaid.

Section 9.2.15. The HEALTH PLAN shall not employ or contract with, directly or indirectly, entities or individuals excluded from participation in Medicaid under Sections 1128 or 1128A of the Social Security Act for the provision of health care, utilization review, medical social work, or administrative services.

Section 9.2.16. The HEALTH PLAN shall not enter into any subcontract that is prohibited, in whole or in part, under Section 4704(a) of the Balanced Budget Act of 1997 or under Minnesota Statutes, Section 62J.71.

Section 9.2.17. The HEALTH PLAN may not give any financial incentive to a health care provider based solely on the number of services denied or referrals not authorized by the provider, pursuant to Minnesota Statutes, Section 72A.20, Subdivision 33 and as required under 42 C.F.R. 417.479.

Section 9.2.18. The HEALTH PLAN 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 HEALTH PLAN from including providers only to the extent necessary to meet the needs of the HEALTH PLAN's Enrollees or from establishing any measure designated to maintain quality and control costs consistent with the responsibilities of the HEALTH PLAN.

Section 9.2.19. The HEALTH PLAN 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 2.32., and in subcontracts for the delivery of mental health services that the subcontractor additionally follow the Medical Necessity definition found in Minnesota Statutes, Section 62Q.53. Subcontracts shall include the definition found in

Section 2.32., and the definition found in Minnesota Statutes, Section 62Q.53 where applicable.

Section 9.2.20. The HEALTH PLAN agrees to pay health care providers on a timely basis consistent with the claims payment procedure described in Section 1902 (a)(37)(a) of the Social Security Act (42 U.S.C. 1396(a)).

Section 9.2.21. ***Nursing Facility Subcontracting and Reimbursement.***

A. The HEALTH PLAN may develop contracts and negotiate rates with Nursing Facilities. The HEALTH PLAN shall include in its payment arrangement for Nursing Facility services provisions that require the Nursing Facilities to cooperate with the STATE procedures for collection of Spenddowns.

B. If the HEALTH PLAN authorizes Nursing Facility care in a Nursing Facility where the HEALTH PLAN does not have a contracted rate, the HEALTH PLAN shall pay the Nursing Facility the appropriate Medical Assistance rate. For Medicaid leave days, fee-for-service pays qualified Nursing Facilities 79% of the applicable case mix payment rate. The HEALTH PLAN shall pay non-contracted facilities whose Nursing Facility occupancy leave rates would otherwise qualify for payment under fee-for-services at this level.

Section 9.3. ***Maintenance, Inspection and Retention of Records.***

Section 9.3.1. The HEALTH PLAN shall provide that the STATE and HCFA or their agents may evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under this Contract.

Section 9.3.2. The HEALTH PLAN shall provide that the STATE and HCFA may evaluate, through inspection or other means, the facilities of the HEALTH PLAN when there is reasonable evidence of some need for that inspection.

Section 9.3.3. The HEALTH PLAN must provide that the STATE and HCFA may evaluate, through inspection or other means, the enrollment and disenrollment records of the HEALTH PLAN, when there is reasonable evidence of need for such inspection.

Section 9.3.4. The HEALTH PLAN shall provide that the STATE, HCFA or the Comptroller General, or their designees, may audit or inspect any books and records of the HEALTH PLAN and its subcontractors or transferees that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the Contract.

Section 9.3.5. The HEALTH PLAN must provide that the STATE and HCFA's right to inspect, evaluate and audit shall extend through six years from the date of the final settlement for any contract period unless: (a) the STATE or HCFA determines there is a special need to

retain a particular record or records for a longer period of time and the STATE or HCFA notify the HEALTH PLAN at least 30 days prior to the normal record disposition date; (b) there has been a termination, dispute, Fraud, or similar default by the HEALTH PLAN, in which case the record(s) retention may be extended to ten years from the date of any resulting final settlement; or (c) the STATE or HCFA determined that there is a reasonable possibility of Fraud and the record may be reopened at any time.

Section 9.3.6. The HEALTH PLAN agrees to maintain such records and prepare such reports and statistical data as may be deemed reasonably necessary by the STATE and HCFA. It is further agreed that all records must be made available to authorized representatives of the STATE and HCFA 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 HEALTH PLAN in fulfillment of the State or federal requirements. It is understood and agreed that the HEALTH PLAN shall be afforded reasonable notice of a request by an authorized representative of the STATE or HCFA to examine records maintained by the HEALTH PLAN or its agents, unless otherwise provided by law.

Section 9.3.7. The HEALTH PLAN agrees to maintain and make available to the STATE and HCFA all records related to Enrollees enrolled pursuant to this Contract for a period of six (6) years after the termination date of this Contract. Records to be retained include, but are not limited to, medical, claims, Care Management, and Prior Authorization records.

Section 9.4. ***Settlement Upon Termination.*** Upon termination of the Contract, or at such time as individual Recipients terminate enrollment in the HEALTH PLAN, and prior to final settlement, the HEALTH PLAN shall, upon request by the STATE, provide to the STATE copies of all information that may be necessary to determine responsibility for outstanding claims of providers, and to ensure that all outstanding claims are settled promptly.

Section 9.5. ***Trade Secret Information.*** The STATE agrees to protect from dissemination information submitted by the HEALTH PLAN to the STATE which the HEALTH PLAN can justify as trade secret information, pursuant to Minnesota Statutes, Section 13.37, Subdivision 1(b). Protected information may be marketing plans and materials, rates paid to providers, or any other information. The HEALTH PLAN must identify information as trade secret prior to its submission for the STATE to consider classifying it as non-public. If information identified by the HEALTH PLAN as trade secret is subject to a data practices request or otherwise subject to publication, and if the STATE determines that the HEALTH PLAN's trade secret identification is colorable, the STATE shall provide the HEALTH PLAN an opportunity to justify in writing that the information meets the requirements of Minnesota Statutes, Section 13.37. Trade secret information may be shared with HCFA. The STATE must notify HCFA that such information is considered trade secret. Pursuant to Minnesota Rules, Section 9500.1459, rates paid to the HEALTH PLAN, the STATE's rate methodology, and this Contract are not trade secrets.

Section 9.6. ***Date of Issue of Enrollee Materials***. The HEALTH PLAN shall submit to the STATE upon request, written confirmation of the dates on which the HEALTH PLAN issues all

new Enrollee materials required by Section 3.2.3. The HEALTH PLAN must notify the STATE and provide a brief explanation in writing within two working days if the HEALTH PLAN cannot comply with the time frame specified in Section 3.2.3.

Section 9.7. ***Data Privacy Responsibilities.***

Section 9.7.1. ***Standard.*** All records collected, used, disseminated and stored by the HEALTH PLAN pertaining to Enrollees shall be maintained in accordance with Minnesota Statutes Chapter 13 and Minnesota Statutes, Section 144.335, safeguarded in accordance with the requirements of 42 C.F.R. Part 431, Subpart F, and retained in accordance with the record retention requirements of 45 C.F.R. Part 74.

Section 9.7.2. ***Privacy Act Compliance.*** The HEALTH PLAN shall comply with the requirements of the Privacy Act, as implemented by 45 C.F.R. 5b and 42 C.F.R. 401(B). The HEALTH PLAN must comply with the confidentiality requirements of 42 C.F.R. 482.24 for medical records and for all other information on Enrollees not covered under the Privacy Act that is contained in the HEALTH PLAN's records or obtained from HCFA or the STATE.

Section 9.7.3. ***Procedures and Controls.*** The HEALTH PLAN agrees to establish and maintain procedures and controls so that no information contained in its records or obtained from the STATE or from others in carrying out the terms of this Contract shall be used by or disclosed by it, its agents, officers, or employees except as provided in Section 1106 of the Social Security Act and implementing regulations.

Section 9.7.4. ***Compliance with Minnesota Governmental Data Practices Act.***

A. ***Part of the Welfare System.*** For the purposes of executing its responsibilities, and to the extent set forth in this Contract, the HEALTH PLAN shall be considered part of the welfare system as defined in Minnesota Statutes, Section 13.46, Subdivision 1. The HEALTH PLAN's employees and agents shall have access to private or confidential data maintained by the Department of Human Services to the extent necessary to carry out its responsibilities under the Contract. The HEALTH PLAN agrees to comply with all the requirements of the Minnesota Government Data Practices Act in providing services under the Contract.

B. ***Responsible Authority.*** The Chief Executive Officer of the HEALTH PLAN is the responsible authority in charge of all data collected, used, or disseminated by the contractor in connection with the performance of this Contract.

C. ***Supervision and Training.*** In accordance with Minnesota Statutes, Section 13.46, Subdivision 10, the HEALTH PLAN accepts responsibility for providing adequate supervision and training to its agents and employees to ensure compliance with the Act. No private or confidential data collected, maintained, or used in the course of performance of this Contract shall be disseminated except as authorized by statute, either during the period of this Contract or thereafter.

Section 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.

Section 9.9. ***Liability.*** The STATE and HEALTH PLAN agree that, to the extent provided for in state law, each shall be responsible for the loss, damage or injury arising from its own negligence in performing this Contract.

Section 9.10. ***Severability.*** If any provision or paragraph of this Contract is found to be legally invalid or unenforceable, such provision or paragraph shall be deemed to have been stricken from this Contract and the remainder of this Contract shall be deemed to be in full force and effect.

Section 9.11. ***Workers' Compensation.*** In accordance with the provisions of Minnesota Statutes, Section 176.182, the HEALTH PLAN shall provide acceptable evidence of compliance with the workers' compensation insurance coverage requirement of Minnesota Statutes, Section 176.181, Subdivision 2.

Section 9.12. ***Affirmative Action.*** The HEALTH PLAN certifies that it has received a certificate of compliance from the Commissioner of Human Rights pursuant to Minnesota Statutes, Section 363.073. County administered HEALTH PLANs are exempt from this statute.

Section 9.13. ***Voter Registration.*** The HEALTH PLAN certifies that it will comply with Minnesota Statutes, Section 201.162.

Section 9.14. ***Fraud and Abuse Requirements.***

Section 9.14.1. ***Fraud and Abuse by HEALTH PLAN and/or its Subcontractor.***

A. The HEALTH PLAN's officers understand that this Contract involves the receipt by the HEALTH PLAN of state and federal funds, and that they are, therefore, subject to criminal prosecution and/or civil or administrative actions for any intentional false statements or other fraudulent conduct related to their obligations under this Contract.

B. The HEALTH PLAN and its subcontractors shall, upon the request of the Minnesota Medicaid Fraud Control Unit (MFCU) of the Minnesota Attorney General's Office, make available to MFCU all administrative, financial, medical, and any other records that relate to the delivery of items or services under this Contract. The HEALTH PLAN shall allow the MFCU access to these records during normal business hours, except under special circumstances when after hours admissions shall be allowed. Such special circumstances shall be determined by the MFCU.

C. The HEALTH PLAN shall report to the STATE and the Minnesota Medicaid Fraud Control Unit (MFCU) any suspected Fraud and/or Abuse by providers within 24

hours after the HEALTH PLAN knows or has reason to believe of such suspected Fraud and/or Abuse. The HEALTH PLAN shall cooperate fully in any investigation of the suspected Fraud and/or Abuse by the STATE and MFCU and in any subsequent legal action that may result from those investigations.

Section 9.14.2. ***Fraud and Abuse by Recipients.*** The HEALTH PLAN shall report to the STATE any suspected Fraud and/or patterns of Abuse by Recipients.

Section 9.14.3. ***Antifraud Report.*** The HEALTH PLAN shall develop a Fraud and Abuse prevention system which will provide for investigation of alleged Fraud or Abuse by Enrollees, subcontractors, providers, or HEALTH PLAN employees, officers or agents, as it pertains to activities under this Contract. The HEALTH PLAN shall report annually to the STATE by August 31, detailing the Fraud and Abuse prevention efforts and results according to guidelines provided by the STATE.

Section 9.15. ***Compliance with HCFA Regulation.*** As required by 42 C.F.R. Part 434.67(e), payments under this Contract will be denied for new Enrollees when, and so long as, payments for those Enrollees are denied by the Health Care Financing Administration pursuant to 42 C.F.R. 434.67 (e).

Article 10. Assignment. The HEALTH PLAN shall neither assign nor transfer any rights or obligations under this Contract without the prior written consent of the STATE.

Article 11. Prohibition Against Discrimination. In the performance of obligations under this Contract, the HEALTH PLAN agrees to comply with provisions of: the Constitutions of the United States and the State of Minnesota; Title VI of the Civil Rights Act of 1964 and pertinent regulations at 45 C.F.R. 80; Executive Order 11246, Equal Employment Opportunity, dated September 24, 1965; 42 C.F.R. Part 434.25; 42 C.F.R. 434.27(a)(2); Section 504 of the Rehabilitation Act of 1973 and pertinent regulations at 45 C.F.R. 84; Age Discrimination Act of 1975 and pertinent regulations at 45 C.F.R. 91; Minnesota Statutes, Section 363.073; Title IX of the Education Amendments of 1972; and any other laws, regulations, or orders that prohibit discrimination on grounds of race, sex, color, age, religion, health status, physical disability, sexual orientation, national origin, or public assistance status.

Article 12. Third Party Liability and Coordination of Benefits.

Section 12.1. ***Agent of the STATE.*** Pursuant to 42 C.F.R. 433, Subpart D and Minnesota Statutes, Section 256B.042, Subdivision 2, Section 256L.03, Subdivision 6, Section 256D.03, Subdivision 8, Section 256.015, Subdivision 1, and Section 256B.37, Subdivision 1, the STATE hereby authorizes the HEALTH PLAN as its agent to obtain third party reimbursement by any lawful means including asserting subrogation interest and filing liens, and to coordinate benefits, for HEALTH PLAN Enrollees whose premiums have been paid in whole or part by the STATE.

Section 12.2. ***Third Party Recoveries.*** The HEALTH PLAN must take reasonable measures to determine the legal liability of third parties to pay for services furnished to HEALTH PLAN

Enrollees. To the extent permitted by state and federal law, the HEALTH PLAN shall use Cost Avoidance and/or Post Payment Recovery Processes, as defined in Article 2 of this Contract, to ensure that primary payments from the liable third party are utilized to offset medical expenses.

Section 12.2.1. The STATE shall include information about known third party resources on the electronic enrollment data given to the HEALTH PLAN twice a month under Section 3.1.2.

Section 12.2.2. The HEALTH PLAN shall report to the STATE any additional third party resources available to an Enrollee discovered by the HEALTH PLAN on a form provided by the STATE, within ten business days of verification of such information. The HEALTH PLAN shall report any known change to health insurance information in the same manner.

Section 12.2.3. The HEALTH PLAN's efforts to determine liability and use Cost Avoidance Procedures or Post Payment Recovery Processes shall not require that the plan spend more on an individual claim basis than could be recovered through those efforts.

Section 12.2.4. The HEALTH PLAN is entitled to retain any amounts recovered through its efforts, provided that:

A. Total payments received do not exceed the total amount of the HEALTH PLAN's financial liability for those services provided by the HEALTH PLAN to the Enrollee;

B. STATE fee-for-service and reinsurance benefits have not duplicated this recovery; and

C. Such recovery is not prohibited by federal or state law.

Section 12.2.5. The HEALTH PLAN may require its capitated Providers to return any third party payments to the HEALTH PLAN.

Section 12.2.6. If the HEALTH PLAN is unsuccessful in its efforts to obtain necessary cooperation from an Enrollee to identify potential third-party resources after 60 days of such efforts, the HEALTH PLAN may inform the STATE in a format to be determined by the STATE that efforts have been unsuccessful.

Section 12.3. ***Coordination of Benefits.***

Section 12.3.1. ***Coordination of Benefits.*** For Enrollees who have private health care coverage, the HEALTH PLAN must coordinate benefits in accordance with Minnesota Rules, Part 9505.0070 and Minnesota Statutes, Section 62A.046. Coordination of benefits includes paying any applicable copayments or deductibles on behalf of an Enrollee, except for MinnesotaCare copays pursuant to Section 4.3.3.

Section 12.3.2. ***Cost Avoidance.***

A. ***General.*** The HEALTH PLAN shall cost avoid all claims or services that are subject to third-party payment, and may deny a service to an Enrollee if the HEALTH PLAN is assured that a third party (i.e., other insurer) will provide the service. The HEALTH PLAN must determine whether it is more cost-effective to provide the service or pay the copays, coinsurance and deductibles to a Non-Participating Provider. If the HEALTH PLAN refers an Enrollee to a third-party insurer for a service which the HEALTH PLAN covers, and the third-party insurer requires payment in advance of all copayments, coinsurance and deductibles, the HEALTH PLAN shall make such payments in advance or at the time such payments are required.

B. For prenatal care services, preventive pediatric services and services provided to a dependent covered by health insurance pursuant to a court order, the HEALTH PLAN must ensure that services are provided without regard to insurance payment issues, even if the HEALTH PLAN must provide the service first and then coordinate payment with the potentially liable third party, if payment would otherwise be made to the policyholder (such as an absent Parent) rather than the provider or HEALTH PLAN.

Section 12.3.3. ***Post Payment Recoveries.*** The HEALTH PLAN shall recover funds post payment in cases where the HEALTH PLAN was not aware of third-party coverage at the time services were rendered or paid for, or the HEALTH PLAN was not able to cost avoid (payment was not available at the time the claim was filed). The HEALTH PLAN shall identify all potentially liable third parties and pursue reimbursement from them. Potentially liable third parties include, but are not limited to, Medicare, Uninsured/Underinsured motorist insurance, First and third party liability insurance, Tortfeasors, Workers' Compensation, Medical payments insurance for accidents (otherwise known as "med pay" provisions or benefits of policy), and Indemnity/accident insurance. The HEALTH PLAN shall develop procedures to identify trauma diagnoses and investigate potential liability. The HEALTH PLAN shall not pursue reimbursement under estate recovery or Medical Support recovery provisions (recovery of medical expenses paid for an Enrollee out of an Enrollee's estate or from an absent Parent).

Section 12.4. ***Reporting of Recoveries.***

Section 12.4.1. Except for litigated cases described in Section 12.4.2. and for recoveries made subsequent to an encounter claim's submission, the HEALTH PLAN shall report, all recovery/cost avoided amounts, including Medicare reimbursements, on the encounter claim as third party payments.

Section 12.4.2. For litigated cases pursued through Post Payment Recovery, the HEALTH PLAN shall provide information regarding the initiation and final disposition or recovery on a form provided by the STATE, in lieu of encounter data required in Section 12.4.1.

Section 12.4.3. The HEALTH PLAN shall, on a quarterly basis, disclose to the STATE all cost avoided and recovered amounts made from private insurance carriers, Medicare, and other responsible third parties, using a format provided by the STATE. This report is due by the 20th of the month following the end of the quarter.

Section 12.5. ***Causes of Action.*** If the HEALTH PLAN becomes aware of a cause of action to recover medical costs for which the HEALTH PLAN has paid under this Contract, the HEALTH PLAN shall file a lien or assert a subrogation interest on the cause of action. The HEALTH PLAN shall follow the STATE's policy guidelines in settlement of any claim.

Section 12.6. ***Determination of Compliance.*** The STATE may determine whether the HEALTH PLAN is in compliance with the requirements in this Article by inspecting source documents for:

Section 12.6.1. Appropriateness of recovery attempt.

Section 12.6.2. Timeliness of billing.

Section 12.6.3. Accounting for third party payments.

Section 12.6.4. Settlement of claims.

Section 12.6.5. Other monitoring deemed necessary by the STATE.

Article 13. Governing Law.

Section 13.1. The HEALTH PLAN shall comply with state and federal law in the performance of its obligations under this Contract, including but not limited to: Minnesota Statutes, Section 256B.69 et seq.; Minnesota Rules, Parts 9500.1450 to 9500.1464; Minnesota Statutes, Section 256D.03; Minnesota Statutes, Section 256L.01 et. seq.; Minnesota Rules, Parts 9506.0010 to 9506.0400; Title XIX of the Social Security Act (42 U.S.C. Section 1396 et. seq.) and the applicable provisions of 42 C.F.R. Part 431.200 et. seq; and waivers or variances approved by HCFA. If any terms of this Agreement are determined to be inconsistent with rule or law, the applicable rule or law provision shall govern.

Section 13.2. Any revisions to applicable provisions of federal or state law and implementing regulations, and policy issuances and instructions, except where otherwise excluded in this Contract, apply as of their effective date.

Article 14. Indemnification. The HEALTH PLAN 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 HEALTH PLAN of any provision of the Minnesota Government Data Practices Act, including legal fees and disbursements paid or incurred to enforce the provisions of this Agreement.

Article 15. Lobbying Disclosure. The HEALTH PLAN certifies that, to the best of its knowledge, understanding, and belief, that:

Section 15.1. No Federal appropriated funds have been paid or will be paid in what the undersigned believes to be a violation of 31 U.S.C., Section 1352, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, the modification of any Federal contract, grant, loan, or cooperative agreement, or in any activity designed to influence legislation or appropriations pending before Congress.

Section 15.2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer of employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

Section 15.3. The undersigned will require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and will require that all sub-Recipients certify and disclose accordingly. This certification is a material representation of facts upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by 31 U.S.C., Section 1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Article 16. C.L.I.A. Requirements. All laboratory testing sites providing services under this contract must comply with the C.L.I.A. requirements in 42 C.F.R. Part 493.

Article 17. Advance Directives Compliance. For purposes of this Section, the term “advance directives” has the meaning given in 42 C.F.R. 489.100. Pursuant to 42 U.S.C. 1396a(a)(57) and (58) and 42 C.F.R. 434.28 and 42 C.F.R. 489.100-104, the HEALTH PLAN agrees:

Section 17.1. To inform all Enrollees at the time of enrollment of their right to

Section 17.1.1. accept or refuse treatment and to execute a living will, durable power of attorney for health care decisions, or other advance directive, and

Section 17.1.2. receive the HEALTH PLAN’s written policies on implementation of that right;

Section 17.2. To document in the Enrollee's medical records whether or not an individual has executed an advance directive;

Section 17.3. To not condition treatment or otherwise discriminate on the basis of whether an individual has executed an advance directive;

Section 17.4. To comply with State law, whether statutory or recognized by the courts of the State, on advance directives, including Laws of Minnesota 1998, Chapter 399, Section 38; and

Section 17.5. To provide, individually or with others, education for HEALTH PLAN staff, providers and the community on advance directives.

Article 18. Americans with Disabilities Act Compliance. In fulfilling the duties and responsibilities of this Contract, the HEALTH PLAN shall comply with P.L. 101-336, Americans With Disabilities Act of 1990, 42 U.S.C., Section 1210, et. seq., and regulations promulgated pursuant to it. The HEALTH PLAN also shall comply with 28 C.F.R. 35.130(d), which requires the administration of services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

Article 19. Disclosure.

Section 19.1. ***Disclosure Requirements.*** The HEALTH PLAN must consent to any financial, character, and other inquiries by the STATE. Upon request by the STATE, the HEALTH PLAN must disclose the following information:

Section 19.1.1. The type of organizational structure, a description of the management plan, the general nature of the HEALTH PLAN's business and general nature of the management plan's business.

Section 19.1.2. The HEALTH PLAN's full legal or corporate name and any trade names, aliases, and/or business names currently used.

Section 19.1.3. The jurisdiction of the HEALTH PLAN and date of incorporation, along with any articles of incorporation and by-laws, if applicable, along with state and federal tax returns for the past five years. If the HEALTH PLAN is an organization other than a corporation, the copies of any agreements creating or governing the organization must be submitted.

Section 19.1.4. The date the HEALTH PLAN commenced doing business in Minnesota, and, if the HEALTH PLAN is incorporated outside of Minnesota, a copy of the HEALTH PLAN's certificate of authority to do business in Minnesota.

Section 19.1.5. Whether the HEALTH PLAN is directly or indirectly controlled to any extent or in any manner by another individual or entity; if so, the HEALTH PLAN must

disclose the identity of the controlling entity and a description of the nature and extent of control.

Section 19.1.6. Any agreements or understandings which the HEALTH PLAN has entered into regarding ownership or operation of the HEALTH PLAN.

Section 19.2. ***Disclosure of Management/Fiscal Agents.*** The HEALTH PLAN must disclose the following, if applicable:

Section 19.2.1. A description of the terms and conditions of any contract or agreement between the HEALTH PLAN and the management or fiscal agent.

Section 19.2.2. All corporations, partnerships or other entities providing management of fiscal agent services.

Section 19.2.3. The management or fiscal agent's full legal or corporate name and any trade names currently used. The legal name, aliases, and previous names of management personnel, to the extent known.

Section 19.2.4. The jurisdiction of the management or fiscal agent and date of incorporation, along with any articles of incorporation and by-laws, if applicable, along with state and federal tax returns for the past five years. Copies of any agreements creating or governing the organization must be submitted if the management or fiscal agent is an organization other than a corporation.

Section 19.2.5. The date the management or fiscal agent commenced doing business in Minnesota, and if they are incorporated outside of Minnesota, a copy of their certificate of authority to do business in Minnesota.

Section 19.3. ***Disclosure of, Compliance With and Reporting of Physician Incentive Plans***. The HEALTH PLAN may operate a Physician Incentive Plan (PIP), as defined in 42 C.F.R. 417.479(c), only if the requirements of 42 C.F.R. 417.479 (as they are interpreted and amended by HCFA from time to time) are met. Such requirements include the following.

Section 19.3.1. The HEALTH PLAN shall operate a PIP only if no specific payment can be made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual.

Section 19.3.2. The HEALTH PLAN must provide the information on its PIPs to any Medical Assistance client, upon request.

Section 19.3.3. The HEALTH PLAN that have PIPs placing a physician or physician group at substantial financial risk for the cost of referral services must provide adequate stop-loss protection to the individual physicians and conduct Enrollee surveys. The STATE shall

conduct the surveys of Enrollees who have disenrolled which are required by this regulation. The STATE shall report results of such surveys to the HEALTH PLAN on a quarterly basis.

Section 19.3.4. The HEALTH PLAN must report adequate information specified in the PIP regulations to the STATE in order that the STATE may adequately monitor the HEALTH PLAN. The disclosure must contain the following information in detail sufficient to enable the STATE to determine whether the incentive plan complies with these requirements:

A. Whether services not furnished by the physician or physician group are covered by the incentive plan. If only the services furnished by the physician or physician group are covered by the incentive plan, disclosure of other aspects of the plan need not be made.

B. The type of incentive arrangement such as withhold, bonus, or capitation.

C. If the PIP involves a withhold or a bonus, the percent of the withhold or bonus.

D. Proof that the physician or physician group has adequate stop-loss protection, including the amount and type of stop-loss protection.

E. The panel size, and if patients are pooled, the approved method used.

F. In the case of those prepaid plans that are required to conduct beneficiary surveys, the survey results (which must be provided in a timely manner to Medical AssistanceRrecipients upon request.) Also, see 19.3.3.

Article 20. Federal Audit Requirements and Debarment Information. HEALTH PLAN will certify that it will comply with the Single Audit Act, OMB Circular A-133, as applicable. The HEALTH PLAN shall obtain a financial and compliance audit made in accordance with the Single Audit Act, A-133, as applicable. Failure to comply with these requirements could result in forfeiture of federal funds.

Article 21. Modifications. Any material alteration, modification or variation in the terms of this contract shall be reduced to writing as an amendment hereto and signed by the parties.

Article 22. Entire Agreement. The parties understand and agree that the entire agreement of the parties is contained herein and that this Contract supersedes all oral agreements and negotiations between the parties relating to this subject matter. All items referred to in this Contract are incorporated or attached and deemed to be part of the Contract. Any amendments to this Contract shall be in writing, signed by all parties, and attached hereto.

IN WITNESS WHEREOF, the parties hereto have executed this contract. This contract is hereby accepted and considered binding in accordance with the terms outlined in the preceding statements.

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

By:_____

Title:_____

Date:_____

DEPARTMENT OF ADMINISTRATION

By:_____

Title:_____

Date:_____

_____ HEALTH PLAN (Two corporate officers must execute)

By:_____

Title:_____

Date:_____

and

By:_____

Title:_____

Date:_____

Approved as to form and execution by the
ATTORNEY GENERAL

By:_____

Title:_____

Date:_____

Appendix A: Capitation Payment Rates Showing MERC and Disproportionate Population Adjustment

Appendix B: Capitation Payment Rates Showing Risk Adjustment

Appendix C: Risk Adjustment Weights

Appendix D: HEALTH PLAN PMAP, PGAMC and MinnesotaCare Service Areas

PMAP and PGAMC Counties:

MinnesotaCare Counties: