

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**SCHOOL-BASED HEALTH CENTERS
AND MANAGED CARE:**

EXAMPLES OF COORDINATION



DECEMBER 1993

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TABLE OF CONTENTS

	PAGE
INTRODUCTION	1
EXAMPLES	3
• Multnomah County, Oregon	4
• St. Paul, Minnesota	6
• Baltimore, Maryland	7
• Minneapolis, Minnesota	11
• Brooklyn, New York	13
• Hillsborough County, Florida	15
• San Francisco, California	18
APPENDICES	A-1
A: Oregon Senate Bill 760	A-1
B: Contract Between Multnomah County and Good Health Plan	B-1
C: Contract Between Health Start and RamseyCare	C-1

INTRODUCTION

PURPOSE

The purpose of this report is to describe a variety of ways school-based health centers coordinate services with managed care providers. The examples described here were found while collecting data for our report, **School-based Health Centers and Managed Care**, OEI-05-92-00680. That report examined the relationship between school-based health centers and managed care providers.

BACKGROUND

Both school-based health centers and managed care were created to increase access to health care services. Some managed care providers recognize the special expertise school-based health centers can provide to meet the compelling health needs of adolescents. A number of these managed care providers have entered into agreements with school-based health centers so adolescents covered by their plan have the advantages of medical treatment at both sites.

This report describes seven examples of coordination between school-based health centers and managed care providers. In our earlier report, after we reviewed current literature and consulted with experts on this topic, we visited all known sites where coordination exists. During on-site visits we used in-depth, structured personal interviews with representatives from the school-based health centers and managed care providers. The seven examples cited here represent different methods of coordination. Because agreements are new and still being developed, this report does not represent a comprehensive list of agreements between managed care providers and school-based health centers. Nor does it address all operational and policy related questions which present themselves in discussions of this topic, such as the appropriateness of funding streams between managed care organizations and school-based health centers. For further background information on school-based health centers and managed care, consult the companion report, **School-based Health Centers and Managed Care**.

The level of coordination between managed care providers and school-based health centers, where it exists at all, varies widely across the country. The agreements described in this report represent cooperation at different points along a spectrum, ranging from school-based health centers being reimbursed for all services they perform for managed care plan children, to school-based health centers needing prior authorization from a managed care plan before providing a very limited number of services. Managed care plans and school-based health centers are still evolving; agreements between them are embryonic.

As health care reform takes shape, it is crucial to examine how these two types of medical providers coordinate. Both managed care and school-based health centers have important roles in providing universal access to health care services.

EXAMPLES

For each example, we describe the community where the agreement originated, the conditions that promoted coordination, and the mechanism for coordinating.

Multnomah County, Oregon: State law requiring Medicaid managed care providers to coordinate with school-based health centers

St. Paul, Minnesota: Legal contract between managed care provider and school-based health center

Baltimore, Maryland: Protocol for referral and treatment between managed care provider and school-based health center

Minneapolis, Minnesota: Including managed care providers in coalitions which fund and develop school-based health centers

Brooklyn, New York: Public entities that administer both school-based health centers and managed care plans

Hillsborough County, Florida: Managed care providers authorize school-based health centers to provide care and bill Medicaid directly for service

San Francisco, California: Managed care gives expedited patient care on school-based health center referrals

Multnomah County, Oregon

State law requiring Medicaid managed care providers to coordinate with school-based health centers

State laws are playing a major role in increasing coordination between school-based health centers and managed care providers in Oregon. First, in 1991, Oregon enacted Senate Bill 760 (SB 760) affecting county health departments "and other publicly supported programs" that provide services to children and adolescents. (Appendix A contains a copy of SB 760.) The bill requires prepaid Medicaid health providers to contract with these public health providers for certain types of services. Since all Oregon school-based health centers are publicly funded, they are included under this statute. Then in 1992, Oregon passed the Oregon Health Plan, a State health care reform, setting a February 1, 1994 deadline for agreements between managed care providers and public health providers.

Under SB 760, Medicaid prepaid health plans are required to pay public health providers for immunizations, diagnosis and treatment of sexually transmitted diseases, and testing and treatment of tuberculosis. The managed care providers are also encouraged to contract with these providers for maternity case management, well-child care, and pre-natal care. Under this law, public health providers bill Medicaid directly on a fee-for-service basis for HIV counselling and family planning services.

In response to SB 760 and the Oregon Health Plan, negotiations are underway between the Multnomah County health department and the 12 managed care plans in Multnomah County. In addition to the community based clinics operated by Multnomah County, the County also operates seven school-based health centers. Services provided at the school-based health centers are considered part of the County's primary care clinic system.

While mandated contracts have begun to open lines of communication between managed care providers and school-based health centers, school-based health centers still will not receive reimbursement for services they provide that are not specifically covered by SB 760.

One managed care plan, Good Health Plan of Oregon, has contracted with Multnomah County to meet the requirements of SB 760. (Appendix B contains a copy of this contract.) Although this fee-for-service contract runs through 1993, no bills have been submitted to the managed care plan for any Multnomah County services to date. Multnomah County is working with all managed care plans to agree to terms so they may establish common billing protocols, procedures and communications. Without this standardization, receiving reimbursement from managed care plans may result in prohibitive costs to the county.

Unlike other areas where school-based health centers have negotiated with managed care providers, Oregon's school-based health centers face few obstacles when keeping certain health care services confidential. Under Oregon law, children who have reached age 15 have control over their medical care.

St. Paul, Minnesota

Legal contract between managed care provider and school-based health center

Comprehensive school-based health centers and managed health care emerged in the early 1970's in St. Paul. Today, Health Start, a nonprofit corporation, operates school-based health centers in six St. Paul high schools, serving over 3,000 students annually. Approximately half of the students treated at the St. Paul school-based health centers are covered by Medicaid. Health Start has been a Medicaid fee-for-service provider and obtains a sizable amount of its funding from Medicaid billings.

In the spring of 1993, the Minnesota State Medicaid agency required Medicaid recipients in Ramsey County, where St. Paul is located, to choose a managed care provider. The State also encouraged Medicaid managed care providers to coordinate with school-based health centers. By the end of 1994, Health Start estimates that 75 percent of school-based health center enrollees will be covered by managed care plans.

Anticipating the considerable impact Medicaid managed care would have on their ability to continue providing services and the reduction in their largest funding stream, Health Start began negotiations with RamseyCare, the largest Medicaid managed care provider in Ramsey County. Both parties agreed to a contract that made the school-based health centers primary care clinic providers and care coordinators for adolescents enrolled in RamseyCare. (Appendix C contains a copy of this contract.)

Under the contract, RamseyCare reimburses Health Start on a fee-for-service basis, using Medicaid reimbursement rates plus 15 percent. Health Start also bills RamseyCare for Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT) services provided to patients.

This contract allows Health Start to receive reimbursement for confidential services the school-based health centers provide (e.g. mental health services). In the past, the school-based health centers would not bill certain services to Medicaid because of the Medicaid requirement to notify the parents by an explanation of benefits of services provided to their children. This requirement had the potential to inhibit students from using services, so the school-based health centers chose not to bill for these services.

Medical information is exchanged between Health Start and RamseyCare. The school-based health centers provide medical information to RamseyCare through their billing for services. In addition, RamseyCare must give prior authorization for all specialty services. In turn, RamseyCare notifies their primary care clinics whenever emergency room visits are used.

Quality of care is also addressed in the contract. Health Start school-based health centers participate in RamseyCare quality assurance and utilization review programs.

Baltimore, Maryland

Protocol for referral and treatment between managed care provider and school-based health center

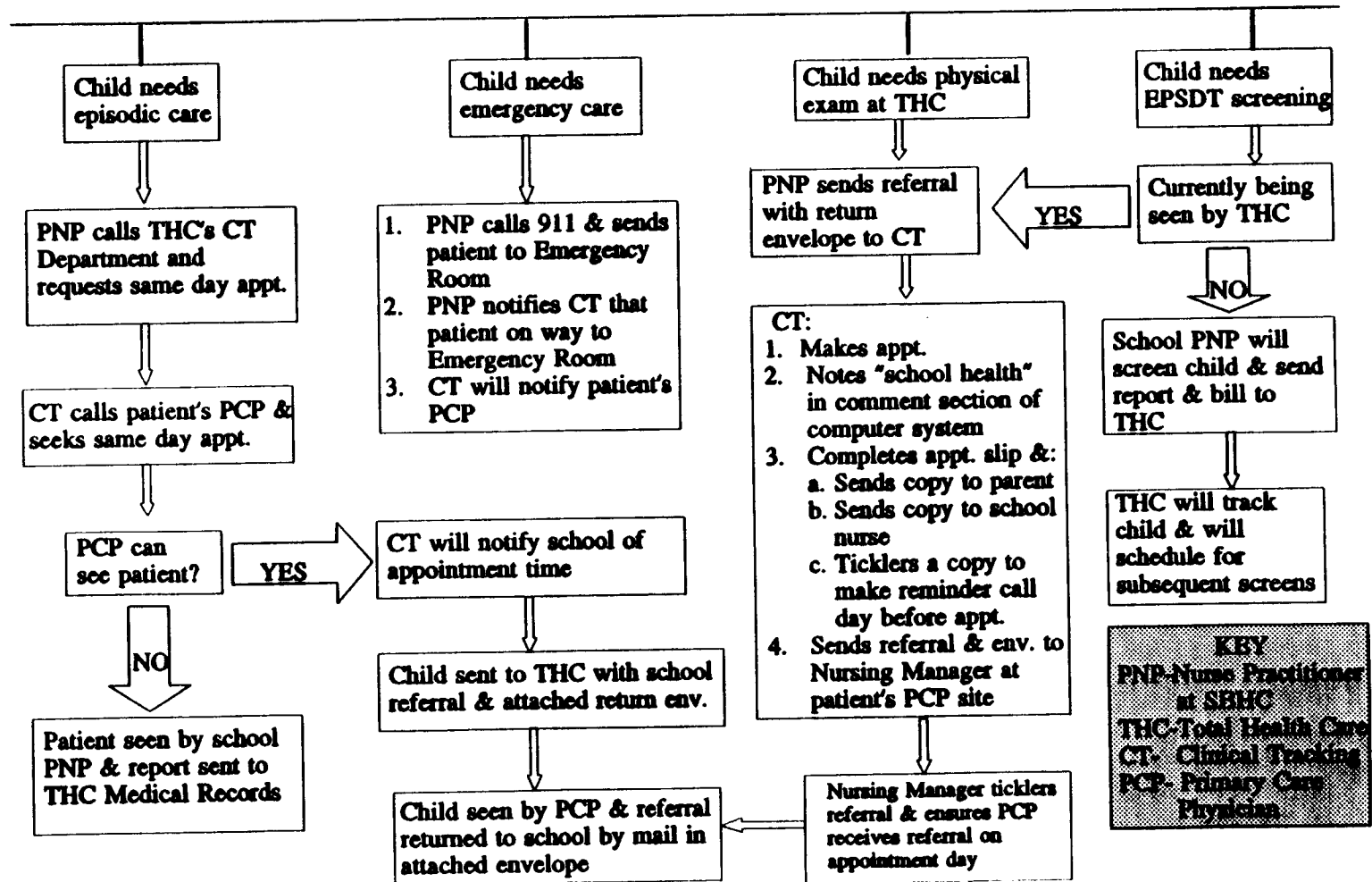
The Baltimore City Health Department began operating school-based health centers in 1985. It now operates 7 of the 10 school-based health centers in middle and high schools throughout the city. The centers provide a range of primary and preventive care aimed at improving primary care for children, promoting positive health behaviors, and increasing health knowledge and decision making skills. The full time staff at most school-based health centers includes: a nurse practitioner, a school nurse, a mental health counselor, a health educator, a medical office assistant, and a health aid. Part time staffing includes supervisory physicians, additional nurse practitioners, substance abuse counselors, case managers, social workers, and nutritionists.

As part of services delivered at the Baltimore school-based health centers, case managers help students make appointments with primary care providers for EPSDT screenings. Many children are enrolled in both a managed care program and a school-based health center. When the case managers noticed that some children with managed care providers waited as much as 6 months for appointments, the school-based health centers began providing EPSDT services to students assigned to managed care providers.

In the school-based health centers, an increasing number of children changed from fee-for-service Medicaid to managed care Medicaid. Many of the students the school-based health centers were treating belonged to Total Health Care, a managed care plan operated by a federally funded community health center. The school-based health centers, which had always provided services to some of these children, initiated a relationship with Total Health Care to become a sub-contractor providing EPSDT exams for students who were not using Total Health Care. At first, this was a contentious issue because Total Health Care viewed this as the school-based health centers taking patients away from their medical home. They saw it as a threat to continuity of care. Eventually, both providers met and worked out an informal agreement on how the Total Health Care enrollees should be treated.

The agreement defines when the school-based health centers should see patients and when they should be referred to Total Health Care. They devised a referral process with a flow chart outlining different situations students may present and what actions should be taken by the school-based health center. The flow chart on the following page gives detail about how and where Total Health Care students receive services depending on the situation. In a letter of agreement to the Baltimore Health Department, Total Health Care guaranteed reimbursement at Medicaid rates for authorized services provided in school-based health centers.

BALTIMORE CITY HEALTH DEPARTMENT SBHCS & TOTAL HEALTH CARE HMO CLIENTS FLOW SHEET



Under the agreement, the school-based health centers recognize the managed care provider as the medical home for the child. The school-based health centers try to arrange for students to receive care at Total Health Care. When a student has an acute care need, the nurse practitioner at the school-based health center calls Total Health Care's clinical tracking department to try to arrange for an appointment. If Total Health Care cannot see the student the same day, the school-based health center is authorized to provide the treatment needed.

For regular EPSDT screenings, if the student has never been to Total Health Care, the school-based health center performs the screening and sends a copy of the information to Total Health Care's records department. The school-based health centers learn which students have never been to Total Health Care by sending a computer file with students registered for the school-based health centers to Total Health Care and having Total Health Care indicate which ones are members, and which of these have never been to Total Health Care. In all other instances, Total Health Care performs EPSDT screenings. The school-based health centers facilitate these EPSDT screenings by making appointments for students to be screened and by sending appointment reminders home with students.

Whenever the school-based health center provides any service to a student enrolled in Total Health Care, they must send a bill for the service and a medical report to be included in Total Health Care records. This helps preserve the continuity of care for patients.

In addition to authorizing and reimbursing the school-based health centers for services, Total Health Care has several responsibilities under the agreement. When scheduling appointments, Total Health Care gives priority to students referred by the school-based health centers. When Total Health Care sees a patient referred by the school-based health centers, a referral form is sent back to the school-based health centers to confirm that the student has completed the referral.

Both Total Health Care and the Baltimore Health Department said that the biggest barrier they had to overcome before reaching an agreement was who would have "ownership" of the patient. At first, the school-based health centers did not want to recognize the managed care provider as the medical home for students. At the same time, Total Health Care felt they should be responsible for all care of each patient. They looked at visits to the school-based health centers as out-of-plan utilization, and did not want to authorize screenings or reimburse the centers for the bills submitted despite their long delays in scheduling EPSDT screenings. Each provider had to develop a mutual respect for the other and see how the other was concerned for the patients.

One way that Total Health Care and the Baltimore Health Department are developing a mutual understanding is through special events that expose each provider to the other and teach students how to use services. The school-based health centers held an educational session for all Total Health Care physicians to explain school-based health centers. They invited physicians to the health center site and allowed them to see how and where their patients would be treated. The school-based health centers sponsor field trips to Total Health Care for students who have never been to their clinics before. The students are transported to the Total Health Care clinics by bus, and Total Health Care teaches them how to access the clinics, provides lunch, gives a tour, and allows students to meet the doctors. Parents may also join this trip to Total Health Care.

During the first 5 months of the agreement, Total Health Care reimbursed the Baltimore Health Department for 120 EPSDT visits. They also will reimburse the Health Department for some authorized follow-up treatment visits, increasing revenue for the Baltimore school-based health centers. In addition to this, coordination has improved continuity of care to students who normally would not have it.

While the agreement between Total Health Care and Baltimore's Health Department allows students to receive EPSDT screening at the school-based health centers, it cannot address many other issues regarding the school-based health centers and managed care providers. The agreement covers a limited number of services, omitting issues such as how confidential reproductive health services should be delivered by school-based health centers. It does not address how services other than EPSDT should be reimbursed, and State Medicaid managed care contracts are unclear on this issue, creating dispute over which services should be reimbursed and at what rates. Also, the agreement applies only to interaction with Total Health Care. It cannot address how the school-based health centers coordinate with other managed care providers in the Baltimore area.

Even with an agreement, Baltimore school-based health centers still face barriers providing services to students who need them, collecting reimbursement for these services, and keeping patient information confidential.

Minneapolis, Minnesota

Including managed care providers in coalitions which fund and develop school-based health centers

The Minneapolis Board of Education established school-based health centers in their high schools 14 years ago. Today these school-based health centers serve over 10,000 students. Hennepin County, the city of Minneapolis, the Minneapolis Children's Medical Center, the University of Minnesota, the Robert Wood Johnson Foundation, Maternal and Child Health block grants, and the local health department provide major funding for the school-based health centers.

There is broad based community support for the Minneapolis school-based health centers. Four health care agencies are major medical sponsors for the school-based health centers, providing medical staff and other support. In addition to these sponsors, numerous other agencies co-locate staff in the school-based health centers.

The Minneapolis-St. Paul area is home to a very competitive managed care market. As Minnesota Medicaid expanded managed care into Hennepin County, Medicaid recipients were required to choose a managed care plan for themselves and their children. Forty percent of the school-based health center patients are Medicaid managed care patients. Of the managed care plans, Medica, a primary care case manager plan, currently covers approximately 70 percent of the Minneapolis Medicaid enrollees.

In recent years, some of the school-based health center's sponsoring agencies attempted, without success, to bring together all involved in adolescent health to discuss the role of school-based health centers in the community and to obtain additional funding or support. But in 1992, Medica performed a utilization study of their members and found that adolescents were not receiving many primary care services from Medica providers. In February 1993, school-based health centers and their community sponsors began negotiating with Medica and other managed care providers to address school-based health centers' providing services to adolescents covered by managed care providers.

As a result of these meetings, Medica, through a foundation, is underwriting the full cost of the Minneapolis school-based health center at Southwest High School for a year. During this year, this school-based health center will not bill Medica for any treatments provided to children enrolled with Medica.

The other managed care plans are collaborating with the school-based health center program and are considering pledging \$1 million to fund the other Minneapolis school-based health centers. By November 22, 1993, these managed care providers will announce their contributions to this effort. In the interim, Medica is providing an additional \$110,000 to keep the school-based health centers operating.

After this school year, Medica and the other managed care providers will evaluate their experiences and collaborate with school-based health centers to decide which health services should be delivered in school-based health centers and which services should be delivered elsewhere.

Brooklyn, New York

Public entities that administer both school-based health centers and managed care plans

We visited three communities where federally funded community health centers operate school-based health centers as well as managed care plans. To illustrate this example, we will discuss one of these community health centers, the Sunset Park Family Health Center of Lutheran Medical Center in Southwest Brooklyn, New York.

Sunset Park Family Health Center is a federally funded community health center that operates 10 school-based health centers in elementary and middle schools in the Brooklyn area. They also provide an array of community-based outreach and education programs, a mental health and substance abuse program, and two satellite health centers in Brooklyn. They have incorporated their school-based health centers into the overall system at Sunset Park.

The school-based health centers serve large numbers of Medicaid eligible children. Sunset Park Family Health Center bills about 41 percent of the visits to the school-based health centers to Medicaid. Sunset Park recently started Health Care Plus, a managed care plan for Medicaid clients, and students enrolled in Health Care Plus may choose a school-based health center as a primary care provider.

When school-based health centers are the primary care providers for students, they need no authorization to treat patients enrolled in Health Care Plus, and they will be reimbursed through Sunset Park for the services provided. Because the school-based health centers are part of the managed care network, continuity of care is not an issue for these students.

Until recently, Sunset Park faced barriers to integrating the school-based health centers into their managed care network. One problem Sunset Park had to address was how to ensure that other providers in the Family Health Center network could access patient information when necessary. Sunset Park has created a database system that should address this issue. An Active Patient Identification System contains demographic information and visit histories on all patients using any of the Sunset Park Family Health Center facilities, including the School Health Program. The school-based health centers are electronically linked to this system, so that visit information is available network-wide.

While this arrangement has potential benefits for children enrolled in Health Care Plus, Sunset Park still faces many obstacles to treating children at school-based health centers. For example, parents may not understand that they can choose their child's school-based health center as the primary care provider in Health Care Plus. If parents do not choose the school-based health centers as a primary care provider for

their children, and the children receive care at the school-based health center, reimbursement is not provided and coordination of care becomes more difficult.

Another drawback to this arrangement is that it does not address how or whether the school-based health centers treat students enrolled in other managed care plans. Because Sunset Park runs a managed care program, other managed care providers see Sunset Park as a competitor for patients. This impedes coordination with other managed care providers whose enrolled patients receive services at the school-based health centers.

Hillsborough County, Florida

Managed care providers authorize school-based health centers to provide care and bill Medicaid directly for service

Several States told us that some managed care providers authorize school-based health centers to provide services to children enrolled with managed care providers. One site we visited, the Hillsborough County Public Health Unit in Tampa, Florida, sponsors several school-based health centers that serve many children enrolled with managed care providers. The Hillsborough County Public Health Unit recently began to seek authorization to perform EPSDT screening and limited services on managed care enrolled students who are registered at their health centers.

The State of Florida's Department of Health and Rehabilitation Services awards over \$9 million in Supplemental School Health Grants to 192 schools throughout Florida. This grant program provides funds for school health projects at nine Hillsborough county schools at the elementary, middle, and high school level. Four of these schools deliver services through on-site school-based health centers. This program, called the Healthy Student and Healthy Young Student program serves two high schools, one middle school, and one alternative school for pregnant teenagers. The Hillsborough County Health Department manages the project with close cooperation from the Hillsborough County School System.

The schools involved in this program share three mental health therapists, a clinic nurse, a nurse practitioner, a community health nurse, a nutritionist, health aides, a program manager, and a physician. These professionals deliver a range of services, including: triage for medical injuries and illness, health education and counseling, mental health assessment and counseling, injury prevention, pregnancy counseling services, and baby and mother services. The alternative school for pregnant teenagers provides all pre-natal and post-partem care for its enrolled students and their newborn babies up to 6 weeks following the birth.

The project is funded primarily through the Supplemental School Health Grants, but school-based health centers also receive in-kind contributions of staff from the County Health department. The County Public Health Unit bills for Medicaid services provided at the school-based health centers. The County Public Health Unit has set a goal for school-based health centers to provide EPSDT screenings to all Medicaid eligible students in these schools.

To ensure that all children are screened, the school-based health centers are trying to obtain authorization to screen those children enrolled with Medicaid managed care providers. Without an authorization number, however, any service the school-based health centers provide to Medicaid children enrolled in managed care plans will not be reimbursed by Medicaid. Due to time constraints and the priority of screening eligible

students, the school-based health centers are focusing authorization efforts on EPSDT services.

Students registering for school-based health centers must indicate if they are Medicaid eligible. If eligible, the school-based health centers ask students to supply their Medicaid identification number. Using the Medicaid identification number, or in some cases the child's name and supporting information, the county public health unit generates printouts of the Medicaid eligible children and their primary care providers. The school-based health centers then separate out those who are assigned to a Medipass provider (Florida's managed care Medicaid plan for individual physicians to become primary care providers), or to a managed care health plan.

When a student assigned to a managed care provider needs an EPSDT screening, staff from the Hillsborough county school-based health centers call the primary care provider for that student. They explain that the health center will perform the screening and request an authorization number so that they may bill Medicaid for the service. If the physician agrees, the county public health unit receives an authorization number for that particular service and performs the screening. The school-based health centers can then bill Medicaid for the service through the county public health unit and be reimbursed at the regular Medicaid rate for EPSDT.

Sometimes, the county public health unit does not have time to receive pre-authorization for screenings. In these cases, they perform screenings on children who need them and bill Medicaid for the service. These Medicaid bills will be rejected or accepted based on whether the managed care provider authorizes the service.¹

The county public health unit also has billed Medicaid for pregnancy related services provided at the alternative school. Using the same process as with the EPSDT screening, the school-based health center calls the primary care provider to authorize care. Usually, the primary care provider will authorize the school to provide pregnancy related services to this hard to reach population. In this case, the school-based health centers are reimbursed at the regular Medicaid rate for a pregnancy.

The biggest barriers to this type of coordination have been overcoming the competitive nature of managed care, and the school-based health centers' lack of time to obtain authorization to provide service. For providers to make money, they must provide services. By authorizing someone else to deliver service to their patients, they potentially lose some income, and they may feel that in the long run, they will lose patients. This issue makes some primary care providers reluctant to authorize the school-based health centers to provide care. The other barrier is that calling for

¹ Since Hillsborough County started requesting authorization for EPSDT screening, obtaining authorization has become more difficult because the State Medicaid agency no longer accepts authorization for services after they have been provided. This need to pre-authorize services will delay a child's screening or force the school-based health centers to perform screening without reimbursement when there is no time to obtain authorization numbers before delivering services.

authorization of care is time-consuming, particularly in schools where only a few staff members run the school-based health centers.

Hillsborough county says they have been able to build the trust of managed care providers in many cases because the physician who works at the school-based health centers is well-known and respected in the community.

The issue of time constraints continues to be a problem, but Hillsborough county tries to address this by prioritizing their calls to managed care providers. The County Public Health Unit calls physicians they have worked with before, or physicians who will be more likely to authorize service first. They still screen all the students who need it, regardless of insurance status. But, by prioritizing their calls, school-based health centers maximize the reimbursement they will receive for performing EPSDT.

The arrangement is helpful because it allows the schools to serve students enrolled in managed care conveniently, and the school-based health centers are reimbursed for services that have gone uncompensated in the past.

San Francisco, California

Managed care gives expedited patient care on school-based health center referrals

Balboa Teen Health Center was established in 1986 in cooperation with the Department of Public Health and the San Francisco Unified School District. Since opening, Balboa's Teen Health Center has provided a full range of primary care, including routine examinations, acute care, mental health programs, health education, and other services. All services are provided confidentially and at no charge to Balboa High School students, regardless of their insurance status. The only requirement for treatment is that parents sign a blanket waiver consenting to services when enrolling children at the school-based health center.

As part of a baseline budget for children's programs established by proposition J, California's Children's Budget Initiative, Balboa Teen Health Center receives funding from the local health department. This funding was intended to cover Balboa Teen Health Center's financial needs for 10 years; however, recent budget difficulties have threatened the stability of this funding source. In addition to these funds, the State of California recently authorized Balboa Teen Health Center to bill for services provided to students enrolled in Medi-Cal, California's Medicaid program. However, none of the San Francisco area managed care providers authorize Medi-Cal to reimburse Balboa Teen Health Center for services it provides to their patients.

Many of the students at Balboa High School are insured with Kaiser Permanente, either privately or through the Medi-Cal program. In an effort to supplement its health care capabilities and to guarantee continuity of care, Balboa Teen Health Center has established an expedited referral process with Kaiser Permanente for all students covered by that provider.

For students covered by Kaiser Permanente, whether Medi-Cal recipients or not, the Balboa Teen Health Center performs a triage function. Balboa provides basic primary or acute care to students who register for the health center. If follow-up or treatment beyond the capabilities of the Balboa Teen Health Center is necessary, the health center immediately refers the student to Kaiser Permanente. Balboa Teen Health Center telephones the physician contact at Kaiser Permanente, explains the problem, and schedules an appointment for the patient. For these students, continuity of care is ensured.

Balboa Teen Health Center shares patient information with Kaiser only when referring students for emergency care, follow-up visits, or additional services not available at Balboa. Although information is usually shared informally by telephone or facsimile machine, all information shared outside the school-based health center with facilities other than the San Francisco Department of Public Health requires specific patient release of information.

There is no formal contract between the two providers. However, Balboa Teen Health Center recently drafted a letter to the physician contact at Kaiser Teen Clinic in San Francisco to create a more formal structure for their working relationship. Kaiser has agreed to and followed the terms of this letter. While this agreement helps ensure continuity of care for Kaiser Permanente patients, it does not address the funding issues raised when school-based health centers provide uncompensated care to students enrolled in managed care plans.

APPENDIX A

OREGON SENATE BILL 760

Enrolled
Senate Bill 760

Sponsored by Senator KENNEMER; Senators BRENNEMAN, CEASE, COHEN, GOLD, HAMBY, McCOY, TROW, Representatives BARNES, BAUMAN, CARTER, CLARK, HAYDEN, MASON, McTEAGUE, MEEK, MILLER, SHIPRACK, SOWA, STEIN (at the request of Clackamas County, Coalition of Local Health Officials)

337

CHAPTER

AN ACT

Relating to poverty level medical programs.

Be It Enacted by the People of the State of Oregon:

SECTION 1. It is the purpose of this Act to take advantage of opportunities to:

- (1) Enhance the state and local public health partnership;
- (2) Improve the access to care and health status of women and children; and
- (3) Strengthen public health programs and services at the county health department level.

SECTION 2. The Adult and Family Services Division, the Office of Medical Assistance Programs and the Health Division shall endeavor to develop agreements with local governments to facilitate the enrollment of poverty level medical assistance program clients. Subject to the availability of funds therefor, the agreement shall be structured to allow flexibility by the state and local governments and may allow any of the following options for enrolling clients in poverty level medical assistance programs:

- (1) Initial processing shall be done at the county health department by employees of the county, with eligibility determination completed at the local office of the Adult and Family Services Division;
- (2) Initial processing and eligibility determination shall be done at the county health department by employees of the Adult and Family Services Division; or
- (3) Application forms shall be made available at the county health department with initial processing and eligibility determination shall be done at the local office of the Adult and Family Services Division.

SECTION 3. To capitalize on the successful public health programs provided by county health departments and the sizable investment by state and local governments in the public health system, state agencies shall encourage agreements that allow county health departments and other publicly supported programs to continue to be the providers of those prevention and health promotion services now available, plus other maternal and child health services such as prenatal outreach and care, child health services and family planning services to women and children who become eligible for poverty level medical assistance program benefits pursuant to section 4 of this Act.

SECTION 4. In order to make advantageous use of the system of public health services available through county health departments and other publicly supported programs and to insure access to public health services through contract under ORS chapter 414, the state shall:

- (1) Unless cause can be shown why such an agreement is not feasible, require and approve agreements between prepaid health plans and publicly funded providers for authorization of payment for point of contact services in the following categories:

- (a) Immunizations;
 - (b) Sexually transmitted diseases; and
 - (c) Other communicable diseases;
- (2) Continue to allow enrollees in prepaid health plans to receive family planning services from fee-for-service providers;
- (3) Encourage and approve agreements between prepaid health plans and publicly funded providers for authorization of and payment for services in the following categories:
- (a) Maternity case management;
 - (b) Well-child care; and
 - (c) Prenatal care; and
- (4) Recognize the social value of partnerships between county health departments and other publicly supported programs and other health providers, and take appropriate measures to involve publicly supported health care and service programs in the development and implementation of managed health care programs in their areas of responsibility.

Passed by Senate May 23, 1991

Donna Merrill
Secretary of Senate

Paul G. Pata
President of Senate

Passed by House June 4, 1991

Larry Combs
Speaker of House

Received by Governor:

11:00 AM June 18, 1991

Approved:

9:19 AM June 25, 1991

Barbara Roberts
Governor

Filed by Office of Secretary of State:

11:21 AM June 25, 1991

Phil Keisling
Secretary of State

APPENDIX B

CONTRACT BETWEEN MULTNOMAH COUNTY AND GOOD HEALTH PLAN

Letter of Agreement

1. Services will be provided by the Multnomah County Department of Health, hereinafter referred to as "Provider", to Good Health Plan of Oregon Medicaid-sponsored members, who are Office of Medical Assistance Programs (OMAP) eligible recipients who have enrolled with the Good Health Plan, hereinafter referred to as "Members", or "Member". Services will be provided for immunizations, sexually transmitted diseases, and other communicable diseases of public health concern. Good Health Plan of Oregon will hereinafter be referred to as "Health Plan".
2. Health Plan will furnish Provider each month with a current roster of enrolled Members, which will indicate all existing Primary Care Physician designations.
3. Services will be provided within the scope and guidelines of SB 760 with the intent to involve publicly supported health care and service programs in the development and implementation of managed health care programs in their areas of responsibility.
4. Provider agrees to bill services to Health Plan, not to Members. Provider will make every effort to bill in a timely manner. Bills will be submitted beginning 14 days after date of service, but they may be submitted up to one year from date of service. Any bill submitted more than one year after the date of service will not be payable by either Health Plan or Member. Provider will submit bills on standard HCFA 1500 forms, using CPT codes and ICD-9 codes. Services for individual Members will be billed separately, and Provider will bill for all services provided to Member regardless of whether services are covered by this Agreement. Health Plan will pay only for those services covered by this Agreement. Clean claims will be paid within 30 working days. Provider must appeal any claims adjudications or other matters within 90 days of the date of payment and if Provider fails to do so, Provider will be deemed to have waived any appeals rights.
5. Provider agrees to accept Health Plan's payment as payment in full for covered services. Health Plan's payment will be as listed in Attachment A. Appropriate services covered by this Agreement that are not listed specifically in Attachment A will be reimbursed at the Health Plan allowable for the service. Payments will be considered payment in full for applicable charges. Provider agrees that no copayment will be charged at time of service.
6. Provider agrees to provide Members with the same quality and timeliness of care as other patients. Quality of care will be commensurate with the professional standards of the community.
7. Provider through the state of Oregon, is self-insured under provisions of ORS 30.260 through 30.300 (as now or hereafter amended) for its tort liabilities. Pursuant to ORS 30.260 through 30.300, Provider and its employees are insured against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of, or failure to perform, any Provider service provided hereunder, the use of any property and facilities provided by Provider, and activities performed by Provider in connection with this Agreement. A letter certifying Provider's insurance shall be provided to Health Plan upon request.

8. The parties hereto mutually agree to indemnify, defend, and hold each other (including their officers, agents, and employees) harmless against any and all claims, demands, damages, liabilities, and costs incurred by the other party, including reasonable attorneys' fees, arising out of or in connection with, either directly or indirectly, the performance of any service, or any other act or omission by or under the direction of the indemnifying party, its officers, agents, or employees.
9. Provider hereby agrees that in no event, including but not limited to non-payment by Health Plan, insolvency of Health Plan, or breach of this Letter of Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Member, or other persons acting on their behalf, other than Health Plan, for covered services provided pursuant to this Letter of Agreement. This is further dictated by the Federal Medicaid Act and applicable Oregon Statutes and Oregon Administrative Rules concerning the provision of Medical Services under prepaid capitated health plans.

Provider further agrees that this provision shall survive termination of this Letter of Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Health Plan's Member; and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Member, or persons acting on their behalf. This provision applies to services provided during a time period for which Member premiums have been paid.

10. Provider agrees to maintain all required licenses, certificates, and/or registrations as issued by the appropriate State, Federal, and local governmental agencies to provide the health care services which Provider undertakes to provide to Members under this Letter of Agreement.
11. Provider agrees, except in accordance with provisions, spirit and intent of this Agreement not to differentiate or discriminate in its provision of services to Members because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age.
12. Attachment B lists current service locations. Provider will notify Health Plan of service location changes as they occur.
13. Provider will make every reasonable effort to direct the Member to Member's primary care physician for services not included in this contract. Members may be billed only for those services not covered by Medicaid.
14. Provider and Health Plan may agree to contract for certain services not included in this Agreement on an as-needed basis. Provider and Health Plan will agree at time of service on rates and charges associated with such services. Services will include but are not limited to obstetrical case management and specialized programs sponsored by Provider.
15. In the event of any dispute arising out of or relating to this Agreement, the parties shall attempt in good faith to mutually resolve the dispute. Any appeals on decisions related to treatment or services will be mediated between Health Plan and Provider.

16. This Letter of Agreement may be terminated at any time without cause by either party upon sixty (60) days advance written notice to the other party.
17. The term of this Letter of Agreement shall commence on January 1, 1993 and shall continue in effect through December 31, 1993 and thereafter until December 31 of each following year unless terminated by either party pursuant to the terms stated herein. The fee schedule as listed in Attachment A may be revised concurrent with renewal.

AGREED AND ACCEPTED:

Sisters of Providence
Health Plans in Oregon
Good Health Plan of Oregon HMO
"Health Plan"

Multnomah County, Oregon
Department of Health
"Provider"

By: *Ted von Glahn*
Ted von Glahn
Chief Operating Officer

By: *Gladys McCoy*
Gladys McCoy
Multnomah County Chair

Date: 10/3/92

Date: 1/6/93

93-0863097
Employer I.D. Number

By: *Bill Odegaard*
Bill Odegaard, Director, Health Dept.

Date: 12/23/92

By: *Mary L. Hendrick*
Program Manager, Health Department

Date: _____

REVIEWED:

LAURENCE B. KRESSEL, County Counsel
for Multnomah County, Oregon

By: *Laurence B. Kressel*

Addendum A

This Addendum to the Letter of Agreement serves to establish operational protocol and procedures to help ensure coordinated delivery of the health services specified in the Letter of Agreement, which Medicaid-sponsored, Managed Care Program enrollees may receive from both County health department personnel and their Good Health Plan of Oregon (Plan) providers.

- (1) **Primary Care Physician (PCP) Coordination:** Plan PCPs are to be informed of Plan-reimbursed, optional health care services received by their members at County health clinics.
 - The respective County will bill the Plan for each service encounter in a format that identifies the date, member name, diagnostic code(s), and procedure code(s) enabling the Plan to generate a report for entry by the PCP in the member's medical record.

- (2) **Protocol to Support Compliance with Recommended Immunization Schedules -**
The Involved PCP and County clinic will adhere to the following procedures:
 - During the initial office visit, the PCP is expected to discuss the immunizations delivery option and help the member determine where they will most readily comply with immunization schedules, at their PCP's office or at a County clinic.
 - If a member self-directs to the County for immunization services, she will be encouraged to remain with the County provider to completion of the immediate immunization schedule.
 - The Plan will assist PCPs with a tracking and recall system.

- (3) **Protocol Related to Sexually Transmitted Diseases:** Routine screening, treatment, and monitoring for recurrence of STDs will be provided exclusively by the PCP in the course of providing the member's primary care.
 - Both the involved County and the PCP will screen and treat sexually transmitted diseases when a member presents episodically.
 - The Plan expects the County to proceed with treatment and all immediate followup to assure that this episodic treatment was effective.
 - Members will be directed to their PCPs for annual gynecological examinations, which include routine STD screening, and ongoing monitoring of conditions previously treated by the County.
 - The point-of-service contact may arise directly from STD concerns or from the delivery of family planning services, which routinely involve a PAP test and, secondarily, may detect the presence of a STD.

Continued

- (4) **Protocol Related to Other Communicable Diseases:** The County will provide necessary diagnostic testing and counseling when a member contact presents the opportunity to screen for a communicable disease of public health concern (i.e., TB, HIV/AIDS, and viral hepatitis). The County will refer the member to the PCP for treatment and concurrently notify the member's PCP of the referral, to facilitate PCP follow up, as soon as the member is informed of an HIV/AIDS diagnosis or TB diagnosis (services typically involve skin test/chest x-ray/INH).
- The PCP, in providing primary care, routinely will screen for communicable diseases.
 - When the PCP makes a TB diagnosis, she/he may refer the member to the County for treatment if justified by the County's capability to treat more effectively; otherwise, treatment will be provided routinely by the PCP or referred to a Plan specialist.
 - The County will be asked to furnish the Plan with informational material about its communicable disease prevention and treatment services, which may be used to inform PCPs more fully about this treatment option.
- (5) **Referral to Plan Pharmacies:** To ensure efficient dispensing, prescriptions for members should be called in or taken to a Plan pharmacy (see listing provided as Addendum B).
- The Plan will supply all County clinics with updated Plan Pharmacies listings as issued.
 - The rationale for this restriction is the likelihood that a non-Plan pharmacy will deny service to a Medical Card holder designated as an enrollee of the Good Health Plan.
- (6) **Access to Family Planning Services:** Members may obtain OMAP-covered family planning services from the County or any other licensed, enrolled OMAP provider. Counseling on methods of family planning is the only service covered by the Good Health Plan. However, the member's PCP, as an individually-enrolled OMAP provider, can provide OMAP-covered family planning medical services and prescriptions on a fee-for-service reimbursement basis.
- When the County provides covered family planning services to a GHPO-Medicaid member, the County will bill OMAP for these services on a fee-for-service basis. Therefore, neither the Plan nor the member's PCP will be notified of County-provided family planning services.
 - To ensure access to provider options for family planning services, member materials will promote the publicly-funded 1-800-SAFENET telephone information and referral service, which can direct the member to her County health department and community providers of all-options family planning. Plan Providers will be furnished SafeNet promotional materials for additional distribution to members.

APPENDIX C

CONTRACT BETWEEN HEALTH START AND RAMSEY CARE

PREPAID MEDICAL ASSISTANCE PROGRAM

PRIMARY CARE PROVIDER AGREEMENT

This Agreement, made and entered into this first day of Dec., 1992, by and between the party executing this Agreement on the Signature and Declaration Page attached hereto ("Provider") and NW HEALTH NETWORK, INC. ("Health Plan")

SECTION I PARTIES AND PURPOSE

Section 1.1 Parties. The Health Plan is a Minnesota nonprofit corporation licensed and organized as a health maintenance organization to arrange to provide health care services to residents of Minnesota on a prepaid basis. The Health Plan has been duly approved and designated by the State of Minnesota as a vendor of health care services for the Prepaid Medical Assistance Program ("PMAP") for eligible Medical Assistance ("MA") recipients who enroll in the Health Plan. Provider is a community health care clinic and is duly licensed by the State of Minnesota.

Section 1.2 Purpose. The Health Plan wishes to contract with Provider to provide Primary Health Care Services under PMAP to recipients enrolled in the Health Plan. Provider agrees to work with the Health Plan in the delivery of health care services to eligible persons participating in PMAP who are enrolled in the Health Plan. Provider is willing to provide such persons with Primary Health Care Services as provided under federal and Minnesota law and regulations governing PMAP and the Health Plan, and to receive payment in full the payment specified in this Agreement.

SECTION II: DEFINITIONS

The following definitions shall apply to this Agreement and all exhibits and addenda attached hereto:

Section 2.1 "Care Coordination". The initial and periodic assessment of each Enrollee's health and social situation and the development, implementation and monitoring of care plans for each Enrollee.

Section 2.2 "Care Coordinator". The nurse, social worker or other appropriate professional person who is designated by Provider or selected Primary Care Site medical staff to perform Care Coordination for assigned Enrollees.

Section 2.3 "Clinic Professional". All medical doctors and other duly qualified licensed or registered health care professionals who are members, partners, shareholders, owners, agents, or employees of Provider or are otherwise affiliated with Provider.

Section 2.4 "Covered Services". Those health care products and services included in the PMAP benefit package and described in the Health Plan's Description of Benefits.

Section 2.5 "Emergency Care". The provision of medical services necessary Covered Services which are required to treat an immediate medical emergency.

Section 2.6 "Enrollee". An MA-eligible individual whose enrollment in the Health Plan under PMAP has been entered into the State Client Information File.

Section 2.7 "Enrollee Certificate". A contract, certificate or other evidence of coverage issued to an Enrollee that describes

the Covered Services available to the Enrollee under PMAP and the Health Plan's Description of Benefits.

Section 2.8 "Health Plan Quality Assurance Protocol". The standards and operating procedures adopted from time to time by the Health Plan as necessary to maintain the Health Plan's quality assurance program in accordance with Minnesota law and acceptable to the United States Department of Health and Human Services (DHHS).

Section 2.9 "MA Care Protocol". The utilization and quality assurance standards and procedures identified and developed from time to time by the Health Plan to be used in the care of Enrollees. The MA Care Protocol includes specific penalties for non-compliance with established standards and provides an appeals process for participating providers affected by the Protocol. The MA Care Protocol is subject to the Quality Assurance Plan and is contained in the MA Care Manual maintained by the Health Plan and is incorporated herein by reference.

Section 2.10 "MA Medical Director". A physician appointed by the Health Plan to oversee the quality of Covered Services delivered to Enrollees and to review cases of excessive utilization of Covered Services. The MA Medical Director shall have the authority to make determinations in accordance with the MA Care Protocol.

Section 2.11 "MA Participating Provider". A provider of Covered Services under PMAP who is a Primary Care Provider, Referral Provider or other provider under contract with the Health Plan to provide such health services.

Section 2.12 "Medical Emergency Services". Covered Services provided as Emergency Care. For purposes of this contract, "Medical

Emergency" shall mean a condition that if not treated immediately could cause a person serious physical or mental disability, the continuation of severe pain or death. Labor and delivery is a medical emergency if it meets this definition.

Section 2.13 "Out-of-Plan Care". Health care provided to an Enrollee by providers who are not under contract with the Health Plan to provide health services under PMAP.

Section 2.14 "PreAdmission Screening/Elderly Waiver Program". The State program mandated by Minnesota Statutes, Section 256B.69 (1990), section 256B.0915 (Supp. 1991), and Minnesota Rules, parts 9505.2390 to 9505.2500.

Section 2.15 "Prepaid Medical Assistance Program (PMAP)". The program authorized under Minnesota Statutes, Section 256B.091 (1990), Section 256B.0915 (1992) and Minnesota Rules, parts 9500.1450 to 9500.1464.

Section 2.16 "Primary Care". A type of medical care emphasizing first contact care and the assumption of ongoing responsibility for the patient in both health maintenance and therapy for illness or injury. It is comprehensive in scope and involves the overall coordination of care of the patient's health problems whether biological, behavioral or social.

Section 2.17 "Primary Care Provider". A primary care physician or other provider of health care who has entered into a contract with and who is authorized by the Health Plan to provide Primary Care Covered Services to Enrollees and to authorize Covered Services to be performed by Referral Providers.

Section 2.18 "Primary Care Site". A medical clinic location

whose medical staff agrees to serve as the primary control point for an Enrollee's medical care needs.

Section 2.19 "Provider Manual". The official Minnesota Department of Human Services' publication, entitled "Medical Assistance and General Assistance Medical Care Provider Manual," which is issued to providers by the State to clarify policy, procedures, or definitions of Covered Services under PMAP.

Section 2.20 "Referral Provider". A provider of health care who delivers Covered Services to Enrollees as requested by a duly authorized Primary Care Provider and who has entered into a Referral Provider contract with the Health Plan to deliver such Covered Services.

Section 2.21 "Referral Services". Covered Services provided to Enrollees by Referral Providers as requested by a Primary Care Provider.

Section 2.22 "Urgent Care". Covered medical services which are medically necessary in order to prevent a serious deterioration of the health of an Enrollee who is temporarily outside the service area, Ramsey County of the State of Minnesota, when the need for care arises.

SECTION III: PROVISION OF SERVICES

Section 3.1 Obligation to Provide Covered Services. Provider is a Primary Care Provider and shall provide, or arrange for the provision by MA Participating Providers designated by the Health Plan pursuant to the MA Care Protocol, to Enrollees who choose to obtain services from Provider, all medically necessary and appropriate

Covered Services including those services in Appendix I to this Agreement, attached and incorporated herein. Provider shall, to the maximum extent possible, provide Care Coordination for each Enrollee who chooses to obtain services from Provider, including all Covered Services rendered to such Enrollee by providers not affiliated with Provider. The Health Plan may make deletions from or additions to the Covered Services as may be required from time to time by federal or state law subject to approval by the Minnesota Department of Health. The Health Plan shall give written notice of any such deletions or additions to Provider within seven (7) days of being so notified by appropriate persons responsible for the PMAP.

Section 3.2 C.L.I.A. Requirements. All laboratory testing sites providing services for PMAP pursuant to arrangements under this Agreement shall have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

Section 3.2 Standard of Service. Provider is responsible for and agrees to provide Covered Services to Enrollees in accordance with the professional standards of the community and in accordance with the Health Plan Quality Assurance Protocol and the MA Care Protocol. All Covered Services provided in accordance with this Agreement shall be at least equal in quality, completeness and promptness to services provided by Provider to other persons not

covered by this Agreement.

Section 3.4 Information Regarding Services. Provider shall furnish to the Health Plan without charge reports and data concerning Covered Services provided by Provider to Enrollees in such form and at such times as may be reasonably required by the Health Plan, the State of Minnesota, or the United States Department of Health and Human Services ("DHHS").

Section 3.5 Control of Operations. The operation and maintenance of the offices, facilities and equipment of Provider shall be solely and exclusively under the control and supervision of Provider. The Health Plan shall have no right, authority or control over the selection of staff or the supervision of personnel of Provider. Each Clinic Professional shall maintain the same doctor/patient relationship as would arise in the absence of this Agreement, and no provision of this Agreement shall have the effect of infringing upon a Clinic Professional's professional relationship with each Enrollee.

Section 3.6 Enrollee Identification. Based on information made available to the Health Plan by the State of Minnesota, the Health Plan shall maintain such lists as are needed for the purpose of enabling Provider to establish procedures for identification of eligible Enrollees. The Health Plan shall also issue an identification card to each Enrollee, promptly after his or her enrollment, bearing the name of the Enrollee, Enrollee number, and effective date of coverage. Provider agrees to use reasonable efforts to verify the current status of an Enrollee's eligibility for Covered Services.

Section 3.7 Primary Care Sites. At the time of enrollment, Enrollees shall be notified of the names of MA Participating Providers who have been designated by the Health Plan to serve as Primary Care Sites. Enrollees shall be notified that they are to seek Covered Services exclusively from those Primary Care Sites or from Referral Providers to whom Enrollees are referred in writing by a Primary Care Provider. Provider agrees to make the Primary Care Site as designated by Provider available to each Enrollee. Provider will furnish the Health Plan with a current list of all Clinic Professionals who will be providing Covered Services and shall provide the Health Plan with an amended list within ten (10) working days of any changes.

Section 3.8 Site Designation Enrollees. Enrollees will also be notified that the Health Plan retains the right to designate a specific Primary Care Site for each Enrollee and will do so when it is judged appropriate by the Health Plan. If an Enrollee is informed that he or she has been assigned to receive Covered Services from a specific Primary Care Site, then all subsequent Covered Services for that Enrollee must be provided or arranged for by such Site. Only Covered Services authorized by Enrollee's designated Primary Care Site will be covered by the Health Plan, except for Medical Emergency Services and "out-of-plan" Urgent Care services, as defined herein and in the Enrollee Certificate.

Section 3.9 Other Providers. Except in cases of Medical Emergency or as provided otherwise in PMAP or as expressly specified by the Health Plan in writing from time to time, if Provider is unable for any reason to render a necessary Covered Service to an

Enrollee, Provider shall arrange to have such Covered Services rendered to Enrollee by another MA Participating Provider if possible. The Health Plan will make available to Provider a list of all MA Participating Providers, as modified from time to time. Providers shall obtain prior authorization from the Health Plan for any such arrangement to have Covered Services rendered by a provider that is not a Primary Care Provider under contract with the Health Plan to provide services under PMAP.

SECTION IV PAYMENT FOR SERVICES

Section 4.1 Payment Procedure. The Health Plan shall pay Provider for the provision of Covered Services to Enrollees and the other responsibilities assumed by Provider under this Agreement, as provided in Exhibit A attached hereto and incorporated herein. Provider shall send all invoices for Covered Services provided to Enrollees to the Health Plan's Claim Department as specified by the Health Plan. Information required to be submitted in such invoices by Provider includes, but is not necessarily limited to the following:

- a) primary and secondary diagnosis codes using ICD-9 coding;
- b) procedure codes including modifiers;
- c) unit of service and date of service;
- d) place of service (e.g. inpatient hospital, outpatient hospital, outpatient clinic, physician office, etc.); and,
- e) MA identification number.

Provider must file all such invoices within sixty (60) days following the close of the calendar quarter in which the services invoiced were provided.

Section 4.2 Exclusive Payment. Provider agrees that the payment for Covered Services specified in this Section constitutes the entire payment for the Covered Services provided and responsibilities assumed by Provider under this Agreement, and that Provider shall not charge Enrollees for additional amounts for said Covered Services. If payment for any Covered Service is denied due to non-compliance with the MA Care Protocol or the Health Plan Quality Assurance Protocol, Provider agrees not to bill the Health Plan or the Enrollee for such Covered Services.

Provider shall accept as payment in full for Covered Services rendered to Enrollees such amounts as are paid pursuant to this Agreement. PROVIDER AGREES NOT TO BILL, CHARGE, COLLECT A DEPOSIT FROM, SEEK REMUNERATION FROM, OR HAVE ANY RECOURSE AGAINST AN ENROLLEE OR PERSONS ACTING ON THEIR BEHALF FOR SERVICES PROVIDED UNDER THIS AGREEMENT. THIS PROVISION APPLIES TO BUT IS NOT LIMITED TO THE FOLLOWING EVENTS: (1) NONPAYMENT BY THE HEALTH MAINTENANCE ORGANIZATION OR (2) BREACH OF THIS AGREEMENT. THIS PROVISION DOES NOT PROHIBIT THE PROVIDER FROM COLLECTING COPAYMENTS OR FEES FOR UNCOVERED SERVICES.

THIS PROVISION SURVIVES THE TERMINATION OF THIS AGREEMENT FOR AUTHORIZED SERVICES PROVIDED BEFORE THIS AGREEMENT TERMINATES, REGARDLESS OF THE REASON FOR TERMINATION. THIS PROVISION IS FOR THE BENEFIT OF THE HEALTH MAINTENANCE ENROLLEES. THIS PROVISION DOES NOT APPLY TO SERVICES PROVIDED AFTER THIS AGREEMENT TERMINATES.

THIS PROVISION SUPERSEDES ANY CONTRARY ORAL OR WRITTEN AGREEMENT EXISTING NOW OR ENTERED INTO IN THE FUTURE BETWEEN THE PROVIDER AND THE ENROLLEE OR PERSONS ACTING ON THEIR BEHALF REGARDING LIABILITY FOR PAYMENT FOR SERVICES PROVIDED UNDER THIS AGREEMENT.

SECTION V: CASE MANAGEMENT AND UTILIZATION PROTOCOLS

Provider agrees to cooperate and comply with all protocols established from time to time by the Health Plan with respect to the provision by Provider of Covered Services to Enrollees under this Agreement, including, without limitation, protocols related to hospital admissions, length of stays, referrals, and medical case management. Provider understands that failure to obtain necessary prior authorization from the Health Plan may result in a financial penalty to Provider.

SECTION VI QUALITY REVIEW AND EVALUATION

Section 6.1 Performance of Duties. Provider agrees to comply with any and all quality evaluation, quality assurance, and quality control responsibilities, including the Clinic Professional credentialing and recredentialing process, which may be established by the Health Plan from time to time or to which the Health Plan may be subject under local, state or federal law with respect to PMAP. Provider agrees to abide by the decisions of the MA Medical Director and the Health Plan during the term of this Agreement.

All Clinic Professionals retain their right to make independent decisions affecting individual patient care and to advocate the needs of patients. Clinic Professionals' primary consideration shall be the quality of services rendered to Enrollee.

Section 6.2 Evaluation. Provider shall participate as reasonably requested in the Health Plan's ongoing evaluation of the delivery of Covered Services and shall provide such information at no charge as may be reasonably requested to enable the Health Plan to implement the Health Plan Quality Assurance Protocol and MA Care Protocol.

Section 6.3 Audit, Inspection. Provider shall make available during normal business hours all records pertaining to MA Enrollees that are relevant to this Agreement to authorized representatives of the State and DHHS and at such times, places, and in such manner as such authorized representatives may reasonably request for purpose of audit, inspection, and examination of the quality, appropriateness, and timeliness of services performed by Provider pursuant to this Agreement.

SECTION VII CONSUMER COMPLAINT PROCEDURES

Section 7.1 Adoption of Procedure. Provider shall adopt and implement the Health Plan's consumer complaint system and procedures with respect to PMAP as modified from time to time. Such procedures shall comply with all applicable statutes, rules and regulations.

Section 7.2 Role of the Health Plan. The Health Plan shall make available written procedures for the handling and resolving of complaints, inquiries and opinions with respect to PMAP in a fair and reasonable manner.

Section 7.3 Designation of Representative. Provider shall designate a person with appropriate authority who shall be responsible for the handling and resolving of all such complaints, inquiries and opinions.

Section 7.4 Cooperation. Provider shall inform the Health Plan of all written complaints, inquiries and opinions filed with Provider by Enrollees and shall cooperate and assist the Health Plan in resolving such matters. Pursuant to the requirements of Minnesota Statutes Chapter 256, Provider shall inform the State Ombudsman within three (3) working days of its receipt of a formal complaint, provide the Health Plan with copies of correspondence with the State Ombudsman, and provide the Enrollee complaining with the name and number of the State Ombudsman.

Section 7.5 Arbitration. Any complaint which the Enrollee, Provider or the Health Plan determines has not been satisfactorily resolved shall be settled by arbitration in accordance with Minnesota Statutes, Chapter 572, provided that the arbitration is not required when an Enrollee elects to litigate his or her complaint prior to submission to arbitration or a medical malpractice damage claim is involved.

SECTION VIII BOOKS AND RECORDS

Section 8.1 Access by Plan. The Health Plan shall have access to Provider's books, Enrollee patient records, records of accounts and any other relevant documents at reasonable hours and upon reasonable notice for examination and inspection, as may be necessary for the administration of this Agreement or to meet federal or state requirements under PMAP.

Section 8.2 Release of Information. The Health Plan shall be authorized publicly to release aggregate cost, utilization and other information concerning PMAP. Specific information that identifies

Provider shall not be released without Provider's written authorization except as a part of reports required by the State of Minnesota or DHHS. The Health Plan is authorized to release information in its possession or obtained under this Agreement pertaining to providers or Enrollees, necessary to comply with federal and state statutes applicable to the Health Plan.

Section 8.3 Data Privacy. Provider agrees to comply with all the requirements of the Minnesota Government Data Practices Act in providing services under this Agreement. In accordance with Minn. Stat., Section 13.46, subd. 10 (1990), Provider 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 Agreement shall be disseminated except as authorized by statute, either during the period of this contract or thereafter. Provider agrees to indemnify and save and hold the Health Plan, its agents and employees, harmless from all claims arising out of, resulting from, or in any manner attributable to any violation by Provider 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.

Section 8.4 Medical Records. Provider shall provide for the development of a medical record-keeping system through which all pertinent information relating to medical services and management of Enrollees provided by Provider is accumulated and readily available to appropriate health professionals.

Section 8.5 Encounter Data. Provider must maintain

sufficient patient encounter data to identify the physician who delivers services to Enrollees, as required by section 1902(m)(2)(A)(xi) of the Social Security Act (42 U.S.C. § 1396b(m)(2)(A)(xi)).

Section 8.6 Other Required Records. Provider agrees to furnish information from its records to the HEALTH PLAN to be provided to the STATE or its agents which the STATE may reasonably require to administer PMAP including, but not necessarily limited to, the information in the Provider Manual, as defined in Section 2.20 of this Agreement.

Section 8.7 Record Maintenance and Preparation. All records collected, used, disseminated and stored by the Provider pertaining to MA Enrollees shall be maintained in accordance with Minn. Stat. Ch. 13 (1990) and Minn. Stat. § 144.335 (1990), safeguarded in accordance with the requirements of 42 CFR 431 Subpart F and retained in accordance with the record retention requirements of 45 CFR Part 74. Provider agrees to maintain such records and prepare such reports and statistical data as may be deemed necessary by the Health Plan. Provider agrees to furnish or make available without cost all records to authorized representatives of the Health Plan, the State and DHHS during normal business hours and in such form as shall be designated. Provider agrees to maintain and make available to the HEALTH PLAN, the STATE, and DHHS all records related to Enrollees and required under this Agreement for a period of six (6) years after the termination date of this Agreement. Records to be retained include but are not limited to medical, claims, case management, and prior-authorization records.

Upon termination of the contract, or at such time as individual MA Enrollees terminate enrollment, Provider shall, upon request by the HEALTH PLAN and at Provider's expense provide to the HEALTH PLAN copies of all records pertaining to medical services provided MA Enrollee(s).

SECTION IX ADVERTISING AND PROMOTION

Section 9.1 Use of Names. Each party to this Agreement reserves the right to, and control of the use of, its names and all symbols, trademarks and service marks presently existing or hereafter established with respect to it, except that Provider hereby authorizes the Health Plan to use the names, addresses, and phone numbers, for purposes of promotion and advertising by the Health Plan. Such authorization is limited to listing the name of Provider, including clinic or institution names, individual physician names, addresses and phone numbers, in an ethical and reasonable manner for purposes of promotion and advertising.

Section 9.2 Prohibition Against Unauthorized Use. Except as authorized above, each party agrees that it will not use the names, symbols, trademarks, or service marks of any other party in advertising or promotion or otherwise without the prior written consent of such other party and will cease any and all use immediately upon termination.

Section 9.3 RamseyCare The Health Plan shall have sole responsibility for all advertising and promotion and for solicitation of Enrollees under the MA RamseyCare program.

SECTION X DURATION AND TERMINATION

Section 10.1 Term. The term of this Agreement shall commence on the date first above written and continue through June 30, 1994, unless otherwise terminated as provided under this Agreement.

Section 10.2 Termination

a. This Agreement may be terminated by Provider or Plan at any time upon at least one hundred twenty-five (125) days prior written notice to the other party provided that the effective date of termination under this Section 10.2.a. shall not occur prior to June 30, 1994.

b. If Provider violates the Health Plan Quality Assurance Protocol or the MA Care Protocol, as amended from time to time, including the failure of the any Clinic Professional to satisfy the credentialing or recredentialing requirements, the Health Plan may terminate this Agreement immediately upon notice to Provider. In any event, any Clinic Professional who does not satisfy the credentialing or recredentialing process or laboratory testing site that does not meet federal and state requirements will not be permitted to provide Covered Services to Enrollees.

c. This Agreement further may be terminated at the option of any non-breaching party, upon a material breach of any party in substantial performance of any term or covenant in this Agreement, after thirty (30) days prior written notice of such breach is given to the breaching party; provided however that such termination will not limit or otherwise affect any rights or remedies of any non-breaching party otherwise available at law or in equity for such breach.

d. In the event that the Health Plan's arrangement with the State of Minnesota regarding PMAP terminates, this Agreement may be terminated by the Health Plan upon at least thirty (30) days prior written notice to Provider.

Section 10.3 Termination of Obligations. The rights and obligations of each party to this Agreement shall continue until termination of this Agreement. Upon termination, the rights and obligations of each party shall cease; provided, however, that termination shall not relieve the Health Plan or Provider of obligations with respect to Covered Services furnished prior to termination.

Section 10.4 Cooperation. Upon notice of termination of this Agreement, the Health Plan and Provider shall cooperate with each other in giving notice of termination to all Enrollees and Provider shall cooperate with the Health Plan in transferring to other MA Primary Care Providers all Enrollees then under Provider's Care.

SECTION XI MISCELLANEOUS

Section 11.1 Independent Parties. Each party to this Agreement is and shall continue to be an independent entity, and no party is an agent or representative of any other.

Section 11.2 Insurance and Licensing. Provider shall provide and maintain policies of malpractice insurance as shall be necessary to insure Provider and its employees or agents against any claim or claims for damages arising by reason of personal injuries or death incurred directly or indirectly in connection with the performance of any service provided by Provider, and shall provide the Health Plan with evidence that such coverage is in effect. Unless such policies

are "occurrence policies," Provider will maintain such coverage for at least thirty-six (36) months following termination of this Agreement. Provider and each Clinical Professional providing Covered Services hereunder shall maintain all federal, state, and local licenses, permits, and association memberships required to operate a medical or dental clinic in the State of Minnesota, as applicable, and shall comply with all applicable state and federal statutes and regulations. Provider shall notify the Health Plan as soon as reasonably possible of any actions brought against Provider or any Clinic Professionals by any federal or state agency restricting, suspending, or terminating Provider's authority to operate a clinic or the Clinic Professional's license to practice.

Section 11.3 Hold Harmless by Provider. Provider shall hold the Health Plan harmless from any claims, demands, and expenses of any kind by reason of any act or omission caused or alleged to have been caused by Provider, or any agent or employee thereof, or any person or group to whom referral is made by Provider.

Section 11.4 Hold Harmless by the Health Plan. The Health Plan shall hold Provider harmless from any claims, demands, and expenses of any kind by reason of any act or omission caused or alleged to have been caused by the Health Plan, or any agent or employee thereof, in the discharge of its responsibilities to an Enrollee under this Agreement.

Section 11.5 Confidential Information. Provider shall keep all quality assurance and utilization review information of the Health Plan (including but not limited to all statistical data, reports and standards), and all financial information relating to

this Agreement confidential, and shall use its best efforts to prevent and protect such information from unauthorized disclosure by its agents or employees. Provider shall not use or allow its agents or employees to use any such information to the competitive disadvantage or detriment of the Health Plan. Provider shall comply with all applicable confidentiality laws and regulations.

Section 11.6 Amendment and Interpretation. This Agreement may be amended by mutual written agreement of the parties hereto at any time. In addition, the Health Plan may inform Provider in writing of reasonable interpretations, clarifications and guidelines which do not materially alter the terms of this Agreement.

Section 11.7 No Assignment. This Agreement and the rights and obligations of the parties hereto shall not be assigned or transferred without the written consent of all parties hereto, except that the Health Plan may assign any or all of its rights and responsibilities to any corporation that is a subsidiary or affiliate of the Health Plan as allowed by federal or state law.

Section 11.8 Severability. The provisions of this Agreement are intended to be severable. In the event any provision of this Agreement shall be held invalid or unenforceable by any court of competent jurisdiction, such holding shall not validate or render unenforceable any other provision hereof.

Section 11.9 No Waiver The failure of either party to insist upon the strict observation or performance of any provision of this Agreement or to exercise any right or remedy shall not impair or waive any such right or remedy.

Section 11.10 Prohibition Against Discrimination. In the

performance of obligations under this contract, Provider agrees to comply with provisions of: the Constitution of the United States and the State of Minnesota; the Civil Rights Acts of 1964; Executive Order 11246, Equal Employment Opportunity, dated September 24, 1965, 42 CFR 434.25; Minn. Stat. 363.073 (1990); and any other laws, regulations, or orders which prohibit discrimination on grounds of race, sex, color, age, religion, health status, disability, national origin or public assistance status.

Section 11.11 Compliance with Environmental Laws. In the performance of obligations under this contract, Provider shall comply with all applicable standards, orders or requirements issued under section 306 of the Clean Air Act, 42 U.S.C. 1857 (h), Section 5.08 of the Clean Water Act, 33 U.S.C. 1368, Executive Order 11738, and Environmental Protection Agency regulations (40 C.F.R. Part 15) which prohibit the use of facilities included on the EPA List of Violating Facilities.

Section 11.12 Compliance with Energy Policy and Conservation Laws. In the performance of obligations under this contract, Provider agrees to comply with Public Law 94-165 and the provisions of the State Energy Conservation Plan.

Section 11.13 Compliance with State and Federal Law. Provider shall comply with state and federal law in their performance of its obligations under this contract, including but not limited to Minn. Stat., section 256B.69, Minn. Rules, parts 9500.1450 to 9500.1464, Title XIX of the Social Security Act (42 U.S.C. § 1396 et. seq.), and the applicable provisions of 42 C.F.R. section 431.200 et. seq. Minn. Rules, parts 9500.1450 to 9500.1464 are attached as Appendix

III and incorporated herein. If any terms of this agreement are determined to be inconsistent with rule or law, the applicable rule or law provision shall govern.

Section 11.14 Affirmative Action. Provider certifies that it has received a certificate of compliance from the Commissioner of Human Rights pursuant to Minn. Stat., section 363.073 (1990).

Section 11.15 Voter Registration. Provider certifies that it will comply with Minnesota Statutes, section 201.162 (1990).

Section 11.16 Lobbying Disclosure. Provider certifies that, to the best of its knowledge, understanding, and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid in what the Provider believes to be a violation of section 1352, title 31, U.S. Code, by or on behalf of Provider 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, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (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 or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in

connection with any Federal contract, grant, loan, or cooperative agreement, provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

- (3) Provider will require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and will require that all subrecipients 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 this transaction imposed by section 1352, title 31, U.S. Code. 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.

Section 11.17 Mediation. If either party requests that the Commissioner of Health order that a dispute pertaining to the terms of renewal or maintenance of this Agreement be submitted to mediation in accordance with Minnesota law, then the Health Plan and Provider agree that the party requesting the mediation will bear the cost of the mediation.

Section 11.18 Entire Agreement. This Agreement, including the exhibits and any addenda attached hereto, and any separate agreement made a part hereof, constitute the entire understanding between the

parties hereto concerning the subject matter hereof. This Agreement supersedes all prior agreements and any amendments thereto concerning such subject matter with respect to all obligations and rights hereunder arising as of the effective date of this Agreement.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed on the day and year first written above.

See Signature and Declaration Page

Exhibit A

Fee for Service Payment for Services

- I. **General Terms for Payment**
 1. **MA Provider shall submit directly to NWNL Health Network, on forms approved by the Plan, all statements for Covered Services rendered by MA Provider to Enrollees, and shall contain complete statistical and descriptive medical and patient data.**
 2. **For all Covered Services eligible for payment, NWNL Health Network shall pay GAMC Provider an amount equal to the lesser of:**
 - a. **one hundred fifteen percent (115%) of the Maximum Fee for Health Services, as set forth in the NWNL Health Network RamseyCare MA Fee Schedule, or**
 - b. **GAMC Provider billed charges.**
 3. **The NWNL Health Network RamseyCare MA Fee Schedule will be based on the State of Minnesota's Medical Assistance Rates, as may be modified from time to time by NWNL Health Network. Changes to the NWNL Health Network RamseyCare MA Fee Schedule will be communicated in writing to the MA Provider thirty (30) days prior to the effective date of such changes.**

APPENDIX I

SERVICE DELIVERY REQUIREMENTS

The Provider shall provide to Enrollees all Covered Services set forth in section 3.01 of the contract, and as clarified in this appendix.

A. Service Requirements

1. Prenatal Care Services

As a means of reducing the number of low birth weight and preterm births occurring in the population eligible for MA, the Minnesota Department of Human Services ("DHS") has instituted a special prenatal care initiative. This prenatal care initiative is designed to identify women who are at risk of having a low birth weight/preterm baby, assure increased access to prenatal care and provide additional services tailored to the special prenatal care needs of high risk pregnant women. Consistent with the fee-for-service requirements, Provider must perform the following tasks:

- a. All pregnant women must be screened during their initial prenatal care office visit to determine their risk of poor pregnancy outcome. A referral to the Women, Infants, Children Supplemental Food and Nutrition Program (WIC) should be made at this time.
- b. The DHS Prenatal Risk Assessment Form DHS-3060, or an alternative form approved by DHS, must be completed at this initial visit and forwarded to DHS within thirty (30) days of the assessment, unless directed otherwise by the Health Plan, and maintained in Provider's medical records for the Enrollee.
- c. Those women who are identified at high risk (a score of 10 or more points on the DHS Risk Assessment Form) must be offered enhanced perinatal services. Enhanced perinatal services include: high risk antepartum management, prenatal health education, prenatal nutrition education, childbirth education, and a high risk follow-up home visit.

2. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services/Child and Teen Checkups

EPSDT is a comprehensive screening program provided to a recipient under the age of 21 to identify a potentially handicapping condition and to provide for diagnosis and treatment of specific medical conditions. The intent of the EPSDT Program is to provide the standards by which children receive preventive health care and early interventive

services. DHS recommends that the provision of EPSDT services become a regular part of ongoing well child care physical exams. The following EPSDT services are currently covered by MA when performed in accordance with EPSDT program standards:

- . Health history
- . Assessment of physical growth
- . Physical examination
- . Oral examination
- . Vision evaluation
- . Hearing evaluation
- . Developmental screening
- . Sexual development
- . Nutritional assessment
- . Immunizations
- . Laboratory tests
- . Health education

The obligations of the Provider with regard to EPSDT services are described below.

- a. The Provider must notify Enrollees under the age of 21 of the availability of EPSDT services.
- b. The Provider must provide all of the required screening components according to the EPSDT standards and periodicity schedule as directed by the Health Plan. The Provider must offer additional preventive services beyond these minimum standards.
- c. The Provider must record the results of the EPSDT health screening on the EPSDT Child Screening Form (DHS-1973) and forward the top copy of the form to DHS within thirty (30) days of the assessment.

3. Mental Health and Chemical Dependency (MH/CD) Services

The Provider is responsible for referring MH/CD services as needed by Enrollees to MA Participating Providers who are MH/CD providers as determined by the Health Plan.

4. Serving Minority and Special Needs Populations

The Provider must provide or arrange to provide appropriate services for the following special needs groups when required and requested. If the Provider already provides specialized services to the following populations as described in this section, the Provider agrees to make these services available to Enrollees served pursuant to this Agreement. If the Provider does not provide such specialized services, the Provider will make arrangements with the Health Plan to assure that appropriate services are delivered.

- a. Seriously and Persistently Mentally ill (SPMI): ongoing medications review and monitoring, day treatment, and "milieu" alternatives to conventional therapy, coordination with the individual's case manager to assure appropriate utilization of all needed psychosocial services.
- b. Elderly, physically handicapped and chronically ill: inpatient services, neurological assessments.
- c. Abused children and adults, abusive individuals: comprehensive assessment and diagnostic services, specialized treatment techniques for victims and perpetrators of maltreatment (physical, sexual, emotional).
- d. Southeast Asians and other groups with language barriers: interpreter services, bilingual staff, culturally appropriate assessment and treatment. Whenever an individual requests an interpreter in order to obtain health care services, the individual must be provided with access to an interpreter.
- e. Cultural and racial minorities: culturally appropriate services rendered by Clinic Professionals with specialized expertise in the delivery of health care services to various cultural and racial minority groups.
- f. Dual MH/Developmentally Disabled (DD), or MH/CD clients: comprehensive assessment, diagnostic and treatment services provided by staff who are trained to work with clients with multiple disabilities and complex needs.
- g. Lesbians and gay men: sensitivity to critical social and family issues unique to these clients.
- h. Hearing impaired: access to TDD and hearing impaired interpreter services.
- i. Persons in need of gender specific MH/CD treatment: Enrollees must be provided with an opportunity to receive MH/CD services from the same sex therapist and the opportunity to participate in an all male/all female group therapy program.
- j. 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 Provider delivers must be provided in the least restrictive clinical setting, individualized to meet the specific needs of each child, and designed to insure early identification and treatment of mental illness. Services must be coordinated with the child's county case manager.

- k. Developmentally Disabled (DD): specialized mental health and habilitative 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, ongoing medical skill rechecks, 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 individual's county DD case manager. The treatment plan must identify the persons responsible for providing services and a case manager. For those Enrollees with multiple handicaps, a multidisciplinary provider consultation should be arranged. Although continuity of care should be a major consideration in the treatment planning process, referrals to specialists and subspecialists must be made when medically indicated.

B. Enrollee Access to Services

The Provider must insure proper MA Enrollee access to services and must comply with all of the requirements listed below:

1. Provider must agree to accept all eligible MA Enrollees who select or who are assigned to the Health Plan without regard to current or previous medical condition.
2. Provider agrees to not set any enrollment limits on the number of MA recipients which it will serve unless other arrangements are made with the Health Plan.
3. MA Enrollees in the Health Plan may not be charged any deductible costs or be asked to make any copayments for covered services under PMAP.
4. Provider may not discriminate against any MA Enrollee on the basis of: race, sex, color, religion, health status, age, handicap, national origin, public assistance status, or sexual orientation.
5. Provider must insure that its services are accessible to handicapped MA Enrollees. A barrier-free service delivery access point must be available for Enrollees who use wheelchairs.

6. Provider services must be available to MA Enrollees to the same extent that such services are available to the general population. Some walk-in or unscheduled clinic hours must be available each week to accommodate MA Enrollees who are ill.
7. The Provider must have available a 24 hour/day number for Enrollees to call in case of an emergency.
8. Upon request, Provider must arrange with the Health Plan for any Enrollee to obtain a second medical opinion by a MA Participating Provider, and an out of plan second medical opinion for MH/CD services, when the Provider determines through the initial assessment process that no structured treatment is required.
9. Provider must insure Enrollee confidentiality, as required by Minnesota Statutes Chapter 13 (1986), the Minnesota Government Data Practices Act.
10. Provider must safeguard the confidentiality of certain services (i.e. family planning, diagnosis of pregnancy, diagnosis and treatment of sexually transmittable diseases, and MH/CD services) provided to Enrollees who are minors (under age 21), to the extent allowable by law.

C. Case Management

Provider's case management system must be designed to coordinate the provision of services to 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 Provider's case management system must incorporate the following elements:

- a. Procedures for the provision of an individual needs assessment, the development of an individual treatment plan, the establishment of treatment objectives, the monitoring of outcomes, and a process to insure that treatment plans are revised as necessary. These procedures must be designed to accommodate the specific cultural and linguistic needs of the 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 through the Consolidated Chemical Dependency Treatment Fund, child protection, court ordered treatment, or a state medical review team or social security disability determination.

- d. Procedures and criteria for making referrals to specialists and subspecialists.
- e. Capacity to implement; when indicated, case management functions such as: individual needs assessment, including screening for special needs (e.g. mental health/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; revision of treatment plan.
- f. Procedures for insuring that appropriate Clinic Professionals interact with the school districts and participate in developing individualized education plans (IEPs) or individualized family service plans (IFSP) for school age Enrollees, and providing for transportation, if services in the IEP or IFSP are provided outside of the child's school.