CHAPTER 9506
DEPARTMENT OF HUMAN SERVICES
MINNESOTACARE

9506.0010 DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 9506.0010 to 9506.0400 have the meanings given them in this part.

[For text of subps 2 to 13, see M.R.]

Subp. 13a. **Managed care health plan or health plan.** "Managed care health plan" or "health plan" means a vendor of medical care, including a county, that contracts with the department to provide covered health services to enrollees on a prepaid capitation basis. Among managed care health plans are health maintenance organizations, integrated service networks and community integrated service networks defined in Minnesota Statutes, section 62N.02, and competitive bidding programs.

[For text of subps 14 and 15, see M.R.]

Subp. 15a. **Nonrisk contract.** "Nonrisk contract" means a contract between the department and a managed care health plan under which the health plan is not responsible for the costs of inpatient hospital services for enrollees

[For text of subps 16 and 17, see M.R]

Subp. 17a. **Participating provider.** "Participating provider" means a provider who is employed by or under contract with a health plan to provide health services to enrollees.

[For text of subp 18, see M.R.]

Subp. 18a. **Risk contract.** "Risk contract" means a contract between the department and a managed care health plan under which the cost the health plan incurs providing inpatient hospital services may exceed the payments made by the department for inpatient hospital services under the contract.

Statutory Authority: *MS s 256.9352; 256.9363*

History: *20 SR 495*

9506.0050 COORDINATION OF MINNESOTACARE AND MEDICAL ASSISTANCE.

[For text of subps 1 to 4, see M.R.]

Subp. 5. **Continuing health plan participation.** An enrollee in a managed care health plan who becomes eligible for medical assistance or general assistance medical care shall remain in that health plan if the health plan has a contract with the department to provide health services in that geographic area to recipients of medical assistance or general assistance medical care.

Statutory Authority: *MS s 256.9352; 256.9363*

History: *20 SR 495*

9506.0070 APPEALS.

[For text of subps 1 and 2, see M.R.]

Subp. 3. **Health plan complaint and appeal procedure.** An enrollee participating in a managed care health plan may utilize the health plan's internal complaint procedure but is not required to exhaust the internal complaint procedure before appealing to the commissioner. The appeal rights and procedures in part 9500 1463 apply to health plan enrollees.

Statutory Authority: *MS s 256.9352; 256.9363*

History: *20 SR 495*

9506.0090 COPAYMENTS AND ELIGIBLE PROVIDER REIMBURSEMENT.

Subpart 1 **Copayments required.** Adult enrollees must pay eligible providers and managed care health plans or participating providers the copayments required under Minnesota Statutes, sections 256.9353, subdivision 7, and 256.9363, subdivision 6. Adult enrollees who are not eligible for medical assistance must pay inpatient hospital charges above the annual MinnesotaCare benefit limit to the hospital that provided the inpatient hospital services.

Subp. 2. **Reimbursement for covered health services.** Covered health services are reimbursed at the same rate and subject to the same conditions established for medical assistance, except:

A. federally qualified health centers, rural health clinics, and Indian health facility services are reimbursed as provided in Minnesota Statutes, section 256.9362, subdivision 2;

B inpatient hospital services are reimbursed as provided in Minnesota Statutes, section 256.9362, subdivisions 3 to 6; and

C. managed care health plans are paid as provided in part 9506.0300.

[For text of subp 3, see M.R.]

Subp. 4. **Commissioner's access to enrollee medical records.** Eligible providers and managed care health plans or participating providers must provide the commissioner access to enrollees' personal medical records to monitor compliance with parts 9506.0010 to 9506 0400 and to identify fraud, theft, or abuse.

Statutory Authority: *MS s 256.9352; 256.9363*

History: *20 SR 495*

9506.0200 PREPAID MINNESOTACARE PROGRAM; GENERAL.

Subpart 1. **Designation of geographic area.** The commissioner shall designate geographic areas in which enrollees must receive covered health services through a managed care health plan.

A. In designating geographic areas, the commissioner shall consider area size, size of the population to be served, accessibility of health services, the availability of health plans, and any other factors necessary to provide the most economical care consistent with high medical standards.

B. The commissioner shall implement either a multiple health plan model or a single health plan model in a designated geographic area.

(1) A multiple health plan model is a health services delivery system in which more than one managed care health plan is offered to enrollees in the geographic area

(2) A single health plan model is a health services delivery system in which only one health plan is available to enrollees in the geographic area.

C. The commissioner may limit the number of health plans with which the department contracts within a designated geographic area, taking into consideration:

(1) the number of enrollees within the designated geographic area;

(2) the number of potential health plan contractors;

(3) the size of the provider network offered by health plans;

(4) the health services offered by a health plan;

(5) qualifications of health plan personnel;

(6) accessibility of services to enrollees;

(7) health plan assurances of enrollee confidentiality,

(8) health plan marketing and enrollment activities;

(9) health plan compliance with parts 9506.0010 to 9506.0400;

(10) health plan performance under other contracts with the department to serve MinnesotaCare enrollees and medical assistance or general assistance medical care recipients; or

(11) any other factors necessary to provide the most economical care consistent with high medical standards.

Subp. 2 **Contracts.** Contracts between the department and a health plan to provide covered services to enrollees must:

A. require the health plan to serve medical assistance recipients and general assistance medical care recipients;

B. comply with the requirements of United States Code, title 42, section 1396a(a)(23)(B), prohibiting the health plan from restricting enrollee access to family planning services, and Minnesota Statutes, section 62Q.14; and

C. permit the commissioner to terminate the contract upon 90 days notice to the health plan.

Subp. 3. **Multiple health plan model areas.** After the department has executed contracts with health plans to provide covered health services in a multiple health plan model area, the department or an entity under contract with the department shall:

A. inform applicants and enrollees, in writing, of available health plans, when written notice of health plan selection must be submitted to the department, and when health plan participation begins;

B. randomly assign to a health plan enrollees who fail to notify the department in writing of their health plan choice; and

C. notify enrollees, in writing, of their assigned health plan before the effective date of the enrollee's health plan participation.

Subp 4. **Single health plan model areas.** After the department has executed a contract with a health plan to provide covered health services as the sole health plan in a geographic area.

A the department shall assure that applicants and enrollees are informed, in writing, of participating providers in the health plan and when health plan participation begins,

B. the health plan may require the enrollee to select a primary care provider and may assign to a primary care provider enrollees who fail to notify the health plan of their selection; and

C. the health plan shall notify enrollees, in writing, of their assigned providers before the effective date of health plan participation.

Subp. 5. **Changing health plans or primary care providers.**

A. In multiple health plan model areas, enrollees may change health plans once within the first year the enrollee participates in a health plan. After the first year of health plan participation, enrollees may change health plans during the annual 30–day open enrollment period. The department or entity under contract with the department shall notify enrollees when the annual open enrollment period will occur.

B. In single health plan model areas, enrollees may change primary care providers at least once during the first year of health plan participation. After the first year of health plan participation, enrollees may change primary care providers at least annually. The health plan shall notify enrollees of this change option.

C. If a health plan's contract with the department is terminated for any reason, enrollees in that health plan shall select a new health plan and may change health plans or primary care providers within the first 60 days of participation in the second health plan.

D. Enrollees may change health plans or primary care providers for cause as determined through an appeal under part 9506.0070 and as provided in subitems (1) and (2).

(1) In multiple health plan model areas, enrollees may change health plans without a hearing if the travel time from the enrollee's residence to the enrollee's primary care provider is over 30 minutes or the enrollee's health plan was incorrectly designated due to department error. Requests for change under this subitem must be submitted to the department in writing. The department shall notify enrollees whether the request is approved or denied within 30 days after receipt of the written request.

(2) In single health plan model areas, enrollees may change primary care provider without a hearing if the travel time from the enrollee's residence to the enrollee's primary care provider is over 30 minutes or the enrollee's primary care provider was incorrectly designated due to health plan error. Requests for change under this subitem must be submitted to the health plan in writing. The health plan shall notify enrollees whether the request is approved or demed within 30 days after receipt of the written request.

Subp. 6. **Family participation in a health plan.** All family members enrolled in MinnesotaCare must receive health services from the same health plan.

Statutory Authority: *MS s 256 9352; 256 9363*

History: *20 SR 495*

9506.0300 HEALTH PLAN SERVICES; PAYMENT.

Subpart 1. **Covered services; additional health services.** Except as provided in subparts 2 and 3, a health plan must provide and pay for all covered health services listed in Minnesota Statutes, section 256.9353. A health plan may offer enrollees additional health services that are not covered by MinnesotaCare.

Subp. 2. **Payment for inpatient hospital services.** The commissioner may contract with a health plan for inpatient hospital services for enrollees on either a risk or a nonrisk basis.

A. If the commissioner contracts with a health plan for inpatient hospital services on a nonrisk basis:

(1) except as authorized under subpart 3, the health plan must require enrollees to receive inpatient hospital services from participating providers;

(2) the health plan must comply with units (a) to (c) when arranging inpatient hospital services for enrollees.

(a) parts 9500.1090 to 9500.1140 and Minnesota Statutes, sections 256.9685, 256.9686, 256 969, and 256.9695 governing inpatient hospital payment rates for medical assistance;

(b) parts 9505.0170 to 9505.0475 and Minnesota Statutes, section 256.9353, subdivisions 1 to 5, establishing standards for services covered by medical assistance; and

(c) part 9506.0080, subpart 3, governing hospital admission certification;

(3) the department shall pay for inpatient hospital services according to part 9506.0080, subpart 2, and shall make payment to the health plan to pass through to the hospital;

(4) the hospital shall collect from adult enrollees required MinnesotaCare copayments and costs not covered by MinnesotaCare or medical assistance; and

(5) the health plan must report enrollee inpatient hospital admissions to the department within 30 days after the admission date, in a form prescribed by the department.

B. If the commissioner contracts with a health plan for inpatient hospital services on a risk basis:

(1) except as authorized under subpart 3, the health plan must require enrollees to receive inpatient hospital services from participating providers;

(2) the health plan shall pay for all inpatient hospital services for children and up to the annual benefit limit established for adult enrollees;

(3) the hospital shall collect from adult enrollees required MinnesotaCare copayments and costs not covered by MinnesotaCare or medical assistance; and

(4) the health plan must report enrollee inpatient hospital admissions to the department within 30 days after the admission date, in a form prescribed by the department.

Subp. 3. **Payment for out–of–plan services.**

A. A health plan is not liable for payment for health services provided enrollees by providers not participating in the health plan, except, a health plan must pay for:

(1) enrollee emergency services, as defined in Minnesota Statutes, section 256B.0625, subdivision 4;

(2) any other health services required under the contract with the department or by law; and

(3) out–of–plan services authorized by the health plan or a participating provider; the health plan is not required to pay more than the rate under part 9506.0090, subpart 2, for authorized out–of–plan services unless another payment rate is required by law.

B. The department is not liable to nonparticipating providers for payment for health services.

Subp. 4. **Enrollee costs.** Except for copayments required under Minnesota Statutes, section 256.9353, subdivision 7, and inpatient hospital charges that exceed the MinnesotaCare benefit limit, enrollees are not liable for any costs for covered services or for authorized out–of–plan services.

Subp. 5 **Payment to health plans.**

A. Payments to health plans for covered health services for enrollees shall be prospective, per capita payments, made on an actuarially sound basis as determined by the commissioner; except, the commissioner may allow health plans to arrange for inpatient hospital services on a risk or nonrisk basis as provided in subpart 2.

B. By the tenth day of each month, the commissioner shall prepay the health plan the capitation rate specified in the contract.

C. The department shall make payment rates and contracts with health plans available to the public upon request.

Statutory Authority: *MS s 256.9352; 256.9363*

History: *20 SR 495*

9506.0400 OTHER MANAGED CARE HEALTH PLAN OBLIGATIONS.

Subpart 1. **Financial accountability.** A health plan is accountable to the commissioner for the fiscal management of covered health services. The state of Minnesota and enrollees shall be held harmless for the payment of obligations incurred by a health plan if the health plan or a participating provider becomes insolvent and the department has made the payments due the health plan under the contract

Subp. 2. **Educational materials.**

A. A health plan shall provide the commissioner copies of educational materials explaining covered health services for distribution to applicants and enrollees as specified in the contract. A health plan shall not distribute any materials designed to solicit health plan participation without prior approval from the department.

B. A health plan shall provide each enrollee a certificate of coverage approved by the commissioner, a health plan identification card, a list of participating providers, and a description of the health plan complaint and appeal procedure. All written information provided enrollees must be understandable to a person reading at the seventh grade level, using the Flesch scale analysis readability score as determined under Minnesota Statutes, section 72C.09.

Subp 3. **Case management.** A health plan shall have available a system of case management in which an individual enrollee's medical needs may be assessed to determine the appropriate plan of care. A plan of care must be developed, implemented, evaluated, monitored, revised, and coordinated with other health care providers as appropriate and necessary.

Subp. 4. **Submission of information.** The health plan contract must specify the information that the health plan shall submit to the commissioner, and to the federal Health Care Financing Administration when applicable, the form of submission, and when the information must be available to the commissioner If the commissioner requires additional information, the health plan shall provide the additional information within 30 days after receiving the commissioner's written request.

Subp. 5 **Quality assurance.**

A. A health plan shall have an internal quality assurance system that provides ongoing review of:

(1) enrollee use of services;

(2) case review of problem cases and of a random sample of all cases that includes reviewing medical records and assessing the care provided;

(3) enrollee complaints and disposition of complaints, and

(4) enrollee satisfaction as determined through at least annual surveys.

B. A health plan shall develop a corrective action plan based on the results of case reviews and shall monitor the effectiveness of its corrective actions.

C. A health plan shall permit the commissioner or the commissioner's agents to evaluate the quality, appropriateness, and timeliness of covered health services through inspections, site visits, and review of medical records

D. The commissioner shall notify a health plan, in writing, if the commissioner finds a deficiency in the quality of health services offered enrollees. If the health plan fails to correct the deficiency within 60 days after receiving the written notice, the commissioner may withhold all or part of the capitation premium payments until the deficiency is corrected to the satisfaction of the commissioner

Subp. 6. **Third-party liability.** To the extent required under part 9506.0080 and Minnesota Statutes, section 62A.046, a health plan shall coordinate benefits for or recover the cost of health services provided enrollees who have other health coverage. Coordination of benefits by a health plan includes paying applicable copayments or deductibles on behalf of an enrollee.

Subp. 7 **Enrollee acceptance.** A health plan shall accept all enrollees who choose or are assigned to the health plan by the department, regardless of an enrollee's health status or previous utilization of health services.

Subp. 8. **Financial capacity.** A health plan shall demonstrate that its financial risk capacity is acceptable to its participating providers; except, a health plan licensed as a health maintenance organization or a nonprofit health plan, under Minnesota Statutes, chapters 62C and 62D, or an integrated service network or a community integrated service network under Minnesota Statutes, chapter 62N, is not required to demonstrate financial risk capacity beyond the requirements in those chapters for licensure or a certificate of authority.

Subp. 9. **Chemical dependency assessments.** A health plan shall assess the need for chemical dependency services and placement according to the criteria in parts 9530.6600 to 9530.6660.

Subp. 10. **Immunization.** A health plan shall collaborate with the local public health agencies to ensure immunization of children who are enrollees and must provide a recommended immunization schedule to families with children

Subp. 11. **Second medical opinion.** A health plan must include in its certificate of coverage information about enrollees' right to a second medical opinion according to items A to C.

A. Upon enrollee request, the health plan shall provide at health plan expense a second medical opinion by a participating provider within the health plan.

B. The health plan shall comply with Minnesota Statutes, section 62D.103, and shall provide at health plan expense a second medical opinion by a qualified nonparticipating provider when the health plan determines that an enrollee's chemical dependency or mental health problem does not require structured treatment.

C. The health plan shall provide at health plan expense a second medical opinion when ordered to do so by a state human services referee under Minnesota Statutes, section 256.045.

Subp. 12. **Data privacy.** The contract between the commissioner and the health plan must specify that the health plan is an agent of the welfare system and shall have access to welfare data on enrollees to the extent necessary to carry out the health plan's responsibilities under the contract. The health plan shall comply with Minnesota Statutes, chapter 13, the Minnesota Government Data Practices Act, and applicable federal privacy law.

Subp. 13. **Complaint and appeal procedure.** Part 9500.1463, which establishes complaint and appeal procedures, applies to health plans and enrollees.

Subp. 14. **Contract termination.** If the commissioner or a health plan terminates a contract, the health plan must notify its enrollees at least 60 days before the termination date, in writing, that the contract will terminate.

Statutory Authority: *MS s 256.9352; 256.9363*

History: *20 SR 495*