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.

Subp. 2. **Applicant.** "Applicant" means a person who submits a written application to the department for a determination of eligibility for MinnesotaCare.

Subp. 3. **Child.** "Child" means a person who is less than 18 years of age.

Subp. 4. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or the commissioner's designee.

Subp. 5. **Covered health services.** "Covered health services" means the services listed in Minnesota Statutes, section 256L.03, subdivisions 1 to 5.

Subp. 6. **Department.** "Department" means the Department of Human Services.

Subp. 7. **Dependent sibling.** "Dependent sibling" has the meaning given in Minnesota Statutes, section 256L.04, subdivision 1, paragraph (b).

Subp. 8. **Eligible provider.** "Eligible provider" means a health care provider who provides covered health services to medical assistance recipients under rules established by the commissioner for that program.

Subp. 9. **Employer-subsidized health coverage.** "Employer-subsidized health coverage" means health coverage for which the employer pays at least 50 percent of the cost of coverage for the employee. Employer-subsidized health coverage includes employer contributions to Internal Revenue Code, section 125 plans.

Employer-subsidized health coverage excludes dependent coverage unless the employer offers dependent coverage to employees and pays at least 50 percent of the cost of dependent coverage. Employer-subsidized health coverage for children includes coverage through either parent, including a noncustodial parent.

Subp. 10. **Enrollee.** "Enrollee" means an individual who:

A. has been determined eligible by the department to receive covered health services under MinnesotaCare; and

B. has paid the required premium under part 9506.0040.

Subp. 11. **Family.** "Family" means a parent or parents and their children, or guardians and their wards who are children, and dependent siblings, residing in the same household. The term includes children and dependent siblings temporarily absent from the household in settings such as schools, camps, or visitation with noncustodial parents. Family also means an emancipated minor and an emancipated minor's spouse, spouses in households without children, and single individuals in a one-person household.

Subp. 12. **General assistance medical care.** "General assistance medical care" has the meaning given in Minnesota Statutes, section 256D.02, subdivision 4a.

Subp. 13. **Local social service agency.** "Local social service agency" means the local agency under the authority of the county welfare or human services board or county board of commissioners that is responsible for providing human services.

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.

Subp. 14. **Medical assistance.** "Medical assistance" means the program authorized under title XIX of the Social Security Act and Minnesota Statutes, chapter 256B.

Subp. 15. **MinnesotaCare.** "MinnesotaCare" means the program authorized in Minnesota Statutes, sections 256L.01 to 256L.12, to promote access to appropriate covered health services to assure healthy children and adults.

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.

Subp. 16. **Other health coverage.**

A. "Other health coverage" means:

(1) basic hospital coverage;

(2) medical-surgical or major medical coverage;

(3) Medicare part A or part B coverage under title XVIII of the Social Security Act;

(4) supplemental Medicare coverage under Minnesota Statutes, sections 62A.31 to 62A.44;

(5) coverage through a health maintenance organization under Minnesota Statutes, chapter 62D;

(6) coverage through a health maintenance organization under Minnesota Statutes, chapter 62D, combined with Medicare benefits under title XVIII of the Social Security Act; or

(7) coverage through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) under United States Code, title 10, chapter 55, sections 1079 and 1086.

B. "Other health coverage" does not mean:

(1) medical assistance;

(2) general assistance medical care;

(3) coverage under a regional demonstration project for the uninsured funded under Minnesota Statutes, section 256B.73;

(4) coverage under the Hennepin County assured care program; or

(5) coverage under the Group Health, Inc., community health plan.

Subp. 17. **Parent.** "Parent" means the birth, step, or adoptive mother or father of a child.

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.

Subp. 18. **Permanent residency.** "Permanent residency" has the meaning given in Minnesota Statutes, section 256L.09.

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.

Subp. 19. **Spenddown.** "Spenddown" means the process by which a person who has income in excess of the income standard allowed under the medical assistance program becomes eligible for medical assistance as a result of incurring medical expenses that are not covered by a liable third party and that reduce the excess income to zero.

Subp. 20. **Third-party payer.** "Third-party payer" means a person, entity, agency, or other health coverage that has a probable obligation to pay all or part of the costs of an enrollee's health services.

Statutory Authority: *MS s 256.9352; 256.9363; 256L.02; 256L.12*

History: *19 SR 1286; 20 SR 495*

9506.0020 ELIGIBILITY FOR MINNESOTACARE.

Subpart 1. **General eligibility requirements.** Except as provided in subparts 2, 3, and 5, an applicant or enrollee must:

A. be a permanent resident of Minnesota;

B. be ineligible for medical assistance without a spenddown, including medical assistance for pregnant women, except that an enrollee who receives inpatient hospital services may be eligible for medical assistance with or without a spenddown during the months of hospitalization;

C. not simultaneously be covered by general assistance medical care and MinnesotaCare;

D. not currently have other health coverage nor have had other health coverage during the four months immediately preceding the date coverage begins;

E. not have access to employer-subsidized health coverage during the 18 months immediately preceding the date coverage begins;

F. identify potentially liable third-party payers and assist the department in obtaining third-party payments;

G. have gross annual income that does not exceed the amounts in Minnesota Statutes, section 256L.15, subdivision 2; and

H. comply with the family enrollment requirements in subpart 4.

Subp. 2. **Exceptions to general eligibility requirements.**

A. Subpart 1, items D and E, do not apply to an applicant who is terminated from medical assistance, general assistance medical care, or coverage under a regional demonstration project for the uninsured funded under Minnesota Statutes, section 256.73, the Hennepin County assured care program, or the Group Health, Inc., community health plan if the department receives a MinnesotaCare application before the last day of the month following the month in which termination occurred.

B. Subpart 1, item E, does not apply under the following circumstances:

(1) if the employer-subsidized health coverage was lost for reasons that would not disqualify the applicant from receiving reemployment benefits under Minnesota Statutes, section 268.095, and the applicant has not had access to employer-subsidized health coverage since the loss; or

(2) to children of an individual whose employer-subsidized coverage was lost for reasons that disqualify the individual for reemployment benefits if the children have not had access to employer-subsidized coverage since the disqualifying event.

Subp. 3. **Children in families with income at or below 150 percent of the federal poverty guidelines.** A child in a family with income at or below 150 percent of the federal

poverty guidelines is eligible for MinnesotaCare from the first day of the month in which the child's first birthday occurs to the last day of the month in which the child becomes 18 years old if the child:

A. meets the requirements under subpart 1, items A to C and F to H; and

B. is not otherwise insured for the covered health services. A child is not otherwise insured for covered health services when subitem (1), (2), or (3) applies:

(1) the child lacks coverage in two or more of the areas listed in units (a) to (e):

(a) basic hospital coverage;

(b) medical-surgical coverage;

(c) major medical coverage;

(d) dental coverage;

(e) vision coverage;

(2) coverage requires a deductible of $100 or more per person per year; or

(3) a child with a particular diagnosis lacks coverage because the child has exceeded the maximum coverage for that diagnosis or the policy of coverage excludes that diagnosis.

Subp. 4. **Family enrollment.** Families must comply with items A to F.

A. Parents who enroll must enroll all eligible children and dependent siblings.

B. Children and dependent siblings may be enrolled without parents enrolling, unless other insurance is available.

C. If one parent in a household enrolls, both parents in the household must enroll, unless other insurance is available.

D. If one child in a family is enrolled, all children in the family must be enrolled, unless other insurance is available.

E. If one spouse in a household is enrolled, the other spouse in the household must enroll, unless other insurance is available.

F. Except as provided in item B, families cannot enroll only certain uninsured members.

Subp. 5. **Continuous eligibility.** An enrollee remains eligible for MinnesotaCare regardless of age or the presence or absence of children in the household as long as the enrollee:

A. maintains permanent residency in Minnesota;

B. meets all other eligibility criteria, except subpart 1, item G;

C. pays the full cost of coverage if gross annual family income after initial enrollment exceeds the limits in Minnesota Statutes, section 256L.15, subdivision 2; and

D. is continuously enrolled in MinnesotaCare or medical assistance. To be continuously enrolled, an enrollee's reapplication must be received by the department before the last day of the first calendar month following the date of notice of termination of coverage from MinnesotaCare or medical assistance.

Subp. 6. **Annual redetermination required.** The commissioner shall annually redetermine continued MinnesotaCare eligibility for each enrollee.

Subp. 7. **Enrollee cooperation with annual redetermination.** Enrollees must annually provide the information needed to redetermine eligibility before the anniversary date of initial eligibility. The anniversary date of initial eligibility is the yearly recurrence of the first day of the month following the date of enrollment in MinnesotaCare.

Statutory Authority: *MS s 256.9352; 256L.02*

History: *19 SR 1286; L 1998 c 265 s 45; L 1998 c 407 art 5 s 47*

9506.0030 APPLICATION; ENROLLMENT; COVERAGE.

Subpart 1. **Application sources.** Applicants may apply directly to the commissioner or through appropriate referral sources.

A. Appropriate referral sources include but are not limited to: eligible provider offices; local social service agencies; school district offices; public and private elementary schools in which 25 percent or more of the students receive free or reduced price lunches; community health offices defined in Minnesota Statutes, section 145A.02; WIC program sites under United States Code, title 42, section 1786.

B. Referral sources that accept applications from applicants must send applications to the department within five working days after receipt.

Subp. 2. **Necessary information for eligibility determination.**

A. Applicants must provide all information necessary to determine eligibility for MinnesotaCare and potential eligibility for medical assistance, including:

(1) Social Security number;

(2) proof of permanent residency; the signature of an applicant on the application attesting to permanent residency meets the affidavit requirement under Minnesota Statutes, section 256L.09, subdivision 4, clause (3);

(3) household composition;

(4) availability of other health coverage, including access to employer-subsidized health coverage;

(5) gross annual family income; and

(6) any additional information needed by the commissioner to determine or verify eligibility.

B. If the commissioner determines an applicant may be ineligible for MinnesotaCare because employer-subsidized coverage was lost for reasons that would disqualify the applicant from receiving reemployment benefits under Minnesota Statutes, section 268.095, the commissioner shall refer the applicant to the Department of Employment and Economic Development for a determination whether the applicant would have been disqualified.

Subp. 3. **Eligibility determination deadline.** Except during the four months after the dates on which adult individuals and families without children become eligible for MinnesotaCare, the commissioner shall determine an applicant's eligibility within 30 days after a complete application is received by the department.

Subp. 4. **Enrollment and beginning of coverage.** The date of enrollment and the date coverage begins are determined as follows:

A. An applicant is enrolled in MinnesotaCare on the date the following are completed:

(1) a complete application is received by the department and the applicant is determined eligible under part 9506.0020; and

(2) the initial premium payment under part 9506.0040 is received by the department.

B. Coverage begins the first day of the calendar month following the date of enrollment, except:

(1) if the initial premium payment is received after noon of the last business day of the month of enrollment, coverage begins the first day of the second following calendar month;

(2) coverage for eligible newborns in an enrolled family begins immediately from the moment of birth;

(3) coverage for eligible adoptive children of a family enrolled in MinnesotaCare begins on the date of placement for the purpose of adoption;

(4) coverage for other new members of an enrolled family begins the first day of the month following the month in which the new member's eligibility is determined and the first premium payment is received; and

(5) coverage of enrollees who are hospitalized on the first day of the month following enrollment begins the day following the date of discharge from the hospital.

Statutory Authority: *MS s 256.9352; 256L.02*

History: *19 SR 1286; L 1998 c 265 s 45; L 2005 c 112 art 2 s 41*

9506.0040 PREMIUM PAYMENTS.

Subpart 1. **Premium payments.** Applicants and enrollees must pay a premium to enroll and to continue enrollment in MinnesotaCare. The amount of premium is the total of the following:

A. $4 per month for each child in a family whose family income is at or below 150 percent of federal poverty guidelines; and

B. for any family member not included under item A, a premium calculated under Minnesota Statutes, section 256L.15.

A premium payment table and an explanation of the table is available upon request from the department.

Subp. 2. **Gross annual family income.** "Gross annual family income" means the total income of all family members determined according to items A to C:

A. the income of self-employed persons, as defined in Minnesota Statutes, section 256L.01, subdivision 4;

B. the income of wage earners, including all wages, salaries, commissions, and other benefits received as monetary compensation from employers before any deduction, disregard, or exclusion, calculated by determining:

(1) income in the four calendar months immediately preceding the month of application for MinnesotaCare, multiplied by three to reflect a 12-month period; or

(2) if the wage earner is employed on a seasonal basis or receives income too infrequently or irregularly to be calculated under subitem (1), total income for the past 12 months; and

C. the following unearned income received in the four calendar months immediately preceding the month of application, multiplied by three to reflect a 12-month period:

(1) Supplemental Security Income under title XVI of the Social Security Act;

(2) Social Security benefits;

(3) veterans' administration benefits;

(4) railroad retirement benefits;

(5) unemployment benefits;

(6) workers' compensation benefits;

(7) child support;

(8) spousal maintenance or support payments; and

(9) income from any other source, including interest, dividends, and rent.

Applicants and enrollees must report to the department any changes from the amounts reported in items A to C that exceed $50 per month. Changes may be reported as a percentage increase or decrease. Gross annual family income will be recalculated by projecting the adjusted income for 12 months.

Subp. 3. **Premiums paid monthly, quarterly, or annually.** Applicants and enrollees may choose to pay premiums on a monthly, quarterly, or annual basis and may change payment schedules at the time a premium is due.

Subp. 4. **Billing notices.** The department shall mail premium payment billing notices as follows:

A. for monthly premiums, by the first day of the month preceding the month for which coverage will be provided;

B. for quarterly premiums, by the first day of the month preceding the first month of the quarter for which coverage will be provided; and

C. for annual premiums, by the first day of the month preceding the first month of the year for which coverage will be provided.

Subp. 5. **Premium payment dates.** Premium payments are due as follows:

A. An initial premium must be received by the department within four months after the date on the applicant's first premium notice.

B. Subsequent premiums must be received by the department as follows:

(1) monthly premiums by the 15th of the month preceding the month for which the premium is paid;

(2) quarterly premiums by the 15th of the month preceding the first month of the quarter for which the premium is paid; and

(3) annual premiums by the 15th of the month preceding the first month of the year for which the premium is paid.

Subp. 6. **Disenrollment.** The commissioner shall disenroll enrollees who fail to pay the required premium when due. MinnesotaCare coverage terminates the last day of the calendar month following the due date specified in subpart 5 unless the premium is received by noon of the last business day of the calendar month following the due date.

Subp. 7. **Reenrollment.** An enrollee disenrolled for failure to pay the required premium may reenroll as provided in items A to D.

A. The enrollee:

(1) may not reenroll until four calendar months after the date coverage terminates, unless the person demonstrates good cause for nonpayment; and

(2) must comply with parts 9506.0010 to 9506.0100 and pay the unpaid premium for any month in which coverage was provided.

B. Good cause for nonpayment does not exist if a person chooses to pay other family expenses instead of the MinnesotaCare premium.

C. Good cause for nonpayment means, generally, circumstances beyond an enrollee's control or that were not reasonably foreseeable that excuse an enrollee's failure to pay the required premium when due, including circumstances such as:

(1) because of serious physical or mental incapacity or illness, the enrollee fails to pay the premium;

(2) the enrollee voluntarily disenrolls under the mistaken belief that other health coverage is available; or

(3) the enrollee does not receive a regular source of income on which the enrollee has relied to pay the required premium.

D. The commissioner shall determine whether good cause exists based on the weight of the supporting evidence submitted by the person to demonstrate good cause.

Subp. 8. **Premium payment adjustments.** The commissioner shall adjust enrollees' premium payments upon receipt of the audit information required under part 9506.0060, subparts 1 and 2. Adjustments to premium payments are effective on the first day of the month following issuance of an adjusted premium invoice.

Statutory Authority: *MS s 256.9352; 256L.02*

History: *19 SR 1286; L 1998 c 407 art 5 s 47*

9506.0050 COORDINATION OF MINNESOTACARE AND MEDICAL ASSISTANCE.

Subpart 1. **Referral of applicants and enrollees potentially eligible for medical assistance to local social service agency.** The commissioner shall refer applicants and enrollees who are potentially eligible for medical assistance without a spend-down to the local social service agency. The commissioner shall determine potential eligibility by considering:

A. age;

B. household income or assets;

C. pregnancy;

D. illness, injury, or incapacity indicating a disability;

E. household composition; and

F. employment status of household members.

Subp. 2. **Enrollment of applicants and enrollees potentially eligible for medical assistance.**

A. If an applicant who is potentially eligible for medical assistance without a spenddown meets the other conditions of eligibility for MinnesotaCare, the commissioner shall enroll the applicant in MinnesotaCare upon receipt of the initial premium payment.

B. An applicant or enrollee who is potentially eligible for medical assistance without a spenddown may continue to be covered by MinnesotaCare until determined eligible for medical assistance, provided:

(1) the applicant:

(a) applies for medical assistance within 60 days from the date MinnesotaCare coverage begins; and

(b) cooperates with the local social service agency in determining eligibility for medical assistance; or

(2) the enrollee:

(a) applies for medical assistance within 60 days after the first day of the month following the month of referral to the local social service agency; and

(b) cooperates with the local social service agency in determining eligibility for medical assistance.

C. An applicant who is determined eligible for medical assistance without a spenddown may be eligible for a refund of the applicant's MinnesotaCare premium payments, depending on family size.

Subp. 3. **Coordination of coverage for hospital inpatient services under MinnesotaCare and medical assistance.** Coverage for inpatient hospital services for enrollees shall be coordinated between MinnesotaCare and medical assistance as provided in this subpart.

A. The commissioner shall notify enrollees who have received inpatient hospital services and who are determined to have a basis of eligibility for medical assistance, in writing, that an application for medical assistance must be completed.

B. By the last day of the third month following the inpatient hospital admission, an enrollee who has received written notice under item A must apply for medical assistance and must cooperate with the local social service agency in determining eligibility for medical assistance.

C. If an enrollee is determined eligible for medical assistance with a spenddown:

(1) the enrollee is covered by medical assistance during the months of inpatient hospitalization;

(2) the enrollee must pay:

(a) the MinnesotaCare premium during the months of inpatient hospitalization;

(b) inpatient hospital costs included in the enrollee's spend-down that are not paid for by MinnesotaCare; and

(c) services not covered by MinnesotaCare or medical assistance;

(3) the enrollee is not responsible for any hospital payments reduced under Minnesota Statutes, section 256L.03, subdivision 3, paragraph (c);

(4) MinnesotaCare shall pay inpatient hospital costs up to the enrollee's spend-down limit or the MinnesotaCare $10,000 annual benefit limit for adults, whichever is less; and

(5) medical assistance shall pay the enrollee's inpatient hospital costs above spenddown amounts.

D. An enrollee who is not eligible for medical assistance may:

(1) remain enrolled in MinnesotaCare; and

(2) unless the enrollee is a child, pay ten percent of the hospitalization charge, up to an annual maximum of $1,000 per person or $3,000 per family, and any hospitalization charges that exceed the $10,000 annual limit on MinnesotaCare benefits for inpatient hospital services.

An enrollee who is not eligible for medical assistance may be eligible for retroactive general assistance medical care under Minnesota Statutes, section 256D.03, subdivision 3, paragraph (b).

Subp. 4. **Disenrollment.**

A. The commissioner shall disenroll an enrollee and the enrollee's family when the enrollee fails to apply for medical assistance or cooperate with determining eligibility, as required under subparts 2 and 3. MinnesotaCare coverage terminates the last day of the calendar month following the month in which the medical assistance application was due.

B. An enrollee, and the enrollee's family, if disenrolled for failure to comply with subpart 2, may reenroll after cooperating with the medical assistance eligibility determination and being determined ineligible for medical assistance without a spenddown.

C. An enrollee, and the enrollee's family, if disenrolled for refusal to comply with subpart 3, item B, may not reenroll.

D. The commissioner shall disenroll an enrollee who is determined eligible for medical assistance without a spend-down. MinnesotaCare coverage terminates the last day of the calendar month in which the department receives notice of the enrollee's medical assistance eligibility.

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; 256L.02; 256L.12*

History: *19 SR 1286; 20 SR 495*

9506.0060 QUALITY CONTROL.

Subpart 1. **Changes.** Enrollees must report to the department any changes in the following:

A. address;

B. household composition;

C. employment status;

D. a change of more than $50 per month of gross income;

E. availability of other health coverage;

F. onset of disability or change in disability; or

G. anticipation of legal action to collect money for an accident or an injury, or benefits available due to an accident or injury.

Subp. 2. **Random audits.** The commissioner shall perform audits of randomly selected enrollees to verify enrollees' gross annual family income and MinnesotaCare eligibility. Enrollees being audited must provide additional income and eligibility information, including:

A. federal income tax returns;

B. federal W2 forms;

C. employment check stubs;

D. family composition;

E. residency;

F. length of time without health insurance;

G. access to employer-subsidized coverage; and

H. any additional information necessary to determine income and eligibility.

Subp. 3. **Disenrollment.** The commissioner shall disenroll enrollees who refuse to provide information required under subparts 1 and 2. MinnesotaCare coverage will terminate the last day of the calendar month in which notice of cancellation is sent. Persons may reenroll after complying with this part and being determined eligible for MinnesotaCare.

Statutory Authority: *MS s 256.9352; 256L.02*

History: *19 SR 1286*

9506.0070 APPEALS.

Subpart 1. **Notice.** The commissioner shall follow the notification procedures in chapter 9505 and Minnesota Statutes, chapter 256B, if the commissioner denies, suspends, reduces, or terminates MinnesotaCare eligibility or covered health services. The commissioner shall mail the person a written notice that describes the action, the reason for the action, and the person's right to appeal the action according to Minnesota Statutes, section 256.045.

Subp. 2. **Appeal process.** An applicant or enrollee aggrieved by a determination or action of the commissioner may appeal the determination or action according to Minnesota Statutes, section 256.045. An applicant or enrollee must submit a written request for a hearing to the department within 30 days after receipt of the written notice of the determination or action, except that a person has 90 days to submit a written request upon showing good cause why the request was not submitted within 30 days.

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; 256L.02; 256L.12*

History: *19 SR 1286; 20 SR 495*

9506.0080 COVERED HEALTH SERVICES.

Subpart 1. **Covered health services.** Health services covered by MinnesotaCare include the services listed in Minnesota Statutes, section 256L.03.

Subp. 2. **Inpatient hospital services.**

A. Enrollees are covered for medically necessary inpatient hospital services including acute care services, mental health services, and chemical dependency services.

B. MinnesotaCare benefits for inpatient hospital services for adult enrollees are limited to $10,000 per calendar year. No benefit limit for inpatient hospital services applies to children.

C. To be reimbursed under MinnesotaCare for inpatient hospital services provided to enrollees, eligible providers must comply with:

(1) 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;

(2) parts 9505.0170 and 9505.0475 and Minnesota Statutes, section 256L.03, subdivisions 1 to 5, establishing standards for services covered by medical assistance;

(3) parts 9505.5000 to 9505.5030 and Minnesota Statutes, section 256B.0625, subdivision 25, requiring prior authorization for certain services; and

(4) parts 9505.0540 and 9505.5035 to 9505.5105, governing second surgical opinions.

Subp. 3. **Hospital admission certification.** Inpatient hospital admissions of enrollees, including admission of a pregnant woman that results in the delivery of a newborn or a stillbirth or an admission where the principal diagnosis or procedure is an inpatient dental procedure, must be certified in accordance with the medical assistance certification criteria in parts 9505.0500 to 9505.0540, except for admissions:

A. approved under Medicare; or

B. authorized under parts 9530.6600 to 9530.6655.

Subp. 4. **Cost avoidance.** The commissioner shall use cost avoidance techniques to ensure benefit coordination for enrollees, including items A to C.

A. MinnesotaCare coverage for covered health services is secondary to other health coverage for which enrollees are eligible, except for coverage under the consolidated chemical dependency treatment fund.

B. Coverage by all potential third-party payers must be exhausted before MinnesotaCare payment for covered health services will be made. An eligible provider must attempt to collect payment from potential third-party payers before billing the department for a covered health service.

C. Private accident and health care coverage must be used according to the rules of the specific health plan. MinnesotaCare shall not pay for services that would have been covered by the primary health coverage if the applicable rules of that health coverage had been followed.

Subp. 5. **Lien.** When the department provides, pays for, or becomes liable for covered health services, the department has a lien for the cost of care upon any and all causes of action accruing to the enrollee, or to the enrollee's legal representatives, as a result of the occurrence necessitating payment for covered health services. All liens under this subpart are governed by Minnesota Statutes, section 256.015.

Statutory Authority: *MS s 256.9352; 256L.02*

History: *19 SR 1286*

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 256L.03, subdivision 7, and 256L.12, 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 256L.11, subdivision 2;

B. inpatient hospital services are reimbursed as provided in Minnesota Statutes, section 256L.11, subdivisions 3 to 6; and

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

Subp. 3. **Copayments not paid.** The commissioner shall reimburse an eligible provider at the full medical assistance rate minus any applicable copayments regardless of whether the eligible provider collects copayments from enrollees who are ineligible for medical assistance.

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; 256L.02; 256L.12*

History: *19 SR 1286; 20 SR 495*

9506.0100 SURVEILLANCE AND UTILIZATION REVIEW.

Parts 9505.2160 to 9505.2245 apply to the MinnesotaCare program.

Statutory Authority: *MS s 256.9352; 256L.02*

History: *19 SR 1286*

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 denied 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; 256L.02; 256L.12*

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 256L.03. 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 256L.03, 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 256L.03, 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; 256L.02; 256L.12*

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 Centers for Medicare and Medicaid Services 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 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; 256L.02; 256L.12*

History: *20 SR 495; L 1997 c 225 art 2 s 62; L 2002 c 277 s 32*