9500.1460 ADDITIONAL REQUIREMENTS.

Subpart 1. **Health plan requirements.** An organization that seeks to participate as a health plan under the PMAP shall meet the criteria in subparts 2 to 17.

Subp. 2. **Medical assistance populations covered.** A health plan may choose to serve the medical assistance population defined in part 9500.1452 or the aged medical assistance population exclusively.

Subp. 3. **Services provided.** A health plan shall provide its enrollees all health services eligible for medical assistance payment under Minnesota Statutes, section 256B.0625, and parts 9505.0170 to 9505.0475 except for services excluded in part 9500.1457, subpart 1, items A to C.

Subp. 4. **Prohibition against copayments.** A health plan shall not charge its enrollees for any health service eligible for medical assistance payment under parts 9505.0170 to 9505.0475 or for a medically necessary health service that is provided as a substitute for a health service eligible for medical assistance payment.

Subp. 5. **Plan organization.** A health plan may choose to organize itself as either a profit or not-for-profit organization.

Subp. 6. **Contractual arrangements.** A health plan shall contract with providers as necessary to meet the health service needs of its enrollees. Before contracting with the state, and on an annual basis after contracting with the state, the health plan shall give the commissioner a current list of the names and locations of the providers under contract with the health plan. These subcontracts shall be submitted to the commissioner upon request. The commissioner shall require a health plan to terminate a subcontract under the following conditions:

A. the subcontractor is terminated as a medical assistance provider under the provisions of parts 9505.2160 to 9505.2245;

B. the commissioner finds through the quality assurance review process contained in subpart 17 that the quality of services provided by the subcontractor is deficient in meeting the department's quality assurance standards and the subcontractor has failed to take action to correct the area of deficiency within 60 days; or

C. the subcontractor has failed to comply with the Department of Health licensure standards under Minnesota Statutes, chapter 62D.

Subp. 7. **Enrollment capacity.** A health plan shall accept all PMAP consumers who choose or are assigned to the health plan, regardless of the PMAP consumers' health conditions, if the PMAP consumers are from the medical assistance category or categories and the geographic area or areas specified in the contract between the health plan and the

state. The commissioner shall limit the number of enrollees in the health plan upon the issuance of a contract termination notice under subpart 12.

Subp. 8. **Financial capacity.** A health plan shall demonstrate its financial risk capacity through a reserve fund or other mechanism agreed upon by the providers within the health plan in the contract with the department. A health plan that is licensed as a health maintenance organization under Minnesota Statutes, chapter 62D, or a nonprofit health plan licensed under Minnesota Statutes, chapter 62C, is not required to demonstrate a financial risk capacity beyond the financial risk capacity required to comply with the requirements of Minnesota Statutes, chapter 62C or 62D.

Subp. 9. **Insolvency.** A health plan must have a plan approved by the commissioner for transferring its enrollees to other sources of health services if the health plan becomes insolvent.

Subp. 10. **Limited number of contracts.** The commissioner may limit the number of health plan contracts in effect under PMAP.

Subp. 11. **Liability for payment for unauthorized services.** Except for emergency health services under Minnesota Statutes, section 256B.0625, subdivision 4, or unless otherwise specified in contract, a health plan shall not be liable for payment for unauthorized health services rendered by a nonparticipating provider. The department is not liable for payment for health services rendered by a nonparticipating provider.

Subp. 11a. **Liability for payment for authorized services rendered by a nonparticipating provider.** When a health plan or participating provider authorizes services for out-of-plan care, the health plan shall reimburse the nonparticipating provider for the out-of-plan care. The health plan is not required to reimburse the nonparticipating provider more than the comparable medical assistance fee for service rate, unless another rate is otherwise required by law. A nonparticipating provider shall not bill the PMAP enrollee for any portion of the cost of the authorized service.

Subp. 12. **Termination of participation as a health plan.** The state may terminate a contract upon 90 days' written notice to the health plan. When the state issues a contract termination notice, the health plan must notify its enrollees in writing at least 60 days before the termination.

Subp. 13. **Financial requirements placed on health plan.** Each health plan shall be accountable to the commissioner for the fiscal management of the health services it provides enrollees. The state and the health plan's 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 if the state has made the payments due the health plan under part 9500.1459.

Subp. 14. **Required educational and enrollee materials.** When contracting with the state, a health plan must provide to the commissioner educational materials to be given to

the medical assistance population specified in the contract. The material should explain the services to be furnished to enrollees. No educational materials designed to solicit the enrollment of PMAP consumers shall be disseminated without the commissioner's prior approval.

When a person enrolls in the health plan, the health plan shall provide each enrollee with a certificate of coverage, a health plan identification card, a listing of plan providers, and a description of the health plan's complaint and appeal procedure.

According to Minnesota Statutes, section 256.016, any educational materials, new enrollee information, complaint and appeal information, or other enrollee materials must be understandable to a person who reads at the seventh grade level as determined by the Flesch readability scale index defined in Minnesota Statutes, section 72C.09.

Subp. 15. **Required case management system.** A health plan shall implement a system of case management in which an enrollee's individual medical needs are assessed to determine the appropriate plan of care. The individual plan of care shall be developed, implemented, evaluated, monitored, revised, and coordinated with other health care providers, as appropriate and necessary.

Subp. 16. **Required submission of information.** The contract between the state and the health plan shall specify the information the health plan shall submit to the commissioner and the Centers for Medicare and Medicaid Services, and the form in which the information shall be submitted. The information submitted must enable the commissioner to make the calculations required under part 9500.1459 and to carry out the requirements of parts 9505.2160 to 9505.2245 and the Centers for Medicare and Medicaid Services. A health plan shall make the required information available to the commissioner at times specified in the contract or, if the commissioner requires additional information for the purposes in this subpart, within 30 days of the date of the commissioner's written request for the additional information.

Subp. 17. **Required quality assurance system.** Each health plan shall have an internal quality assurance system in operation that meets the requirements of title XIX of the Social Security Act. This quality assurance system shall encompass an ongoing review of:

A. use of services;

B. case review of all problem cases and a random sample of all cases, including review of medical records and an assessment of medical care provided in each case;

C. enrollee complaints and the disposition of the complaints; and

D. enrollee satisfaction, as monitored through an annual survey.

Based on the results of the review, the health plan shall develop an appropriate corrective action plan and monitor the effectiveness of the corrective action or actions taken.

The health plan shall permit the commissioner and United States Department of Health and Human Services or their agents to evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed under its contract with the commissioner. If the commissioner or Department of Health and Human Services finds that the quality of services offered by the health plan is deficient in any area, and, after giving the health plan at least 60 days in which to correct the deficiency, the health plan has failed to take action to correct the area of deficiency, the commissioner shall withhold all or part of the health plan's capitation premiums until the deficiency identified under subpart 6 is corrected to the satisfaction of the commissioner or the Department of Health and Human Services.

Statutory Authority: *MS s 256.045; 256B.031; 256B.69*

History: *11 SR 1107; 16 SR 1086; L 2002 c 277 s 32*

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