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 9530.6655.

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*

Published Electronically: *January 14, 2010*