Department of Human Services

Adopted Permanent Rules Relating to the Prepaid Medical Assistance Program (PMAP)

Rules as Adopted

ADMINISTRATION OF THE PREPAID MEDICAL ASSISTANCE PROGRAM

9500.1450 INTRODUCTION.

Subpart 1. **Scope.** Parts 9500.1450 to 9500.1464 govern administration of the prepaid medical assistance program (PMAP) in Minnesota. Parts 9500.1450 to 9500.1464 shall be read in conjunction with title XIX of the Social Security Act, Code of Federal Regulations, title 42, and waivers approved by the Health Care Financing Administration, Minnesota Statutes, chapters 256 and 256B, and rules adopted under them, governing the administration of the title XIX program and PMAP in Minnesota.

Subp. 2. **References.** Parts 9500.1450 to 9500.1464 shall be interpreted as necessary to comply with federal laws and regulations and state laws applicable to the prepaid medical assistance program.

Subp. 3. **Geographic area.** PMAP shall be operated in the counties of Dakota, Hennepin, and Itasca and other geographical areas designated by the commissioner. ~~The commissioner may expand the geographic area beyond the designated counties.~~ If the geographic area is expanded beyond Dakota, Hennepin, and Itasca counties, participating counties in the expanded area shall receive ~~timely~~ at least 180 days notice from the commissioner before implementation of PMAP and shall be governed by parts 9500.1450 to 9500.1464.

9500.1451 DEFINITIONS.

[For text of subpart 1, see M.R. 1989]

Subp. 2. [See repealer.]

Subp. 2a. **Appeal.** "Appeal" means an enrollee's written request for a hearing, filed with the commissioner according to

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Minnesota Statutes, section 256.045, related to the delivery of health services or participation in a health plan.

Subp. 2b. **Authorization.** "Authorization" means a ~~health plan~~ participating provider's written referral for health services provided by a ~~nonhealth-plan~~ nonparticipating provider. Authorization includes an admission request by a ~~health-plan~~ participating provider, on behalf of a PMAP enrollee, following the established health plan admission procedures for inpatient health services.

Subp. 2c. **Authorized representative.** "Authorized representative" means a person authorized in writing by a PMAP consumer to act on the PMAP consumer's behalf in matters involving the prepaid medical assistance program.

Subp. 3. [See repealer.]

Subp. 4. **Capitation.** "Capitation" means a method of payment for health services that involves a monthly per person rate paid on a prospective basis to a health plan.

Subp. 4a. **Case management.** "Case management" means a method of providing health care in which ~~an individual or organization or an interdisciplinary team~~ the health plan coordinates the provision of health services to an enrollee.

Subp. 4b. **Commissioner.** "Commissioner" means the commissioner of the Minnesota Department of Human Services or the commissioner's designated representative.

Subp. 4c. **Complaint.** "Complaint" means an enrollee's written or oral communication to a health plan expressing dissatisfaction with the provision of health services. The subject of the complaint may include, but is not limited to, the scope of covered services, quality of care, or administrative operations.

Subp. 5. [See repealer.]

[For text of subp 6, see M.R. 1989]

Subp. 7. **Enrollee.** "Enrollee" means a PMAP consumer who is enrolled in a health plan.

Subp. 7a. **Health plan.** "Health plan" means an organization contracting with the state to provide medical

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assistance health services to enrollees in exchange for a monthly capitation payment.

Subp. 8. **Health services.** "Health services" means the services and supplies given to a recipient by a provider for a health related purpose under Minnesota Statutes, section 256B.0625.

Subp. 9. **Insolvency.** "Insolvency" means the condition in which a health plan is financially unable to meet the financial and health care service delivery obligations in the contract between the department and the health plan.

[For text of subp 10, see M.R.]

Subp. 11. [See repealer.]

Subp. 12. [See repealer.]

[For text of subp 13, see M.R. 1989]

Subp. 14. **Medical assistance population or MA population.** "Medical assistance population" or "MA population" means ~~an aged, blind, disabled, or Aid to Families with Dependent Children (AFDC), AFDC related, medically needy children, or pregnant woman~~ a category of eligibility for the medical assistance program, the eligibility standards for which are in parts 9505.0010 to 9505.0150 and Minnesota Statutes, section 256B.055.

Subp. 14a. **Multiple health plan model.** "Multiple health plan model" means a health services delivery system that allows PMAP consumers to enroll in one of two or more health plans.

Subp. 14b. **Nonparticipating provider.** "Nonparticipating provider" means a provider who is not employed by or under contract with a health plan to provide health services.

Subp. 14c. **Ombudsperson.** "Ombudsperson" means an individual designated by the commissioner under Minnesota Statutes, section 256B.031, subdivision 6, to advocate for PMAP consumers and enrollees and to assist them in obtaining necessary health services.

Subp. ~~14c.~~ 14d. **Open enrollment.** "Open enrollment" means the annual 30-day period during which PMAP enrollees in a multiple health plan model may change to another health plan.

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Subp. 14e. **Participating provider.** "Participating provider" means a provider who is employed by or under contract with a health plan to provide health services.

Subp. ~~14d.~~ 14f. **Personal care assistant.** "Personal care assistant" means a provider of personal care services prescribed by a physician, supervised by a registered nurse, and provided to a medical assistance recipient under Minnesota Statutes, section 256B.0627. A personal care assistant must not be the recipient's spouse, legal guardian, or parent if the recipient is a minor child.

Subp. ~~14e.~~ 14g. **Personal care services.** "Personal care services" has the meaning given it in Minnesota Statutes, section 256B.0627, subdivision 4.

Subp. ~~14f.~~ 14h. **Prepaid medical assistance program or PMAP.** "Prepaid medical assistance program" or "PMAP" means the prepaid medical assistance program authorized under Minnesota Statutes, section 256B.69.

Subp. ~~14g.~~ 14i. **PMAP consumer.** "PMAP consumer" means a medical assistance recipient who is selected to participate in PMAP.

Subp. ~~14h.~~ 14j. **Prepayment coordinator.** "Prepayment coordinator" means the individual designated by the local agency under Minnesota Statutes, section 256B.031, subdivision 9.

Subp. ~~14i.~~ 14k. **Primary care provider health plan model.** "Primary care provider health plan model" means a health services delivery system that allows PMAP consumers to select a primary care physician and primary care dentist from a list of physicians and dentists under contract with the state or a county to provide health services to PMAP consumers.

Subp. 15. **Provider.** "Provider" means a person or entity providing health services.

Subp. 16. **Rate cell.** "Rate cell" means a grouping of recipients by demographic characteristics, established by the commissioner for use in determining capitation rates. The following are deemed to be demographic characteristics ~~may include, but are not limited to,~~: a recipient's age, sex,

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medicare status, basis of medical assistance eligibility, ~~and~~ county of residence, and ~~whether the recipient is a resident~~ ~~of~~ residence in a long-term care facility.

Subp. 16a. **Rate cell year.** "Rate cell year" means the period beginning on the date of enrollment in the health plan and ending on the date of the annual eligibility review or the date of enrollment in a new plan, whichever occurs sooner, and thereafter the 12-month period between eligibility reviews during which an enrollee's rate cell assignment is fixed.

[For text of subp 17, see M.R. 1989]

Subp. 17a. **Spend-down.** "Spend-down" means the process by which a person who has income in excess of the medical assistance income standard becomes eligible for medical assistance by incurring health services expenses, other than nursing home facility per diem charges, that are not covered by a liable third party and that reduce the excess income to zero.

Subp. 17b. **State institution.** "State institution" means all regional treatment centers as defined in Minnesota Statutes, section 245.0312, and all state operated facilities as defined in Minnesota Statutes, section 252.50.

Subp. 18. [See repealer.]

9500.1452 ELIGIBILITY TO ENROLL IN A HEALTH PLAN.

Subpart 1. **Medical assistance eligibility required for PMAP participation.** Only persons who have been determined eligible for medical assistance under parts 9505.0010 to 9505.0150 shall be eligible to participate in the prepaid medical assistance program.

Subp. 2. **Medical assistance categories ineligible for PMAP.** A person who belongs to a category listed in items A to ~~K~~ N is ineligible to enroll in a health plan under the prepaid medical assistance program:

A. a person who is eligible for medical assistance on a spend-down basis as defined in part 9500.1451, subpart 17a;

B. a person who is currently receiving the services of a personal care assistant, or PMAP enrollees who at the end

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of their rate cell year are using the services of one or more personal care assistants;

C. a person who is a resident of a state institution;

D. a person who is receiving benefits under the Refugee Assistance Program, established at United States Code, title 8, section 1522(e);

E. a person who is eligible for medical assistance through an adoption subsidy;

F. a person who is determined eligible for medical assistance due to blindness or disability as certified by the Social Security Administration or the state medical review team, unless the recipient is 65 years of age or older;

G. a person who is eligible for medical assistance but currently has private health insurance coverage through a health maintenance organization licensed under Minnesota Statutes, chapter 62D;

H. a person who resides in Itasca county but who lives near the county border and who chooses to use a primary care provider located in a neighboring county;

I. a person who is a qualified medicare beneficiary, as defined in United States Code, title 42, section 1396(d), who is not otherwise eligible for medical assistance;

J. a person who is terminally ill as defined under part 9505.0297, subpart 2, item N, and who, at the time of notification of mandatory enrollment in PMAP, has a permanent relationship with a primary physician who is not part of any PMAP health plan; ~~or~~

K. a person who is in ~~Title IV-E~~ foster placement~~.~~;

L. a child who prior to enrollment in a health plan is determined to be in need of protection under Minnesota Statutes, sections 626.556 to 626.5561, is identified to the state by the county social service agency, and is receiving medical assistance covered services through a provider who is not a participating provider in PMAP;

M. a child who prior to enrollment in a health plan is determined to be severely emotionally disturbed under

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Minnesota Statutes, sections 245.487 to 245.4887, and is:

(1) coded as severely emotionally disturbed on the Minnesota welfare information system;

(2) receiving county mental health case management services; and

(3) under the primary care of a mental health professional as defined in Minnesota Statutes, section 245.4871, subdivision 27, who is not a participating provider in PMAP; or

N. a person who, at the time of notification of mandatory enrollment in PMAP:

(1) has a communicable disease;

(2) the prognosis of the communicable disease is terminal illness, however, for the purpose of this subitem, "terminal illness" may exceed six months;

(3) the person's primary physician is not a participating provider in any PMAP health plan; and

(4) the physician certifies that disruption of the existing physician-patient relationship is likely to result in the patient becoming noncompliant with medication or other health services.

Subp. 3. ~~Optional exclusions; commissioner approval. Counties participating in PMAP may, subject to the approval of the commissioner, exclude one or more categories of persons listed in items A to C from participation in PMAP.~~

~~A. Children in out of home placements under:~~

~~(1) Rule 5, child caring institutions, parts 9545.0900 to 9545.1090; or~~

~~(2) Rule 8, group homes, parts 9545.1400 to 9545.1500.~~

~~B. Children determined to be severely emotionally disturbed pursuant to Minnesota Statutes, sections 245.487 to 245.4887, and who are coded as severely emotionally disturbed on the Minnesota welfare information system.~~

~~C. Children determined to be in need of protection pursuant to Minnesota Statutes, sections 626.556 to 626.5561, and who are identified to the state by the county social service~~

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~~agency.~~

~~Subp. 4.~~ **Exclusions during phase-in period.** The 65 percent of medical assistance eligible persons in Hennepin county who were not randomly selected to participate in the former medical assistance prepaid demonstration project because they served as a control group must participate in PMAP. Hennepin county may temporarily exclude individuals' participation in PMAP in order to provide an orderly phase-in period for new enrollees. The phase-in period must be completed within one year from the start of the enrollment period for each category of eligible PMAP consumers.

Counties participating in the prepaid medical assistance program for the first time after June 30, 1991, may temporarily exclude PMAP consumers from participation in PMAP in order to provide an orderly phase-in period for new enrollees. The phase-in period must be completed within one year from the start of the enrollment period for each category of eligible PMAP consumers.

Subp. ~~5.~~ 4. **Elective enrollment.** An individual categorically excluded from PMAP under subpart 2, item G, may enroll in PMAP on an elective basis if the private health insurance health plan is the same as the health plan the consumer will select under PMAP.

~~An individual~~ Individuals categorically excluded from PMAP under subpart ~~3, items A to C~~ 2, items K, L, and M, may enroll in the prepaid medical assistance program on an elective basis.

Program requirements are the same for elective and mandatory PMAP enrollees under Minnesota Statutes, section 256B.69.

9500.1453 MANDATORY PARTICIPATION; FREE CHOICE OF HEALTH PLAN.

Subpart 1. **Local agency enrollment of PMAP consumers.** Each local agency shall enroll recipients to participate as PMAP consumers in the prepaid medical assistance program. Health services may be provided to PMAP consumers under a multiple health plan model or a primary care provider health plan model.

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Subp. 2. **Counties using a multiple health plan model, choice.** In a county that uses a multiple health plan model, the local agency shall notify each PMAP consumer, in writing, of the health plan choices available. The PMAP consumer shall be given ~~no less than ten~~ 30 days after receiving the notification to select a health plan and to inform the local agency of the health plan choice. If a PMAP consumer fails to select a health plan within ~~the specified time~~ 30 days, the local agency ~~may provide additional assistance to the PMAP consumer in making a selection but~~ must randomly assign the PMAP consumer to a health plan ~~within the time limit established by the commissioner~~ at the end of the 30-day period. The commissioner shall notify each PMAP consumer in writing before the effective date of enrollment, of the health plan in which the PMAP consumer will be enrolled.

Subp. 3. **Counties using primary care provider health plan model, provider choice.** In a county that uses a primary care provider health plan model, the local agency shall notify each PMAP consumer, in writing, of the primary care physicians and dentists available. The PMAP consumer shall be given ~~no less than ten~~ 30 days after receiving the notification to select a primary care physician and dentist and to inform the local agency of the choice. If a PMAP consumer fails to select a primary care physician or dentist within ~~the specified time~~ 30 days, the local agency ~~may provide additional assistance to the PMAP consumer in making a selection but~~ must randomly assign the PMAP consumer to a primary care physician and dentist ~~within the time limit established by the commissioner~~ at the end of the 30-day period. The local agency shall notify each PMAP consumer in writing of the assigned primary care physician or dentist before the effective date of enrollment.

Subp. 4. **Designation of prepayment coordinator.** To carry out its responsibilities under this part, each local agency shall designate a prepayment coordinator. The prepayment coordinator shall perform the duties set forth under Minnesota Statutes, section 256B.031, subdivision 9. The commissioner

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shall monitor the tasks performed by the prepayment coordinator.

Subp. 5. **Enrollment period in counties using a multiple health plan model; change.** In a county that uses a multiple health plan model, a PMAP consumer shall be enrolled in a health plan for up to one year from the date of enrollment but shall have the right to change to another health plan once within the first ~~60-days~~ year of initial enrollment in PMAP. In addition, when a PMAP consumer is enrolled in a health plan whose participation in PMAP is subsequently terminated for any reason, the PMAP consumer shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. An enrollee shall also have the opportunity to change to another health plan during the annual 30-day open enrollment period. The local agency shall notify enrollees of the opportunity to change to another health plan before the start of each annual open enrollment period. ~~An-enrollee-may-request-to change-health-plans-at-other-than-the-designated-times-by following-the-procedures-under-subpart-7.~~

Subp. 6. **Enrollment period in counties using primary care provider health plan model; change.** In a county that uses a primary care provider health plan model, an enrollee ~~may~~ shall select a primary care physician or dentist for a period up to one year from the date of enrollment but shall have the right to select a new primary care physician or dentist during the first ~~60-days~~ year of initial enrollment. An enrollee shall also have the opportunity to change primary care physicians and dentists on an annual basis. The local agency shall notify an enrollee of this change option. ~~An-enrollee-may-request-to change-primary-care-providers-at-other-than-the-designated-times by-following-the-procedure-under-subpart-7.~~

Subp. 7. ~~Changes-between-enrollment-periods.--An-enrollee in-a-county-that-uses-a-multiple-health-plan-model-may-change health-plans-and-an-enrollee-in-a-county-that-uses-a-primary care-provider-health-plan-model-may-change-primary-care physicians-or-dentists-between-enrollment-periods-for-cause-by~~

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~~demonstrating-to-the-state-human-services-referee-that-the enrollee:~~

~~A.--has-not-received-satisfactory-services-from-the health-plan-or-primary-care-physician-or-dentist;-or~~

~~B.--has-other-good-cause-for-changing-to-another health-plan-or-primary-care-physician-or-dentist.~~

~~Subp.-8.~~ **Enrollment changes without a hearing, substantial travel time.** An enrollee in a multiple health plan model may change a health plan and an enrollee in a primary care provider health plan model may change a primary care provider without a hearing if the travel time to the enrollee's primary care provider is over 30 minutes from the enrollee's residence. The county shall notify the commissioner, in writing, prior to making a change under this subpart.

Subp. ~~9.~~ 8. **Enrollment changes without a hearing when agency error.** Upon an enrollee's request, the ~~state may authorize the~~ county ~~to~~ shall change an enrollee's health plan or primary care physician or dentist without a hearing when the enrollee's health plan or primary care physician or dentist choice was incorrectly designated due to local agency error.

~~Subp.-10.--Mandatory-participation.--A-recipient's mandatory-participation-in-PMAP-does-not-constitute-a restriction-of-free-choice-of-provider-as-provided-under Minnesota-Statutes,-sections-256B.031,-subdivision-5,-and 256B.69,-subdivision-4.~~ The county shall notify the commissioner, in writing, prior to making a change under this subpart.

Subp. ~~11.~~ 9. **Authorized representative.** A PMAP consumer may designate an authorized representative to act on the PMAP consumer's behalf in matters involving the PMAP.

9500.1454 RECORDS.

A health plan shall maintain fiscal and medical records as required in part 9505.0205. A local agency shall comply with part 9505.0135 and maintain a list showing the enrollment choices of recipients who participate in the PMAP.

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9500.1455 THIRD-PARTY LIABILITY.

To the extent required under Minnesota Statutes, section 62A.046 and part 9505.0070, the health plan shall coordinate benefits for or recover the cost of medical care provided to its enrollees who have private health care or Medicare coverage. Coordination of benefits includes paying applicable copayment or deductibles on behalf of an enrollee.

The health plan must comply with the claims settlement requirements under Minnesota Statutes, section 256B.69, subdivision 6, paragraph (b).

9500.1457 SERVICES COVERED BY PMAP.

Subpart 1. **In general.** Services currently available under the medical assistance program in Minnesota Statutes, section 256B.0625 and parts 9505.0170 to 9505.0475 are covered under PMAP. Chemical dependency services provided under this part must fully comply with the requirements of parts 9530.4100 to 9530.6655. The following services are not covered:

A. case management services for serious and persistent mental illness as defined in Minnesota Statutes, section 256B.0625, subdivision 20;

B. nursing home facility per diem services as defined in Minnesota Statutes, section 256B.0625, subdivision 2, and parts 9549.0010 to 9549.0080; and

C. services provided under home-based and community-based waivers authorized under United States Code, title 42, section 1396.

Subp. 2. **Additional services.** A health plan may provide services in addition to those available under the medical assistance program.

Subp. 3. **Prior authorization of services.** A health plan shall be exempt from the requirements of Minnesota Statutes, chapter 256B, parts 9505.0170 to 9505.0475 and 9505.5000 to 9505.5030, that require prior authorization before providing health services to an enrollee.

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9500.1458 DATA PRIVACY.

Under Minnesota Statutes, section 13.46, subdivisions 1 and 2, a health plan under contract with the department is considered an agent of the department and shall have access to information on its enrollees to the extent necessary to carry out its responsibilities under the contract. The health plan must comply with Minnesota Statutes, chapter 13, the Minnesota Government Data Practices Act.

9500.1459 CAPITATION POLICIES.

Subpart 1. **Rates.** On or before the tenth day of each month, the commissioner shall prepay each health plan the capitation rates specified in the contract between the health plan and the state. The capitation rates ~~must be reviewed by an independent actuary with demonstrated experience in the health insurance rate setting area~~ shall be developed in accordance with Minnesota Statutes, section 256B.69. The capitation rates established under this part, the rate methodology and the contracts with the health plan shall be made available to the public upon request. The rates established must be less than the average per capita fee-for-service medical assistance costs for an actuarially equivalent population.

Subp. 2. to 4. [See repealer.]

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 ~~or ensure~~ its enrollees ~~access to~~ all health services eligible for medical assistance payment under Minnesota Statutes, section 256B.0625, and parts 9505.0170 to 9505.0475 except for services ~~referenced~~ excluded in part 9500.1457, subpart 1, items A to C.

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Subp. 4. **Prohibition against co-payments.** 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 **may** shall be ~~reviewed by~~ submitted to the commissioner upon request. The commissioner **may** shall require a health plan to terminate a subcontract ~~when the commissioner determines that~~ 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 ~~does not meet the department's quality assurance standards or~~ 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

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categories and the geographic area or areas specified in the contract between the health plan and the state. The commissioner ~~may~~ shall limit the number of enrollees in the health plan ~~if, in the commissioner's judgment, the health plan cannot demonstrate a capacity to serve additional enrollees~~ 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 ~~who is not part of the health plan~~. The department is not liable for payment for health services rendered by a nonparticipating provider ~~who is not part of the health plan~~.

~~A health plan shall be liable for payment for unauthorized services when the health plan enrollee has already received services from a nonparticipating provider if:~~

~~A. the service was ordered or recommended by a participating provider;~~

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~~B.--the-service-would-otherwise-be-covered,-or-was part-of-a-discharge-plan-of-a-participating-provider,-and~~

~~C.--the-enrollee-was-not-given-prior-written-notice stating-that-this-service-by-a-nonparticipating-provider-would not-be-covered,-and-a-listing-of-participating-providers-of-this service-available-in-the-enrollee's-area.~~

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

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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~~, when medically necessary~~, 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 Health Care Financing Administration, 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 9505.1750 to 9505.2150 and the Health Care Financing Administration. 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

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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, ~~the commissioner may~~ 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 ~~problem~~ deficiency identified under subpart 6 is corrected to the satisfaction of the commissioner or the Department of Health and Human Services.

9500.1462 SECOND MEDICAL OPINION.

A health plan must indicate in the certificate of coverage that enrollees have a right to a second medical opinion according to items A to C.

A. A health plan must provide, at its expense, a second medical opinion within the health plan upon enrollee

request.

B. According to Minnesota Statutes, section 62D.103, a health plan is required to provide a second medical opinion by a qualified ~~nonhealth-plan~~ nonparticipating provider when it determines that an enrollee's chemical dependency or mental health problem does not require structured treatment.

C. According to Minnesota Statutes, section 256.045, subdivision 3a, paragraph (b), a health plan must provide, at its expense, a second medical opinion by a ~~health-plan~~ participating provider or ~~nonhealth-plan~~ nonparticipating provider when ordered by a state human services referee.

9500.1463 COMPLAINT AND APPEAL PROCEDURES.

Subpart 1. and 2. [See repealer.]

Subp. 3. **Health plan complaint procedure.** A health plan shall have a written procedure for reviewing enrollee complaints. This complaint procedure must be approved by the commissioner. The complaint procedure must include both an informal process, in which a determination is made within ten calendar days after the date a health plan receives a verbal complaint, and a formal process to handle written complaints. The formal process shall provide for an impartial hearing containing the elements in items A to E.

A. A person or persons with authority to resolve the case shall be designated to hear the complaint.

B. The enrollee has the right to be represented at the hearing by a representative of his or her choice, including legal counsel.

C. The enrollee and the health plan may call witnesses to provide relevant testimony.

D. A determination shall be made and written notice of the decision shall be issued to the enrollee within 30 days after the date the written complaint is received by the health plan. The written notice shall include notice of the enrollee's right to appeal to the state.

E. The health plan must notify the ombudsperson

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within three working days after any written complaint is filed by a PMAP enrollee.

Each health plan shall provide its enrollees with a written description of the health plan's complaint procedure and the state's appeal procedure at the time of enrollment. The written description shall clearly state that exhaustion of the health plan's complaint procedure is not required before appealing to the state. The health plan's complaint procedure and revisions to the complaint procedure must be approved by the commissioner. Approved revisions in the health plan's complaint procedure must be communicated, in writing, to its enrollees at least two weeks before the revisions are implemented.

Subp. 4. **Health plan notice requirements.** When a health plan denies, reduces, or terminates a health service, it must notify the enrollee or the enrollee's authorized representative in writing ~~within the time period in its contract,~~ of the right to file a complaint or appeal according to Minnesota Statutes, section 256.045, subdivision 3. The notice must ~~be in a form acceptable to the commissioner and must~~ explain:

A. the right to a second opinion within the plan;

B. how to file a complaint;

C. how to file a state appeal, including the name and telephone number of the state ombudsperson;

D. the circumstances under which health services may be continued pending an appeal; and

E. the right to request an expedited hearing under Minnesota Statutes, section 256.045, subdivision 3a, paragraph (c).

For purposes of this subpart, a health plan does not include the treating physician, second opinion physician, or other treating health care professional whether employed by, or contracting with, the health plan.

Subp. 5. **State appeal procedure.** An enrollee may appeal the refusal to change a health plan or primary care provider under part 9500.1453, subparts 7 and 8, a health plan's or ~~plan~~ participating provider's denial, delay, reduction, or

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termination of health services or a health plan's resolution of a complaint or any other ruling of a prepaid health plan by submitting a written request for a hearing as provided in Minnesota Statutes, section 256.045, subdivision 3. The enrollee may request an expedited hearing by contacting the appeals referee or ombudsperson. A state human services referee shall conduct a hearing on the matter and shall recommend an order to the commissioner. An enrollee is not required to exhaust the health plan's complaint system before filing a state appeal. An enrollee may request the assistance of the ombudsperson or other persons in the appeal process.

Subp. 6. **Services pending state appeal or resolution of complaint.** If an enrollee files a written complaint with the health plan or appeals in writing to the state under Minnesota Statutes, section 256.045, on or before the tenth day after the decision is communicated to the enrollee by the health plan to reduce, suspend, or terminate services the enrollee had been receiving on an ongoing basis, or before the date of the proposed action, whichever is later, and the treating plan physician or another plan physician has ordered the services at the present level and is authorized by the contract with the health plan to order the services, the health plan must continue to provide services at a level equal to the level ordered by the plan physician until written resolution of the complaint is made by the health plan or a decision on the appeal is made by the human services referee. If the resolution is adverse, in whole or part, to the enrollee, the enrollee must be notified of the right to a state appeal. If the enrollee appeals a health plan's written resolution within ten days after it is issued, or before the date of the proposed action, whichever is later, services must be continued pending a decision by the human services referee. A resolution is made or issued on the date it is mailed or the date postmarked, whichever is later. For the purposes of this subpart, "plan physician," where appropriate, includes a plan dentist, mental health professional, chiropractor, or osteopath, nurse practitioner, or nurse midwife.

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Subp. 7. **State ombudsperson.** The commissioner shall designate a state ombudsperson to help enrollees resolve health plan service related problems. Upon an enrollee's request, the ombudsperson shall investigate the enrollee's case and ~~shall~~ when appropriate attempt to resolve the problem in an informal manner by serving as an intermediary between the enrollee and the health plan. If the enrollee requests appeal information, or if the ombudsperson believes that an informal resolution is not feasible or is unable to obtain a resolution of the problem, the ombudsperson shall explain to the enrollee what his or her complaint and appeal options are, how to file a complaint or appeal, ~~and~~ how the complaint or appeal process works and assist the enrollee in presenting the enrollee's case to the appeals referee, when requested. The ombudsperson must be available to help the enrollee file a written complaint or appeal request. The ombudsperson must notify the appropriate health plan of a state appeal within three working days after the state appeal is filed.

Subp. 8. **Record keeping and reporting requirements.** The health plan must maintain a record of all written complaints from enrollees, actions taken in response to those complaints, and the final disposition of the complaints. The health plan must report this information to the commissioner on a semiannual basis.

REPEALER. Minnesota Rules, parts 9500.1451, subparts 2, 3, 5, 11, 12, and 18; 9500.1459, subparts 2, 3, and 4; and 9500.1463, subparts 1 and 2, are repealed.

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