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STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

In the Matter of Proposed Rules of the Department of Human Services Relating to Prepaid Medical Assistance Program; Parts 9500.1450 to 9500.1464

STATEMENT OF NEED AND REASONABLENESS

INTRODUCTION

The Prepaid Medical Assistance Program is a continuation of the former Medical Assistance Prepaid Demonstration Project (MAPDP) under Minnesota Rules, parts 9500.1450 to 9500.1464. The three counties that participated in the original demonstration project are the only counties who currently participate in the Prepaid Medical Assistance Program, although a number of non-demonstration counties have expressed an interest in participating in the Prepaid Medical Assistance Program in the future.

BACKGROUND

The most common system used to pay for Medical Assistance (MA) services is to reimburse medical providers each time a covered service is delivered to a MA recipient. This system of payment is known as the "fee-for-service" system.

The Medical Assistance Prepaid Demonstration Project was established to determine whether contracting with prepaid health plans would allow the state and participating counties to contain medical costs while still providing quality health care services to Medical Assistance (MA) consumers. The Medical Assistance Prepaid Demonstration Project was one of five original demonstration projects authorized by the Health Care Financing Administration to test cost effective alternatives for payment and delivery of Medicaid services. Minnesota submitted an initial application in April 1982 and received a grant award to design the project in June of that year.

In 1983, the Minnesota Legislature passed enabling legislation for the Medical Assistance Prepaid Demonstration Project which was codified under Minnesota Statutes, section 256B.69. The Department has been providing Medical Assistance services through a prepaid health plan system since July of 1985.

The MA Prepaid Demonstration Project is authorized by Minnesota Statutes, section 256B.69 and is a Health Care Financing Administration (HCFA) Demonstration Project operating under the authority of section 1115 of the Social Security Act. The original three year waiver terminated December 30, 1989. Section 507 of Public Law 100-485 authorized continuation of the waiver through June 30, 1990, and the Budget Reconciliation Act of 1989 extended the

The Legislative Commision to Review Administrative Rules
MAR 1991

authority through June 30, 1991. Federal legislation has been enacted to continue the program through June 30, 1996. Federal waivers allow the State to:

* Require mandatory enrollment of MA recipients in prepaid health plans.
* Require enrollees to be locked-in to a health plan enrollment for 12 months, except for designated times to change plans.
* Implement a program that is not statewide.
* Provide flexibility in provider contracting, provider reimbursement, and service provision.

The original goals of the Prepaid Medicaid Demonstration Project were to:

* Test the feasibility of a prepaid capitated approach for the Medicaid population.
* Contain Medicaid costs through cost effective management of health service delivery.
* Provide for more predictable budgeting in the Medicaid program.
* Test administrative systems related to a prepaid capitated approach.
* Provide access to quality health care for enrolled populations.

The Demonstration Project is operational in three counties: Dakota, Hennepin, and Itasca. These counties serve as suburban, urban and rural test sites, respectively. Medical Assistance populations included in the program are virtually all recipients eligible for Aid to Families with Dependent Children (AFDC) and Aged recipients in Dakota and Itasca counties and 35 percent of these populations in Hennepin County. On July 1, 1990, Hennepin County began phasing-in 100 percent of the AFDC recipients and effective January 1, 1991, will begin to phase in 100 percent of the Aged recipients. Previously, 65 percent of the program eligible population in Hennepin County remained on fee-for-service to provide a control group for study purposes.

There are also several groups within the MA population who are excluded from the demonstration project. These groups include:

1. Medically needy individuals who are Medical Assistance eligible on a spend-down basis.
2. Recipients of the Refugee Assistance Program.
3. Blind and disabled MA recipients.
4. Residents of Regional Treatment Centers.
5. A group of recipients in Itasca County who traditionally use out-of-county providers for medical care.
6. Foster children and children involved in subsidized adoptions.
7. Recipients who have private HMO coverage.

Under the prepaid medical assistance program, health plans are paid a fixed amount each month, known as the capitation rate. The capitation rate is paid for each MA recipient enrolled in the health plan whether service is rendered or not. The health plans are responsible for delivering or arranging for the delivery of the full array of MA covered services to their enrolled populations. As a result, the health plans receiving the capitation payment are "umbrella" organizations, contracting with a broad array of acute and long-term care providers (hospitals, physicians, dentists, nursing homes, home health agencies, pharmacists, etc.). Health plans are required to meet a number of criteria related to scope of service, financial risk capability, cost-utilization reporting, quality assurance and grievance procedures, before contracting with the State. The capitation rate is paid directly to competing health plans in Dakota and Hennepin counties, and directly to the Social Services Department in Itasca County. Capitation rates have traditionally been based on the historical fee-for-service experience of an actuarially equivalent population. Risk sharing mechanisms are also available.

On December 1, 1990, there were approximately 45,314 individuals enrolled in the demonstration program in the three participating counties.

REASON FOR AMENDMENTS

Amendments to the rule are necessary to comply with legislative changes in the program; to correct rule cites no longer accurate due to revisions in the Medical Assistance rule; and to provide more efficient administration of the program. Since promulgation of the original rule, the legislature has changed the grievance and appeals process; changed the method of determining capitation rates; added groups that are exempt from the program and modified provider selection requirements if a provider ends participation. Federal legislation has been enacted to continue the program through June 30, 1996.

The legislature has also authorized prepaid health plans under Minnesota Statutes, section 256B.031 for recipients of Aid to Families With Dependent Children (AFDC). No distinction is made in the rule between MA recipients receiving AFDC and other MA recipients.

In addition to statutory changes, the former Medical Assistance Rule under Minnesota Rules, parts 9500.0750 to 9500.1080 has been superseded by parts 9505.0170 to 9505.0475. Therefore, MAPDP rule parts that cite the former Medical Assistance Rule need to be amended to reflect this numbering change.

The Department is also changing the name of the Medical Assistance Prepaid Demonstration Project (MAPDP) to the "Prepaid Medical

Assistance Program (PMAP). This change is being made for two reasons. First, as the name change indicates, the department is no longer testing the viability of a prepaid program since it has been demonstrated that it is a cost-effective alternative, which can be replicated elsewhere, for the fee-for-service system. Second, other counties may participate in prepaid medical assistance in the future and retention of the former demonstration project name would create confusion between the original demonstration project counties and counties in the expanded prepaid medical assistance program.

STATUTORY AUTHORITY FOR RULE

The statutory authority for this rule is Minnesota Statutes, sections 256B.031, 256B.69, 256.045, and waivers approved by the Health Care Financing Administration, United States Department of Health and Human Services.

RULE DEVELOPMENT PROCEDURES

In the development of the proposed amendments, the Department used the procedures mandated by the Administrative Procedures Act and internal department policies that insure maximum public input. Public input was sought through a Notice to Solicit Outside Opinion published February 21, 1989, in the State Register (13 S.R. 2049) and establishment of a Rule 62, Prepaid Medical Assistance Program, advisory committee. The Rule 62 advisory committee had representatives from the following counties, health plans, organizations, and advocacy groups:

- Hennepin County
- Dakota County
- Itasca County
- Group Health
- MedCenters Health Plan (1989 only)
- Metropolitan Health Plan
- Physicians Health Plan
- PreferredOne (1989 only)
- UCare Minnesota
- Blue Cross and Blue Shield of Minnesota (1989 only)
- Minneapolis Legal Aid Society
- Southern Minnesota Regional Legal Services
- Washburn Child Guidance Center
- Care Providers of Minnesota
- Minnesota Alliance for Health Care Consumers
- Minnesota Nurses Association
- Minnesota Association of Homes for the Aging
- Minnesota Association of Medicare Rehabilitation Agencies (MAMRA)

The rule advisory committee met on April 5, 1989 and June 2, 1989. In August 1989, work on the rule was temporarily halted due to uncertainty over continuation of the demonstration program. On June 6, 1990, the advisory committee met for the third and final time.

SMALL BUSINESS CONSIDERATION

In preparing amendments to the Prepaid Medical Assistance Program rule, the Department considered the requirements of Minnesota Statutes, section 14.115 and determined that the amendments are exempt from these requirements. Under Minnesota Statutes, section 14.115, subdivision 7, item (3) the small business consideration requirement does not apply to service businesses regulated by government bodies, for standards and costs, such as nursing homes, long-term care facilities, hospitals, providers of medical care, day care centers, group homes, and residential care facilities, but not including businesses regulated under chapter 216B or 237.

RULE AMENDMENTS

9500.1450 INTRODUCTION.

Subpart 1. **Scope.** The revision in this subpart is necessary to change the name of the "medical assistance demonstration project (MAPDP)" to the "prepaid medical assistance program (PMAP)." The testing phase has concluded and the name change is necessary to reflect the establishment of a permanent program. Prior to 1989, sunset dates were established in statute or rule for terminating the demonstration program. In the enabling legislation adopted in 1983, the legislation provided that if the project implementation phase had not begun by July 1, 1985, the enabling legislation was automatically repealed. The Department published proposed emergency rules which became effective on October 29, 1984.

In 1986, the permanent demonstration project rules provided a December 31, 1988, sunset date unless otherwise extended by the legislature. In 1987, the legislature continued the effective date for Minnesota Rules, parts 9500.1450 to 9500.1464 through December 31, 1990 (Laws of Minnesota 1987, chapter 403, article 2, section 101). In 1989, the legislature amended Minnesota Statutes, section 256B.69 by adding subdivision 17 which authorized the commissioner to continue the provisions of section 256B.69 after June 30, 1990, in any or all of the participating counties if necessary federal authority is granted (Laws of Minnesota 1989, chapter 282, article 3, section 90). Subdivision 17 also authorized the commissioner to adopt permanent rules to continue prepaid medical assistance in participating counties. The name change is reasonable since it provides a means of distinguishing the original demonstration program from the permanent program. This subpart is reasonable because it is

consistent with Minnesota Statutes, sections 256B.031 and 256B.69, subdivision 17 which authorize the commissioner to adopt permanent rules governing prepaid medical assistance.

Subp. 2. **References.** The change in this subpart is necessary to change the name of the "medical assistance demonstration project (MAPDP)" to the "prepaid medical assistance program (PMAP)." The name change is necessary to reflect the establishment of a permanent program (See the explanation for the name change under subpart 1). This subpart is reasonable because it is consistent with Minnesota Statutes, sections 256B.031 and 256B.69, subdivision 17 which authorize the commissioner to adopt permanent rules governing prepaid medical assistance.

Subp. 3. **Geographic area.** Minnesota Statutes, section 256B.69, subdivision 3, states, in part, "The commissioner shall designate the geographic areas in which eligible individuals may be included in the medical assistance prepayment programs." Minnesota Statutes, section 256B.031 authorizes the commissioner to contract with health plans to provide medical services to medical assistance recipients. The change in this subpart is necessary to inform individuals consulting the rule that the geographic area of the prepaid medical assistance program may be expanded to counties other than Dakota, Hennepin, and Itasca. If the program is expanded to other counties, such counties will be governed by parts 9500.1450 to 9500.1464. The requirement that participating counties in the expanded area be governed by parts 9500.1450 to 9500.1464 is reasonable because it ensures uniform rule requirements for all counties participating in the prepaid medical assistance program. The change in this subpart also includes a change in the name of the program. The acronym "MAPDP" is changed to "PMAP." This name change is necessary to reflect the permanent nature of the prepaid medical assistance program. This subpart is reasonable because it is consistent with Minnesota Statutes, sections 256B.031 and 256B.69.

9500.1451 DEFINITIONS.

Subp. 2. **[See repealer.]** This subpart defined "Actual costs". Actual costs is a term used in part 9500.1459, subpart 3. [Aggregate loss-sharing]. Part 9500.1459, subpart 3, item C states that there shall be no aggregate loss-sharing available after December 31, 1987. Since aggregate loss-sharing is no longer available, it is reasonable to repeal the term "actual costs" since the term no longer has any applicability to the rule.

Subp. 2a. **Appeal.** This subpart is necessary to clarify a term used in the rule. Although the term "appeal" is used in the existing rule, the term is not defined. Laws of Minnesota 1989, chapter 282, article 5, section 14, established a new subdivision under Minnesota Statutes, section 256.045, dealing with prepaid health plan appeals [Subdivision 3a]. Minnesota Statutes, section 256.045, subdivision

3a, paragraph (b) provides that recipients enrolled in a prepaid health plan under chapter 256B or 256D may contest a prepaid health plan's denial, reduction, or termination of health services or the prepaid health plan's written resolution of a complaint by submitting a written request for a hearing according to subdivision 3. Subdivision 3a, paragraph (b) also states that the commissioner need not grant a hearing if the sole issue raised by a recipient is the commissioner's authority to require mandatory enrollment in a prepaid health plan in a county where prepaid health plans are under contract with the commissioner. It is necessary to include within the definition of appealable issues participation in a health plan since part 9500.1453, subpart 7 permits an enrollee to change health plan between enrollment periods for cause by demonstrating to the state human services referee that the enrollee must travel an unreasonable time to receive health services; the enrollee has not received satisfactory services; or the enrollee has other good cause for changing to another health plan. This subpart is reasonable because it is consistent with Minnesota Statutes, section 256.045, subdivision 3a.

Subp. 2b. **Authorization.** This subpart is necessary to clarify a term used in the rule. A health plan provider may refer enrollees to health services that are provided outside of the health plan or to hospitals that may not be affiliated with the health plan. In those instances, the health plan is responsible for the cost of the authorized health service. Since the health plan is held responsible for health services that it authorizes outside of the health plan under part 9500.1460, subpart 11a, it is reasonable that the term authorization include a "written referral." A written referral provides necessary documentation should questions later arise concerning costs of health services acquired outside of the health plan.

Subp. 2c. **Authorized representative.** This subpart is necessary to clarify a term used in the rule. The definition is necessary to identify individuals who are permitted to act on behalf of the PMAP consumer in matters regarding the prepaid medical assistance program. It is reasonable to only include a person who has been specifically designated in writing to ensure private information concerning the person is not released in violation of Minnesota Statutes, chapter 13 [Government Data Practices Act].

Subp. 3. **[See repealer.]** This subpart defined "Broker" and is being repealed because the state no longer contracts for the services of a broker to educate and enroll MA recipients in the prepaid medical assistance program. The function of the broker is handled by the prepayment coordinator under duties established in Minnesota Statutes, section 256B.031, subdivision 9. Therefore, the definition of broker is no longer necessary.

Subp. 4. **Capitation.** The change in this subpart is necessary to clarify the definition of capitation. The definition has been

amended by striking the word "care" from the phrase "health care services" since capitation means a payment for "health services" as that term is defined in subpart 8. This change is reasonable because the use of the terms "health services" and "health care services" are not interchangeable. The term "medicaid" is also being deleted from the phrase "medicaid health plan" since the modifier implies a direct relationship to the federal medicaid program which does not exist.

Subp. 4a. **Case management.** This subpart is necessary to clarify a term used in the rule. Case management is a term that is common in social services programs but which has a number of different meanings. Therefore, it is necessary to define case management for the purpose of this rule. Currently case management is defined in part 9500.1460, subpart 15. However, since the term "case management" is used in more than one place in the rule, it is being defined under the definition section of the rule and is being deleted from part 9500.1460, subpart 15. In addition to moving the term to the definition section, two changes were made in the former definition by replacing the word "consumer" with the word "enrollee" and by deleting the word "care" in the phrase "health care services". A consumer is a MA recipient who is selected to participate in the prepaid medical assistance program but who is not yet enrolled with a health plan. An enrollee is a consumer who is enrolled in a health plan. Since an enrollee is the individual for whom case management is provided, the definition must use the word "enrollee" rather than the word "consumer." The deletion of the word "care" is reasonable because the use of the terms "health services" and "health care services" are not interchangeable. A similar change in terminology was made in subpart 4. Defining "case management" in the definition section is reasonable because a reader who is uncertain of the meaning of the term would consult the definition section of the rule.

Subp. 4b. **Commissioner.** This subpart is necessary to clarify a term used in the rule and to identify the official responsible for the administration of the Medical Assistance Program under Minnesota Statutes, chapter 256B. It is necessary to include within the definition persons to whom the commissioner may delegate the functions described in the rule because it is impossible for the commissioner to perform all the tasks assigned to her in statute. It is reasonable to allow the delegation to enable the commissioner to delegate responsibilities to qualified staff who can effectively implement program requirements. Including this delegation of responsibility in the definition also serves to notify interested parties of the delegation. Using the term "Commissioner" in lieu of the "Commissioner of the Minnesota Department of Human Services or the commissioner's designated representative" is reasonable to shorten the length of a term frequently used in the rule.

Subp. 4c. **Complaint.** This subpart is necessary to clarify a term used in the rule. Minnesota Statutes, section 256.045, subdivision 3a, provides that whenever a prepaid health plan denies, reduces, or terminates a health service, the prepaid health plan must notify the

recipient of the right to file a complaint or an appeal. Since a recipient has the right to file a complaint and the health plan is required to have a procedure for handling complaints under Minnesota Statutes, section 256B.031, subdivision 1, it is necessary to define the term "complaint". The term "complaint" is defined to include either a written or oral communication of dissatisfaction with the provision of health services. This subpart is reasonable because it is consistent with Minnesota Statutes, section 62D.11, subdivision 1.

Subp. 5. **[See repealer.]** This subpart is being repealed because the term "consumer" has a common meaning much broader than that intended in the rule. The term "consumer" is being replaced with the term "PMAP consumer" (see subpart 14g).

Subp. 7. **Enrollee.** The change in this subpart is necessary to reflect changes made in other parts of the rule. The term consumer under subpart 5 is being repealed and replaced with the term "PMAP consumer" under subpart 14g. The term medicaid health plan is being repealed and replaced with the term "health plan" under subpart 7a.

Subp. 7a. **Health plan.** This subpart is necessary to clarify a term used in the rule. The current rule uses the term "medicaid health plan" to identify the organizations contracting with the state to provide medical assistance health services to enrollees in exchange for a monthly capitation payment. The use of the modifier "medicaid" implies a direct relationship to the federal medicaid program which does not exist and which is unintended. Therefore, the term "medicaid health plan" is being deleted under subpart 12 and it is being replaced with the term "health plan" throughout the rule.

Subp. 8. **Health services.** The change in this subpart is necessary to correct a citation error due to a numbering change by the Revisor of Statutes. Laws of Minnesota 1987, article 2, section 268, paragraph (b), directed the Revisor of Statutes to renumber Minnesota Statutes, section 256B.02, subdivision 8a to 8y as a new section of chapter 256B. These subdivisions have been renumbered under Minnesota Statutes, section 256B.0625. The change in the statutory cite is necessary to reflect this numbering change.

Subp. 9. **Insolvency.** The change in this subpart is necessary to reflect changes made in other parts of the rule. The term "medicaid health plan" is being repealed and replaced with the term "health plan." Therefore, it is necessary to strike the word "medicaid" from the phrase "medicaid health plan."

Subp. 11. **[See repealer.]** This subpart is being repealed because the term "Medical Assistance Prepaid Demonstration Project" or "MAPDP" is being replaced by the term "Prepaid medical assistance program." The name change is necessary to reflect the establishment of a permanent program subject to continued federal waivers. As indicated under part 9500.1450, prior to 1989, sunset dates were established in statute or rule for terminating the demonstration

program. In the enabling legislation adopted in 1983, the legislation provided that if the project implementation phase had not begun by July 1, 1985, the enabling legislation was automatically repealed. The Department published proposed emergency rules which became effective on October 29, 1984. In 1986, the permanent demonstration project rules provided a December 31, 1988, sunset date unless otherwise extended by the legislature. In 1987, the legislature continued the effective date for Minnesota Rules, parts 9500.1450 to 9500.1464 through December 31, 1990 (Laws of Minnesota 1987, chapter 403, article 2, section 101). In 1989, the legislature amended Minnesota Statutes, section 256B.69 by adding subdivision 17 which authorized the commissioner to continue the provisions of section 256B.69 after June 30, 1990, in any or all of the participating counties if necessary federal authority is granted (Laws of Minnesota 1989, chapter 282, article 3, section 90). Subdivision 17 also authorized the commissioner to adopt permanent rules to continue prepaid medical assistance in participating counties. The name change is reasonable since it provides a means of distinguishing the ongoing prepaid medical assistance program from the original demonstration project program.

Subp. 12. **[See repealer.]** This subpart is being repealed because the term "Medicaid health plan or MHP" is being replaced with the term "health plan" (See subpart 7a).

Subp. 14. **Medical assistance population or MA population.** The change in this subpart is necessary to clarify the term medical assistance population. Minnesota Statutes, section 256B.055 sets out eligibility categories for Medical Assistance. The addition of the population groups "AFDC related, medically needy, or pregnant woman" categories is consistent with Minnesota Statutes, section 256B.055. The change in the cited rule parts is necessary because parts 9500.0780 to 9500.0860 have been superseded by parts 9505.0010 to 9505.0150. This change is reasonable because it is consistent with statute and it corrects a rule cite that was changed subsequent to the adoption of the existing prepaid medical assistance rules.

Subp. 14a. **Multiple health plan model.** This subpart is necessary to clarify a term used in the rule. The definition is necessary to identify one of two health services delivery systems which may be used under the proposed rules governing the prepaid medical assistance program. Under the medical assistance prepaid demonstration project, two different health services delivery systems were used by the three counties in the demonstration project. Hennepin and Dakota counties used a multiple health plan model for providing medical assistance health services; Itasca county used a primary care provider health plan model. Under the multiple health plan model, two or more health plans must contract with the state to provide health services to PMAP consumers. Minnesota Statutes, section 256B.031, subdivision 5 states, in part, "Enrollment in a prepaid health plan is mandatory only when recipients have a choice of at least two prepaid health plans." The requirement that a

multiple health plan model consist of two or more health plan is necessary to assure PMAP consumers a choice of health plans. This subpart is reasonable because it is consistent with Minnesota Statutes, section 256B.031, subdivision 5.

Subp. 14b. **Ombudsperson.** This subpart is necessary to clarify a term used in the rule. Minnesota Statutes, section 256B.031, subdivision 6, requires that the commissioner designated an ombudsperson to advocate for persons required to enroll in prepaid health plans. The definition is reasonable because it is consistent with Minnesota Statutes, section 256B.031, subdivision 6 and the role of the ombudsperson under Minnesota Statutes, section 256.045, subdivision 3.

Subp. 14c. **Open enrollment.** This subpart is necessary to clarify a term used in the rule. Minnesota Statutes, section 256B.69, subdivision 4 states, in part, "After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner." Open enrollment is the 30-day period each year in which PMAP enrollees may change to another health plan. This subpart is reasonable because it identifies that period of time when a recipient may change health plans and is consistent with the general definition used by Health Maintenance Organizations with employer contracts.

Subp. 14d. **Personal care assistant.** This subpart is necessary to clarify a term used in the rule. Currently personal care assistant is defined under part 9500.1452. To consolidate all the definitions in one section of the rule, the term is being defined in the definition section of the rule. The definition of personal care assistant is reasonable because it is consistent with MA requirements under Minnesota Statutes, section 256B.0625, subdivision 19.

Subp. 14e. **Personal care services.** This subpart is necessary to clarify a term used in the rule. Subpart 14d defines personal care assistant as a provider of "personal care services" prescribed by a doctor, supervised by a registered nurse, and provided to a medical assistance recipient. Since the term "personal care services" could be subject to numerous interpretations, it is necessary to define the term. The definition of personal care services is reasonable because it has the meaning given it under Minnesota Statutes, section 256B.0627, subdivision 4.

Subp. 14f. **Prepaid medical assistance program or PMAP.** This subpart is necessary to clarify a term used in the rule. The term "Prepaid medical assistance program" or "PMAP" is replacing the former term "medical assistance prepaid demonstration program" or "MAPDP." The change is necessary to reflect the establishment of a permanent program subject to continued federal waivers. As indicated under part 9500.1450, prior to 1989, sunset dates were established in statute or rule for terminating the demonstration program. In the enabling legislation adopted in 1983, the legislation provided that

if the project implementation phase had not begun by July 1, 1985, the enabling legislation was automatically repealed. The Department published proposed emergency rules which became effective on October 29, 1984. In 1986, the permanent demonstration project rules provided a December 31, 1988, sunset date unless otherwise extended by the legislature. In 1987, the legislature continued the effective date for Minnesota Rules, parts 9500.1450 to 9500.1464 through December 31, 1990 (Laws of Minnesota 1987, chapter 403, article 2, section 101). In 1989, the legislature amended Minnesota Statutes, section 256B.69 by adding subdivision 17 which authorized the commissioner to continue the provisions of section 256B.69 after June 30, 1990, in any or all of the participating counties if necessary federal authority is granted (Laws of Minnesota 1989, chapter 282, article 3, section 90). Subdivision 17 also authorized the commissioner to adopt permanent rules to continue prepaid medical assistance in participating counties. The name change is reasonable since it provides a means of distinguishing the ongoing prepaid medical assistance program from the original demonstration project program.

Subp. 14g. **PMAP consumer.** This subpart is necessary to clarify a term used in the rule. In the former rule, the term "consumer" was used. However, due to the broad meaning given the term consumer, it is necessary to precede consumer with a modifier. The modifier is "PMAP." The term "PMAP consumer" is used to qualify the term consumer. This subpart is reasonable because it provides a term that identifies medical assistance recipients who are selected to participate in PMAP.

Subp. 14h. **Prepayment coordinator.** This subpart is necessary to clarify a term used in the rule. Minnesota Statutes, section 256B.031, subdivision 9, requires local agencies to designate a prepayment coordinator to assist the state in implementing Minnesota Statutes, section 256B.69. The duties of the prepayment coordinator are set forth in statute. The definition is reasonable because it is consistent with Minnesota Statutes, section 256B.031, subdivision 9.

Subp. 14i. **Primary care provider health plan model.** This subpart is necessary to clarify a term used in the rule. Itasca County has developed a health services delivery system which is referred to as a primary care provider health plan model. Under this model, Itasca County is the health plan and is responsible for arranging for the delivery of the full array of MA covered services to their enrolled populations. The county has individually contracted with virtually all of the providers in Itasca County to ensure accessibility of health services. Under the primary care provider health plan model, a PMAP consumer is allowed to select a primary care physician and primary care dentist from a list of physicians and dentists under contract with a county. The primary care provider health plan model provides a means of assuring delivery of MA covered services in areas without typical health plan coverage. This subpart is reasonable because it is consistent with Minnesota Statutes, section 256B.69,

subdivision 17. Subdivision 17 states, in part, "The commissioner may continue the provisions of this section after June 30, 1990, in any or all of the participating counties if necessary federal authority is granted."

Subp. 15. **Provider.** The change in this subpart is necessary to reflect changes made in other parts of the rule. The term "health services" is defined in subpart 8. The terms "health care services" and "health services" are not interchangeable. Therefore, it is necessary to overstrike the work "care" from the phrase "health care services" in the definition of provider.

Subp. 16. **Rate cell.** The change in this subpart is necessary to clarify a term used in the rule. Since the Commissioner is the official delegated authority under Minnesota Statute, section 256B.69, subdivision 5, to set prepaid health plan rates, the word "department" is being replaced by "commissioner."

Subp. 16a. **Rate cell year.** This subpart is necessary to clarify a term used in the rule. Currently rate cell year is defined in part 9500.1452. To consolidate all the definitions in one section of the rule, the term is being defined in the definition section of the rule. In addition to moving the definition, the definition is modified to more clearly define what is meant by the term "rate cell year." A rate cell year may be less than a calendar year. It begins on the date of enrollment and ends on the date of the annual eligibility review or the date of enrollment in a new health plan whichever occurs sooner and thereafter the 12 month period between eligibility reviews. Since the rule provides that an enrollee may change health plans within the first 60 days, it is necessary to address this period within the definition of rate cell year.

Subp. 17a. **Spend-down.** This subpart is necessary to clarify a term used in the rule. Part 9500.1452 identifies persons who belong to certain MA categories that are not eligible to enroll in a health plan. Included in this list are persons who are eligible for MA on a spend-down basis. Since the term spend-down is not self-explanatory and it is not defined in the eligibility rule part, it is necessary to define the term in this rule part. The definition is reasonable because it is consistent with the spend-down definition for Medical Assistance under Minnesota Rules, part 9505.0015, subpart 44.

Subp. 17b. **State institution.** This subpart is necessary to clarify a term used in the rule. State institution was previously defined under part 9500.1452. To consolidate all the definitions in one section of the rule, the term is being defined in the definition section of the rule. A change was made in the former definition. The reference to "state operated nursing homes Ah-gwah-ching and Oak Terrace" was deleted and replaced with "all state operated facilities" since legislation has been adopted to transfer many of the residents in regional treatment centers to less restrictive environments. These individuals are currently excluded from

participating in the demonstration program under part 9500.1452, item C. This subpart is reasonable because it is consistent with Minnesota Statutes, section 252.50.

Subp. 18. **[See repealer.]** This subpart defined "Total capitation payments" and is being repealed because the term is used in relation to aggregate loss-sharing which is no longer applicable. Part 9500.1459, subpart 3, item C provided that there shall be no aggregate loss-sharing available after December 31, 1987. Since there is no aggregate loss-sharing, there is no need for the term "total capitation payments." Repealing this subpart is reasonable because the term no longer has any applicability to the rule.

9500.1452 ELIGIBILITY TO ENROLL IN A HEALTH PLAN.

This part has been amended to correct a rule cite; to delete the definitions personal care assistant, rate cell year, and state institution; to identify additional MA categories ineligible for participation in PMAP; and to facilitate readability by breaking the part into subparts.

Subpart 1. **Medical assistance eligibility required for PMAP participation.** This subpart is simply an editorial change necessary to break the rule part into subparts to facilitate readability. The change in the rule cite is necessary because Minnesota Rules, parts 9500.0750 to 9500.1060 have been superseded by parts 9505.0010 to 9505.0150. The name of the former medical assistance prepaid demonstration project is being changed to prepaid medical assistance program to reflect changes made in other parts of the rule. Finally, the terms "Personal care assistant" and "State institution" which were defined in this part have been transferred to part 9500.1451, subparts 14d and 17b, respectively.

Subp. 2. **Medical assistance categories ineligible for PMAP.** The changes regarding persons who are ineligible to enroll in a health plan under the PMAP are necessary to clarify current ineligible groups and to add additional ineligible groups resulting from administrative and legislative changes. The change in item A substitutes "on a spend-down basis" for "with a six-month spend-down under part 9500.0810". This change is necessary because part 9500.0810 has been repealed. Spend-down is defined in the definition section under part 9500.1451, subpart 17a, and is consistent with part 9505.0015, subpart 44.

The change in item B is necessary to change the acronym "MAPDP" to "PMAP" to reflect the name change identified under part 9500.1451, subpart 14f.

The change in item C overstrikes the word "or" since additional categories are added to this rule part as items E to K.

The change in item D deletes unnecessary language since a person receiving benefits under the Refugee Assistance Program is a refugee and it is redundant to state "who is a refugee." The controlling exclusion is a person who is receiving benefits, regardless of whether the person is a "refugee."

Item E is necessary to comply with Minnesota Statutes, section 256B.69, subdivision 4. Subdivision 4 states that the commissioner shall exempt persons eligible for medical assistance according to Minnesota Statutes, section 256B.055, subdivision 1. A person who is eligible for medical assistance through an adoption subsidy is a person who is eligible for medical assistance according to section 256B.055, subdivision 1. This item is reasonable because it is consistent with Minnesota Statutes.

Item F is necessary to comply with the requirements in Minnesota Statutes, section 256B.69, subdivision 4, which exempts persons eligible for medical assistance due to blindness or disability as determined by the social security administration or the state medical review team, unless they are 65 years of age or older. This item is reasonable because it is consistent with Minnesota Statutes.

Item G is necessary to comply with the requirements in Minnesota Statutes, section 256B.69, subdivision 4, which exempts recipients who currently have private health care coverage through a health maintenance organization. The amendment to this subpart is reasonable because HMO's must be licensed under Minnesota Statutes, chapter 62D.

Item H is necessary to exclude those individuals who reside in Itasca County who live near the county border and who choose to use a primary care provider in a neighboring county. This item is reasonable to ensure accessibility to medical services and is consistent with Minnesota Statutes, section 256B.69, subdivision 4.

Item I is necessary to exempt a person who is a "Qualified Medicare Beneficiary" (QMB) because "Qualified Medicare Beneficiaries" are not one of the categories of individuals eligible for MA under Minnesota Statutes, sections 256B.055, 256B.056, and 256B.06. It is reasonable to exclude "Qualified Medicare Beneficiaries" because only individuals eligible for MA under the aforementioned statutes are eligible to participate in the PMAP.

Item J is necessary to exclude terminally ill MA recipients. Based on a recommendation from the rule advisory committee which the department endorses, we believe it is reasonable to exclude terminally ill MA recipients, as defined in part 9505.0297, whose primary care provider is not part of any PMAP health plan, in order to ensure continuity of health care.

Item K is necessary to exclude persons who are in foster placement. This item is reasonable because it is consistent with Minnesota Statutes, section 256B.69, subdivision 4.

Subp. 3. **Optional exclusions, commissioner approval.** This subpart is necessary to identify certain categories of MA recipients who can be excluded from participation in PMAP, if requested by a county participating in PMAP, subject to commissioner approval.

Item A. The optional exclusion of children placed in Rule 5 and Rule 8 facilities is necessary to assure availability of health services for children in out-of-home placements.

Item B. The optional exclusion of children determined to be severely emotionally disturbed when requested by the local agency, subject to the commissioner's approval, is reasonable because the local agencies' social services departments have shown that mandating such children into the PMAP may, in some cases, be disruptive, causing a lack of continuity in health care at a time when consistency and continuity of health care is critical. The statute cited in this subpart contains the definition and criteria for determining who is considered a severely emotionally disturbed child.

Item C. The optional exclusion of children identified by the county social service agency as determined to be in need of protection, is necessary because local agency social service departments have concerns that mandating such children into PMAP may cause disruption in continuity of health care. Minnesota Statutes, sections 626.556 to 626.5561 are cited to clarify how such children are identified by local agency social service staff. This statute governs the reporting of maltreatment of minors.

Subp. 4. **Exclusions during phase-in period.** This subpart is necessary to provide a temporary exclusion during the phase-in period for MA recipients in Hennepin County who were previously exempt from program participation. This subpart is reasonable because it provides an orderly phase-in period for the 65 percent of MA eligible persons in Hennepin County who were not selected to participate in the former MA Prepaid Demonstration Project; who are not part of any excluded category; and who are therefore mandated to participate in PMAP. To ensure that all eligible individuals are enrolled in a timely fashion, it is reasonable to provide a phase-in period of one year from the start of enrollment of each category of eligible PMAP consumers.

Subp. 5. **Elective enrollment.** This subpart is necessary to permit elective enrollment in specific and limited instances.

The first instance where elective enrollment is permitted is for certain individuals excluded from PMAP participation under part 9500.1452, subpart 2, item G due to private health insurance coverage through a health maintenance organization licensed under Minnesota Statutes, chapter 62D. An exception is provided if the private health insurance health plan is the same as the health plan the consumer will select under PMAP. By allowing those individuals who are able to enroll in the same PMAP health plan as their private HMO

plan to elect to participate in the PMAP, 100 percent coverage, including all copayments and deductibles, is assured. It is therefore reasonable to provide for elective enrollment for persons with private health insurance coverage to ensure 100 percent coverage of all MA covered services for eligible individuals.

This subpart also permits elective enrollments to prevent disruptions in health services of some children who may be excluded under part 9500.1452, subpart 3, items A, B, and C. For those children whose families are enrolled in PMAP and for whom, exclusion from PMAP would disrupt their health services, normally received through the family's PMAP provider, it is reasonable to allow elective enrollment of the excluded child in the PMAP.

It is also necessary to include a requirement in the elective enrollment section that requires elective enrollees to conform to the same program requirements as mandatory PMAP enrollees. This is reasonable to ensure uniform program requirements.

9500.1453 MANDATORY PARTICIPATION; FREE CHOICE OF HEALTH PLAN.

The changes in this part are necessary to set forth the local agency requirements and to distinguish the multiple health plan model currently used in Dakota and Hennepin counties from the primary care provider health plan model currently used in Itasca County. To facilitate readability, this part has been subdivided into eleven subparts.

Subpart 1. **Local agency enrollment of PMAP consumers.** The change in the introductory sentence is necessary to place the responsibility for the enrollment of consumers on the local agency rather than the department. The requirement that each local agency enroll recipients as consumers in PMAP is consistent with the responsibilities of the prepayment coordinator designated by the local agency. The prepayment coordinator is responsible for assisting the department in implementing Minnesota Statutes, section 256B.69. Duties of the prepayment coordinator include determining recipient eligibility for medical assistance, educating recipients about available health care options, enrolling recipients in a health plan, and for coordinating complaints and appeals with the ombudsperson. This subpart is reasonable because it is consistent with Minnesota Statutes, section 256B.031, subdivision 9. This subpart also permits health services to be provided under a multiple health plan model or a primary care provider health plan model. Allowing health services to be provided by either model is necessary to reflect the health care delivery systems developed under the original demonstration project. Continuation of the two health care delivery systems is reasonable because it is consistent with Minnesota Statutes, section 256B.69, subdivision 17 which states, in part, "The commissioner may continue the provisions of this section after June 30, 1990, in any or all of

the participating counties if necessary federal authority is granted."

Subp. 2. **Counties using a multiple health plan model, choice.** This subpart is necessary to distinguish the multiple health plan model currently used in Dakota and Hennepin counties from the primary care provider health plan model currently used in Itasca County. In Dakota and Hennepin counties, consumers must choose from an array of prepaid health plans. In Itasca County, the county itself is the health plan and the consumers choose from an array of primary care providers. The major change under this subpart is the identification of health plan choice in Dakota and Hennepin counties and the requirement that the local agency perform the duties of the prepayment coordinator which were previously performed by the department. This subpart is reasonable because it is consistent with the duties of the local agency under Minnesota Statutes, section 256B.031, subdivision 9.

Subp. 3. **Counties using primary care provider health plan model, provider choice.** This subpart is necessary to recognize the health plan model currently used in Itasca County. Using the primary care provider health plan model, Itasca County is the health plan and contracts with the providers in the county to ensure accessibility of MA services. Other than the health plan model used, the program standards for Dakota and Hennepin counties and for Itasca County are similar. Under subpart 2, the local agency must inform each consumer of the health plan choices available to the consumer. Under this subpart, the local agency must inform each consumer of the choices of primary care providers available to the consumer. If a consumer fails to select a provider, the local agency will assign the consumer to a primary care physician and dentist. This subpart is reasonable because it sets a standard for provider choice in counties using the primary care provider health plan model.

Subp. 4. **Designation of prepayment coordinator.** This subpart is necessary to inform local agencies that they must designate a prepayment coordinator. This subpart also informs the local agency that the Commissioner will monitor the tasks performed by the prepayment coordinator. This subpart is reasonable because it is consistent with Minnesota Statutes, section 256B.031, subdivision 9.

Subp. 5. **Enrollment period in counties using a multiple health plan model; change.** This subpart is necessary to address changes in health plan enrollments in counties using a multiple health plan model. The major change in this subpart governs changes when a health plan terminates participation in PMAP. A consumer who is enrolled in a health plan whose participation is subsequently terminated may select a new health plan and is allowed to change health plans within the first 60 days of enrollment with the second health plan. The change in this subpart is reasonable because it is consistent with Minnesota Statutes, section 256B.69, subdivision 4.

Subp. 6. **Enrollment period in counties using primary care provider health plan model; change.** This subpart is necessary to address the primary care provider health plan model that is currently used in Itasca County. In a county using this model, PMAP participants select primary care providers and not a health plan. Therefore, a new subpart is necessary to establish a standard for when an enrollee may select and change primary care providers. This subpart is reasonable because it is consistent with Minnesota Statutes, section 256B.69, subdivision 4.

Subp. 7. **Changes between enrollment periods.** This subpart is necessary to clarify the standard for changing health plans or primary care providers between enrollment periods. The changes to this subpart are necessary to clarify differences between the multiple health plan model and the primary care provider model (change in health plans versus changes in primary care physicians and dentists) and to replace the reference to the former grievance panel with the reference to the human services referee, to reflect the statutory change in Minnesota Statutes, section 256.045, subdivision 3a, paragraph (b) and section 256B.69, subdivision 11.

Subp. 8. **Enrollment changes without a hearing, substantial travel time.** This subpart is necessary to address situations where PMAP enrollees may change health plans without a hearing before a state referee. Evaluation of the former demonstration project over the last four years of operation as well as evaluation of the special grievance process instituted during the first three years of the project, has shown that in those situations where it is apparent that travel time to an enrollee's primary care provider is more than 30 minutes, the appeal process is unnecessary since such situations do not require an enrollee to further demonstrate excess travel time via the appeal process. This subpart is reasonable because it is consistent with Minnesota Statutes, section 256B.69, subdivision 4.

Subp. 9. **Enrollment changes without a hearing when agency error.** This subpart is necessary to address situations where PMAP enrollees may change health plans without a hearing. Evaluation of the former demonstration project over the last four years of operation indicates that it is reasonable to allow an enrollee to change health plans without utilizing the appeal process, when the county acknowledges that the health plan choice was incorrectly designated due to an error on the part of the local agency (usually a clerical error in processing the health plan enrollment form). This subpart is reasonable because it is consistent with Minnesota Statutes, section 256B.69, subdivision 4.

Subp. 10. **Mandatory participation.** This subpart is necessary to inform participants that mandatory participation in PMAP does not constitute a restriction of free choice. This subpart is reasonable because it is consistent with Minnesota Statutes, sections 256B.031, subdivision 5 and 256B.69, subdivision 4.

Subp. 11. **Authorized representative.** This subpart is necessary to emphasize that in matters involving participation in PMAP, an authorized representative may be designated by the PMAP consumer, and may act on behalf of the PMAP consumer. The definition of authorized representative is contained in the definition section under part 9500.1451, subpart 2c. Any reference to the PMAP enrollee applies equally to the authorized representative when such a person has been designated by the PMAP enrollee.

9500.1454 RECORDS.

The amendments to this part are necessary to correct rule cites which are no longer accurate. The former requirements under part 9500.0930 are now contained in part 9505.0205. The former requirements under parts 9500.0920 and 9500.0930 are now contained under part 9505.0135. The changes in this part are reasonable because they correct rule cites made inaccurate by subsequent rule revisions. In addition, the term "MHP" has been repealed and replaced with the term "health plan" and the term "medical assistance prepaid demonstration project" has been replaced with the acronym "PMAP."

9500.1455 THIRD-PARTY LIABILITY.

The amendment to this subpart deletes obsolete emergency rule language and substitutes a requirement for coordination of benefits. This part directs health plans to coordinate benefits to recover the cost of medical care provided to its enrollees who have private health care or Medicare coverage. It is in the health plan's interest to recapture costs from third parties. The benefits must be coordinated so that MA recipients are not required to pay any copayment fees or deductibles. This subpart is reasonable because it is consistent with MA third party liability requirements set forth in part 9505.0070 and Minnesota Statutes, section 62A.046.

9500.1457 SERVICES COVERED BY PMAP.

Subpart 1. **In general.** The amendment to this subpart is necessary to identify services covered under the prepaid medical assistance program. The general statutory reference to Minnesota Statutes, chapter 256B has been replaced by a specific statutory cite and rule parts governing the Medical Assistance Program. The amendment to this subpart also clarifies that chemical dependency services provided under this part must comply with the requirements for licensure of chemical dependency rehabilitative programs, requirements for outpatient alcohol treatment programs, and requirements for chemical dependency care for public assistance recipients as set forth in parts 9530.4100 to 9530.6655.

This subpart also excludes certain services from PMAP coverage.

Item A excludes case management services provided by a county social services agency since those services are county social services and not medical services provided by a health plan.

Item B distinguishes and excludes nursing home living expenses (per diem) paid by the department. Per diem living expenses are not included in the rates paid to the health plan and, as such, are not covered by the health plan.

Item C excludes services provided under home and community based waivered services since these services are addressed under separate programs. The waivered services programs provide both social and medical services to allow recipients to live in the least restrictive environment. Since the home and community based programs are separate and distinct programs, it is reasonable to exclude them from coverage under PMAP.

Subp. 2. **Additional services.** The change in this subpart is necessary to reflect a change made in other parts of the rule. The term "MHP" has been replaced with the term "health plan."

Subp. 3. **Prior authorization of services.** The amendments to this subpart are necessary to correct references to Minnesota Rules which have been repealed and superseded by new rules. The corrected cite is the proper reference for the rule governing prior authorization of services. In addition, the term "MHP" is being deleted and replaced with the term "health plan" to reflect changes made in other parts of the rule.

9500.1458 DATA PRIVACY.

The changes in this part are necessary to reflect changes made in other parts of the rule. The term "medicaid health plan" and its acronym "MHP" has been repealed and is being replaced with the term "health plan."

9500.1459 CAPITATION POLICIES.

Subpart 1. **Rates.** The amendments to this subpart are necessary to comply with Minnesota Statutes, sections 256B.031, subdivision 4 and 256B.69, subdivision 5 which establish standards for payment of the capitation rate. The former language under this subpart dealing with the establishment of capitation rates is being deleted since capitation rates will be established by the commissioner in consultation with an independent actuary. Minnesota Statutes, sections 256B.031 and 256B.69 require the commissioner to contract with an independent actuary to establish prepayment rates. In addition to the requirement that the capitation rate be established by an independent actuary, the rates must be less than the average per capita fee-for-service medical assistance costs for an

actuarially equivalent population. This is a federal requirement that ensures prepaid medical assistance will not be more expensive than the current fee-for-service system.

Finally, this subpart sets a standard for paying the monthly prepayment fee. The monthly fee must be paid on or before the 10th day of each month. This standard is necessary to inform the health plans when they will receive the capitation payment. The amendments to this subpart are reasonable because they are consistent with Minnesota Statutes, sections 256B.031 and 256B.69.

Subp. 2. **[See repealer.]** This subpart is being repealed since it is unnecessary. Under the original program rule, the MAPDP program provided two types of risk sharing, aggregate loss-sharing and individual stop-loss coverage. The aggregate loss-sharing provision sunsetted on December 31, 1987. The remaining risk sharing arrangement is individual stop-loss coverage. The health plan contracts provide that the state will provide the health plan with indemnification for 80 percent of the costs of inpatient hospital services exceeding $15,000 for each MA recipient. The health plan is responsible for the remaining 20 percent of these costs. The health plan must submit information on the actual cost of hospital services as evidence that health plan's expenditures have exceeded the stop-loss point. Since individual stop-loss coverage is provided for in the contract with the health plan, this subpart is no longer necessary.

Subp 3. **[See repealer.]** This subpart dealt with "Aggregate loss-sharing" which expired on December 31, 1987. Since the provision has expired, it is reasonable to deleted the reference to aggregate loss-sharing from the rule.

Subp. 4. **[See repealer.]** This subpart dealt with "Individual stop-loss coverage" and is no longer necessary because individual stop-loss is specifically addressed in the contract with the health plans.

9500.1460 ADDITIONAL REQUIREMENTS.

Subpart 1. **Health Plan requirements.** The amendment to this subpart is necessary to overstrike "16" and insert in lieu thereof "17" since a new subpart, subpart 17, has been added to this rule part. In addition, this subpart includes terminology changes necessary to reflect changes made in other parts of the rule.

Subp. 2. **Medical assistance populations covered.** The amendment to this subpart is necessary to address the medical assistance populations which may be served by a health plan. The change more clearly identifies those MA recipients who are eligible to participate in the PMAP and therefore, those MA recipients who the health plans may serve. Under the PMAP, a health plan may serve the

MA population defined in part 9500.1452. In addition, due to the authority to expand the geographic area beyond Dakota, Hennepin, and Itasca counties, part 9500.1450, subpart 3, a health plan may choose to serve the aged medical assistance population exclusively. The amendment to this subpart is reasonable because it identifies the MA populations which may be covered by a health plan.

Subp. 3. **Services provided.** The amendment to this subpart is necessary to delete an obsolete rule cite and to replace it with the statutory and rule cites governing medical assistance services. This subpart is reasonable because it ensures that the health plan will provide the health services available to other MA recipients.

Subp. 4. **Prohibition against co-payments.** The amendment to this subpart is necessary to correct a rule cite. Part 9500.1070 has been superseded by parts 9505.0170 to 9505.0475.

Subp. 5. **Plan organization.** The amendment to this subpart is necessary to reflect changes in terminology made in other rule parts. The acronym "MHP" is replaced with the term "health plan."

Subp. 6. **Contractual arrangements.** The amendment to this subpart is necessary to enable the department to review contractual arrangements between the health plan and its providers. The review of contractual arrangements will enable the department to ensure that a health plan has a sufficient network of providers to provide the full array of MA covered health services and accessibility to those services. The list of providers is also needed for use during open enrollment periods. The amendment to this subpart is reasonable because it provides a means of assessing the provider network and available health services.

It is necessary to further amend this section to provide general criteria that enables the commissioner to determine when to require the health plan to terminate a subcontract. The general criteria require that subcontractors meet the department's quality assurance standards which are consistent with the State Department of Health licensure standards under Minnesota Statute 62D and with Federal legislation under Title XIX of the Social Security Act as amended by section 1902 (a) (30), paragraph C.

Subp. 7. **Enrollment capacity.** The amendment to this subpart is necessary to ensure that the Commissioner may limit the number of enrollees in an health plan, if in the Commissioner's judgement, the health plan is unable to demonstrate a capacity to serve additional enrollees. The amendment to this subpart is reasonable because it provides a means of restricting enrollment in a health plan to ensure medical services are not compromised due to over enrollment.

Subp. 8. **Financial capacity.** The amendment to this subpart replaces the terminology "MHP" with "health plan." The amendment is necessary because the terminology used to describe the organization that

contracts with the state to provide Medical Assistance health care to enrollees in exchange for a monthly capitation payment, formerly known as the "MHP", is now called the "health plan" as defined in part 9500.1451, subpart 7a.

Subp. 9. **Insolvency.** The amendment to this subpart replaces the word "department" with "commissioner" and the terminology, "MHP" with "health plan." The amendment is necessary to identify the official who must approve a health plan's transfer of enrollees to other sources of health services should a health plan become insolvent. The use of the term "commissioner" is consistent with the delegation of authority for PMAP in Minnesota Statutes, section 256B.69. The use of the term "health plan" is consistent with the change in terminology under part 9500.1451, subpart 7a.

Subp. 10. **Limited number of contracts.** The amendment to this subpart is necessary to replace the term "department" with "commissioner." The use of the term "commissioner" is consistent with the statutory language in Minnesota Statutes, section 256B.69.

Subp. 11. **Liability for payment for unauthorized services.** The amendment to this subpart is necessary to correct a statutory cite. Minnesota Statutes, section 256B.02, subdivision 8, clause 4 has been renumbered as Minnesota Statutes, section 256B.0625, subdivision 4. The amendment in this subpart stating that the health plan shall not be liable for unauthorized services unless otherwise specified in statute is consistent with the statutory cite above and with Minnesota Statutes, section 62D.07, subdivision 3, paragraph (c), clause (1).

Subp. 11a. **Payment for authorized services by nonparticipating provider.** The addition of this subpart is necessary to clarify that a health plan must reimburse a non-participating provider for out-of-plan care to a health plan enrollee when the enrollee's health plan has authorized services for out-of-plan care. Out-of-plan services authorized by the health plan are considered to be covered services. This subpart further clarifies that the health plan cannot bill the PMAP enrollee for any portion of the cost of the authorized service. This subpart is consistent with Minnesota Statutes 256B.0625, parts 9595.0170 to 9505.0475 which defines those services covered under Medical Assistance, including out-of-plan services authorized by the health plan.

Subp. 12. **Termination of participation as a health plan.** The amendment to this subpart is necessary to substitute the word "state" for the word "department" since the contract is entered into by the department on behalf of the state. The reference to part 9500.1459, subpart 4, item B, subitem (3) has been deleted since that subpart has been deleted. It is necessary to amend this subpart to reflect the change in the agreement between the state and the health plans, whereby the state has the sole authority to terminate a contract, upon 90 days' written notice. The change from 30 days to 60 days

notice to its enrollees before termination, is necessary to provide sufficient time to disenroll program participants, to provide the participants with time to make an informed decision about their new health plan, and to reenroll enrollees into the new health plan. The amendment is reasonable because it sets a standard for terminating contracts while providing program participants and the department sufficient time to convert over to another health plan.

Subp. 13. **Financial requirements placed on health plan.** The amendment to this subpart is necessary to clarify the financial arrangements between the state and the health plan. It is also necessary to indicate that the state and the health plan's enrollees shall be held harmless for the payment of obligations incurred by the health plan if the health plan or provider contracted by the plan becomes insolvent and the state has made the payments due the health plan. The term "department" is replaced by "state" or "commissioner" as appropriate. The contract is with the state while the health plan is accountable to the commissioner for the financial management of health services it provides enrollees.

Subp. 14. **Required educational and enrollee materials.** The amendments to this subpart are necessary to eliminate the reference to broker since those functions are delegated to the prepayment coordinator; to set forth the material that a health plan must provide to each enrollee upon enrollment; to require that the materials provided are understandable to a person who reads at the seventh grade level as required in Minnesota Statutes, section 256.016; and to change the term "department" to "commissioner" or "state" whichever is appropriate.

Subp. 15. **Required case management system.** The amendment to this subpart is necessary to set forth the requirements for a case management system. The definition of case management was deleted since the term is defined in part 9500.1451, subpart 4a. The changes in this subpart are more editorial than substantive. A health plan must implement a system of case management in which an enrollee's medical needs are assessed, when medically necessary, to determine the appropriate plan of care. Since each medical situation is unique, the need for case management will vary by individual. It is impossible to establish a single standard for medical case management. However, the individual plan of care must be developed, implemented, evaluated, monitored, revised, and coordinated with other health care providers as appropriate.

Subp. 16. **Required submission of information.** The amendments to this subpart are necessary to replace the word "department" with the word "state" or "commissioner" whichever is more appropriate. The deletion of the sentence dealing with a complaint record and action taken to resolve the complaint is necessary since a quality assurance system requirement is established under subpart 17. The amount of time a health plan has to submit information to the commissioner is

changed from ten days to 30 days to reflect a more reasonable time standard for responding to informational requests.

Subp. 17. **Required quality assurance system.** The amendment to this subpart is necessary to enable the health plans to be reviewed in compliance with Federal legislation (OBRA-1986 as amended by section 1902(a) (30) of the Social Security Act, paragraph C) which requires an annual quality assurance review of the Medicaid services provided by each prepaid health plan with which the State has entered in a risk-based contract. The specific requirements under subpart 17, items A to D are in accordance with specifications in the Minnesota Department of Health quality assurance rules, parts 4685.0100 to 4685.2100, which are based on federal requirements for quality assurance programs of federally qualified health maintenance organizations.

9500.1462 SECOND MEDICAL OPINION.

The amendment to this part is necessary to require a health plan to inform enrollees of their right to a second medical opinion. Previously, the rule provided that an enrollee may request a second medical opinion but was not explicit that the health plan must inform the enrollee of the right to a second medical opinion. Obviously, if an enrollee is not aware of his or her right to a second opinion he or she is unlikely to exercise that right. Therefore, the rule requires a health plan to notify its enrollees in the certificate of coverage of their right to a second medical opinion.

Item A addresses the enrollees right to request a second opinion. This requirement is consistent with current rule requirements. This item includes a minor editing change that is necessary to reflect a change made in other parts of the rule. The acronym "MHP" is changed to "health plan."

Item B requires a health plan to obtain a second medical opinion from a qualified non-health plan provider when it determines an enrollee's chemical dependency or mental health problem does not require structured treatment. This item is reasonable because it is consistent with Minnesota Statutes, section 62D.103.

Item C provides that in accordance with Minnesota Statutes, section 256.045, subdivision 3a, paragraph (b) a state referee may order a second medical opinion. This item is reasonable because it is consistent with Minnesota Statutes, section 256.045, subdivision 3.

9500.1463 COMPLAINT AND APPEAL PROCEDURES.

Subpart 1. **[See repealer.]** This subpart which deals with internal grievance procedures is being repealed because a new and more complete complaint procedure is established in subparts 4 to 8. The

former complaint and appeal procedures set forth in Minnesota Statutes, section 256B.69, subdivision 11 was amended by Laws of Minnesota 1989, chapter 282, article 3, section 89 to require appeals to be heard by state referees under Minnesota Statutes, section 256.045.

Subp. 2. **[See repealer.]** This subpart which deals with state grievance procedures is being repealed because a new state appeals procedure for enrollees in prepaid health plans has been established under Minnesota Statutes, section 256.045, subdivision 3a.

Subp. 3. **Health plan complaint procedure.** This subpart is necessary to comply with Minnesota Statutes, sections 62D.11 and 256.045 and to establish standards governing health plan complaint procedures. The health plan is required to have a written procedure for reviewing enrollee complaints which includes an informal process for addressing verbal complaints and a formal process for written complaints. The formal process must provide for an impartial hearing with the following elements.

Item A. A person with authority to resolve the case shall hear the complaint. This item is necessary to resolve the complaint in a timely manner. Without a requirement that a person with authority hear the complaint, resolution of a complaint could lead to needless delays while the issue is passed on to "higher" authorities.

Item B. The enrollee shall have the right to be represented at the hearing. This item is necessary to ensure that an enrollee's right to present his or her complaint is not compromised.

Item C. This item is necessary to ensure that all facts surrounding the complaint can be fully represented.

Item D. This item is necessary to set a date certain for a written resolution of the complaint.

Item E. This item is necessary to ensure the ombudsperson is notified of any written complaint. Since the ombudsperson is the advocate for consumers and enrollees and is the individual designated to assist them in obtaining necessary health services, it is important that the ombudsperson be made aware of complaints involving the delivery of health services.

In addition to the health plan's complaint resolution system, the health plan must provide enrollees with a description of the state appeal procedure at the time of enrollment. The written description must state that exhaustion of the health plan's complaint procedures is not required before appealing to the state. Finally, if there is a change in the health plan's complaint procedure, it must be approved by the Commissioner and sent to the enrollees at least two weeks prior to implementation.

This subpart is reasonable because it set forth a procedure for resolving complaints governing a health plan's delivery of health services prior to a state appeal.

Subp. 4. **Health plan notice requirements.** This subpart is necessary to establish a notice standard. Whenever a health plan denies, reduces, or terminates a health service, it must inform the enrollee of the procedures for filing a complaint, filing a state appeal, the right to a second opinion, the circumstances under which health services may be continued pending an appeal, and the right to request an expedited hearing. The denial, reduction or termination of a health service is clearly of paramount importance to an enrollee. Therefore, if the enrollee disagrees with the action, he or she must be informed of the various actions available to resolve the disagreement. The only way to ensure that an enrollee is informed of the various options available to them is to impose a notice requirement.

For the purpose of this subpart, a health plan does not include the treating physician, second opinion physician, or other treating health care professional.

This subpart is a reasonable implementation of Minnesota Statutes, sections 62D.11; 256.045, subdivision 3a, and 256B.69, subdivision 6, item (4).

Subp. 5. **State appeal procedure.** This subpart is necessary to set forth the state appeal procedure. The 1989 Legislature changed the grievance procedure to provide the right of a hearing before a state referee. The requirements in this subpart are reasonable because they are consistent with Minnesota Statutes, section 256.045, subdivisions 3 and 3a.

Subp. 6. **Services pending state appeal or resolution of complaint.** This subpart is necessary to establish a standard for receiving health services pending a state appeal or resolution of a complaint. The written complaint or appeal must be filed within ten days of the reduction, suspension, or termination of an ongoing service and the treating physician or another plan physician has ordered the services at the present level. If the complaint or appeal is made within ten days, the ongoing services must be continued until resolution of the complaint or a decision on the appeal is made by the human service referee. If the resolution of a complaint is adverse, the enrollee must be informed of the right to appeal to the state and to continue to receive services if the resolution of the complaint is appealed within ten days.

This subpart is reasonable because it is consistent with Minnesota Statutes, sections 256.045 and 256B.031, subdivision 7.

Subp. 7. **State ombudsperson.** This subpart is necessary to require the Commissioner to designate a state ombudsperson and to set forth

the duties of the ombudsperson. Minnesota Statutes, section 256B.031, subdivision 6 and section 256.045, subdivision 3a set forth duties of the ombudsperson. This subpart is reasonable because it is consistent with Minnesota Statutes.

Subp. 8. **Recordkeeping and reporting requirements.** This subpart is necessary to require health plans to maintain a record of complaints and to report to the commissioner on a semi-annual basis of all written complaints, actions taken in response to those complaints, and the final disposition of such complaints. This subpart is reasonable because it is consistent with Minnesota Statutes, section 256B.69, subdivision 9.

REPEALER

The repealer identifies those rule subparts that are being repealed because they are obsolete or unnecessary due to legislative changes. The individual subparts being repealed have been addressed under the corresponding rule part.

Expert Witnesses

The Department does not plan to have outside expert witnesses testify on its behalf.

DATE: [illegible]

NATALIE HAAS STEFFEN
Commissioner

INDIVIDUALS WHO ATTENDED ONE OR MORE RULE 62 ADVISORY COMMITTEE MEETINGS

Megan Roach
Group Health, Inc.

Sandy Storbakken
Group Health, Inc.

Ruth Krueger
Dakota County Human Services

Dave Schultz
Dakota County Human Services

Sandy Pietag
Dakota County Human Services

Ghita Worcester
UCare Minnesota

Linda Chapeau
PreferredOne

Nancy Bents
MedCenters Health Plan

Judy Bulau
MN Department of Health

Sharon Long
MN Department of Health

Fran Roraff
Hennepin County

Jim Westcott
Hennepin County

Marilyn Miller
Hennepin County

Charles Hogan
Hennepin County

Nancy Obradovich
Itasca County

Dave Johnson
Metropolitan Health Plan

Joan Delich
Metropolitan Health Plan

Karen Watson
Physicians Health Plan

Jan St. Andrew
Physicians Health Plan

Gail Kreiger
Physicians Health Plan

Steve Wolfe
Southern MN Regional Legal Services

Edith See
Minneapolis Legal Aid Society

Laurie Hanson
Minneapolis Legal Aid Society

Chari Konerza
Minnesota Medical Association

Mike Latimore
Minnesota Hospital Assoc.

Gretchen Musicant
Minnesota Nurses Association

Pamela Johnson
Progressive Rehabilitation Center

Victoria Lemberger
MN Assoc. of Homes for the Aging

Joel Jensen
Care Providers of Minnesota

Iris Freeman
MN Alliance for Health Care Consumers

Steve Lapinski
Washburn Child Guidance Center

Brian Strong
MAMRA/Progressive Rehabilitation Center