Chapter 2

Health Care Programs and Services

The Minnesota Department of Human Services (DHS) ensures basic health care coverage for low-income Minnesotans through four major publicly subsidized health care assistance programs. More than half a million Minnesotans have health care coverage through the DHS-administered Minnesota Health Care Programs (MHCP). The three major programs that comprise MHCP are:

- Medical Assistance (MA);
- General Assistance Medical Care (GAMC); and
- MinnesotaCare.

This chapter outlines specifics for each major program and sub-program, including eligibility, income/asset limits, covered services, and service limitations. This chapter also outlines Minnesota’s Waivered Services Programs and the Minnesota Restricted Recipient Program.

Definitions

**Copay:** A pre-determined sum for which an MHCP recipient/enrollee is responsible, to offset the overall costs for services. Copays are to be paid by the MHCP recipient/enrollee to the provider. Copay amounts for MHCP recipients and enrollees are determined by the Minnesota Legislature and may change. Refer to Billing Policy (ch. 4), Spenddown and Copays section and Copay Guidelines section for additional copay information.

**FPG:** Federal Poverty Guideline, a means by which the federal government measures and evaluates eligibility for publicly subsidized health care and cash programs administered by each state.

**IMD:** Institute for Mental Disease, a residential facility with 17 or more beds that is primarily engaged in providing diagnosis, treatments, or care of persons with mental diseases, including medical attention, nursing care and related services.

**Prepaid health plan:** A health plan contracted with DHS to provide health care services to recipients of Prepaid Minnesota Health Care Programs (PMHCP).

**Spenddown:** An amount the recipient is responsible to pay on the first day they are eligible for MHCP. Refer to Billing Policy (ch. 4), Spenddowns and Copays section and Spenddowns section for additional spenddown information.

Medical Assistance (MA)

Medical Assistance, also called MA, established under Title XIX of the federal Social Security Act, is a program that provides medical care for low-income persons. State and federal governments jointly fund MA. Within broad federal rules, each state decides the types of health
care services that will be covered by its MA program. In Minnesota, MA includes the following sub-programs:

- **MA for Families and Children, and persons who are blind, disabled or age 65 and over:** Pays for current and future medical bills for covered health care services.

- **MA for Pregnant Women and Infants:** Pays for covered health care services provided to pregnant women, and children under age two.

- **MA for Disabled Children (TEFRA):** Available for some disabled children who ordinarily would not be eligible for MA because of parental income. Applicants must be reviewed by the State Medical Review Team.

- **MA for Employed Persons with Disabilities (MA-EPD):** Allows working people with disabilities to qualify for MA under higher income and asset limits.

- **Qualifying Individuals (QI):** Helps people pay for all or part of their Medicare Part B premiums.

- **Qualified Medicare Beneficiaries (QMB):** Helps people pay their Medicare premiums, and the deductibles, coinsurance, and copays for Medicare-covered services.

- **Qualified Working Disabled Individuals (QWD):** Helps people pay for their Medicare Part A premiums.

- **Program NM:** Available for certain non-citizens who have authorization to reside in the United States but are barred from federal funding under MA. The 1997 Minnesota Legislature passed legislation (MS 256B.06, subd. 4), providing MA funding for these non-citizens under program NM. Program NM provides all the same service benefits to recipients as the MA program. Effective October 1, 2003, program NM covers people receiving services from the Center for Victims of Torture (CVT) who are not otherwise eligible for MA or GAMC.

- **Program HH:** Helps eligible Minnesotans gain access to medical care. Program HH is administered and eligibility is determined at the state level. A program HH recipient is eligible to receive one or more of the following five program HH benefit sets:
  1. **Drug Benefits:** Covers a recipient’s portion of the cost of drugs from a limited formulary.
  2. **Insurance Benefits:** Pays premiums for a recipient’s cost-effective health, dental or vision policies (the cost of the premium may be applied toward the recipient’s MA spenddown).
  3. **Dental Benefits:** Covers the same dental benefit set as MA with the addition of a third annual cleaning.
  4. **Nutrition Benefits:** Covers up to $60.00 per calendar month of prescribed enteral nutritional products.
  5. **Mental Health Benefits:** (Effective March 1, 2005) Covers a select procedure set limited to outpatient services such as individual, group, family and couples therapy. This benefit does not have its own eligibility type; however, it is an MHCP FFS program.

Eligibility for Program HH is very limited. In some cases, a recipient may be dually enrolled in program HH and another MHCP. For more information about program HH, or to verify which benefit set a recipient is eligible to receive, call the Program HH Office at (651) 431-2414 or 1-800-657-3761.
• **Program IM**: Covers a limited set of benefits for recipients who reside in an Institute for Mental Disease (IMD) if they are otherwise eligible for MA or GAMC. Effective October 1, 2003, some recipients are not eligible for federally funded MA while residing in an IMD, but may be eligible for the state-funded MA program NM.

• **Refugee (county administered) (Program RM)**: Provides the same services as MA for refugees in the U.S. for eight months or less and who are ineligible for MA.

• **Service Limited Medicare Beneficiaries (SLMB)**: Helps people pay for their Medicare Part B premiums.

• **Minnesota Family Investment Program (MFIP)**: Authorized under the federal Temporary Assistance to Needy Families (TANF) block grant to provide cash assistance and employment support to needy families. MFIP recipients are also covered by MA.

**Eligibility for Medical Assistance**

- Persons wanting to apply for MA should contact their local county human services agency. Eligibility is determined at the local county human services agency.

- Under certain conditions, MA eligibility may be available for up to three months prior to the month of application.

- If a GAMC recipient, disabled by HIV or AIDS, is under your care and has not yet applied for MA, refer the patient to his/her local county human services agency. Providers are encouraged to refer individuals who are not eligible for MA or GAMC to the Program HH Office at (651) 431-2414 or 1-800-657-3761. Many services are available for people with HIV infection regardless of their MHCP eligibility. Contact the Minnesota AIDS Line for information at (612) 373-2437 or 1-800-248-2437.

- Adults between the ages of 21 and 65 residing in an IMD are not eligible for MA but may be eligible for GAMC.

- In order to meet the income eligibility guidelines for MA, some recipients may have to pay part of the cost of their medical bills. The portion of the medical bills that the recipient must pay is called a *spenddown*.

- Persons who are inmates of correctional facilities are ineligible for MA. Some inmates who are conditionally released to work release programs may be eligible for MA if they do not reside in a public detention facility and are housed in a non-secure community facility.

**Emergency Medical Assistance (EMA)**

EMA is available to non-citizens who are not eligible for federally-funded MA because of their immigration status. This includes undocumented and non-immigrant people, as well as non-qualified non-citizens who might also be eligible for the state-funded MA program NM.

To qualify for EMA, non-citizens must meet all MA eligibility requirements not related to immigration status. They must have an MA basis, be Minnesota residents and meet applicable income and asset limits.

A qualifying emergency for EMA may be either a short-term, acute condition (including labor and delivery) or an ongoing chronic condition. For short-term emergencies, eligibility exists for
the duration of the emergency only and may begin or end mid-month. EMA for services related to chronic conditions meeting the emergency definition may continue indefinitely.

EMA Service Limitations

EMA does not cover:

- Child and Teen Check-up services
- Family planning services
- Health promotion and counseling PHN visits
- Hearing screening, hearing aids
- Home care for non-chronic care for those on EMA
- Immunizations
- Non-emergency transportation for routine/preventive care
- Organ transplants and related services/drugs
- Pharmacy – vitamins, aspirin, Viagra, Levitra, Cialis (drugs that treat impotence of organic origin), Muse, Caverject, acne medications, contraception, smoking deterrents, organ rejection drugs, fertility drugs, drugs to promote weight loss, growth hormone, ADHD drugs, Antabuse, Drysol, antihyperlipidemic agents, hydroquinone cream, drugs not covered by Medical Assistance
- Prenatal services
- Preventive dental: oral exams, x-rays, cleaning, fluoride, sealants, and oral hygiene instruction
- Preventive, routine, screening, and counseling/risk factor reduction services
- Screening tests – lab, x-rays, mammograms, etc.
- Sterilization
- Vision screening, eyeglasses
- Waivered services

General Assistance Medical Care (GAMC)

The purpose of GAMC (Program GM) is to provide payment for certain types of medical services to persons in need. GAMC is determined by state law and supported by state funds. Effective October 1, 2003, full benefits remain available to recipients with incomes no greater than 75% of the FPG, and eligibility for GAMC begins no earlier than the date of application.

Eligibility for GAMC

- Persons wanting to apply for GAMC should contact their local county human services agency. Eligibility is determined at the local county human services agency.
- If a GAMC recipient, disabled by HIV or AIDS, is under your care and has not yet applied for MA, refer the patient to their local county human services agency. Providers are encouraged to refer individuals who are not eligible for MA or GAMC to the Program HH Office at (651) 431-2414 or 1-800-657-3761. Many services are available for people with
HIV infection regardless of their MHCP eligibility. Contact the Minnesota AIDS Line for information at (612) 373-2437 or 1-800-248-2437.

- Adults between the ages of 21 and 65 residing in an IMD are not eligible for MA but may be eligible for GAMC.
- Persons are ineligible for GAMC while residing in a penal institution unless they meet the following conditions:
  - Detainment must be for less than one year in a county correctional or detention facility, or the person must be an inpatient in a hospital on a criminal hold order, AND
  - The person must have been a recipient of GAMC at the time of arrest or admission to the hospital on a criminal hold order, AND
  - The person must be otherwise eligible for GAMC.
- GAMC-related copays are outlined.

**GAMC Hospital Only (GHO) Program**

The GHO program offers benefits for adults without children who have incomes between 75% and 175% of the FPG. Benefits in GHO are limited to:

- Inpatient hospital services
- Physician services provided during the inpatient hospital stay; and
- Certified registered nurse anesthetist (CRNA) services for hospitals that have elected to have CRNA costs excluded from the inpatient hospital rates during the admission.

**Minnesota Children with Special Health Needs (MCSHN) Program**

MCSHN (previously programs EE and TT) is no longer a funding resource for children with chronic illnesses or disabilities. Staff from this program is available to assist families of children with special health care needs throughout Minnesota to identify services and supports (including financial support) that might be available. Staff is also available to problem-solve with providers and county workers who are trying to locate resources for families. For assistance, call (651) 215-8956 or 1-800-728-5420.

**MHCP Benefits by Program - MA/GAMC/GHO/EMA**

The following table summarizes covered benefits for MA, GAMC, GHO and EMA. Specific coverage policy is listed in specific provider service chapters in this manual. Recipients and enrollees are entitled to these benefits regardless of whether they are fee-for-service or enrolled in a prepaid health plan.

Follow the guidelines for these covered services as specified in this manual.
<table>
<thead>
<tr>
<th>Benefit Set</th>
<th>Medical Assistance (MA), Program NM and IM</th>
<th>General Assistance Medical Care (GAMC)</th>
<th>GAMC Hospital Only (GHO)</th>
<th>Emergency Medical Assistance (EMA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(May be enrolled in a health plan)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Adult Mental Health Rehab/Adult Mental Health Crisis Services</td>
<td>X (A,C)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol/Drug Treatment: Residential &amp; Outpatient</td>
<td>X</td>
<td>X</td>
<td>Inpatient hospital only</td>
<td>X</td>
</tr>
<tr>
<td>Case Management</td>
<td>X(A)(C)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child &amp; Teen Check-Ups (C&amp;TC)</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic:</td>
<td>$3 copay</td>
<td>X</td>
<td>$3 copay</td>
<td></td>
</tr>
<tr>
<td>Common Carrier Transportation and Mileage Reimbursement</td>
<td>X(B)</td>
<td>X(B)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>Includes orthodontia in limited circumstances</td>
<td>Includes orthodontia in limited circumstances; 50% copay for restorative services</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$6 copay for non-emergency visits to the ER</td>
<td>$25 copay for non-emergency visits to the ER</td>
<td>Not covered when billed separately; Covered when combined with inpatient billing</td>
<td>$6 copay for non-emergency visits to ER</td>
</tr>
<tr>
<td>Eye Exams:</td>
<td>$3 copay</td>
<td>X</td>
<td>$3 copay</td>
<td></td>
</tr>
<tr>
<td>Eyeglasses</td>
<td>$3 copay</td>
<td>$25 copay</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Family Planning</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Home Care</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunizations</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Education Plan (IEP) Services</td>
<td>X(C)</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Inpatient Hospitalization</td>
<td>X</td>
<td>X</td>
<td>$1,000 copay per admission</td>
<td>X</td>
</tr>
<tr>
<td>Interpreters (hearing, language)</td>
<td>X</td>
<td>X(D)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Lab, X-ray and Diagnostic</td>
<td>X</td>
<td>X</td>
<td>Not covered for screening procedures</td>
<td></td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
**Benefit Set**

<table>
<thead>
<tr>
<th>Benefit Set</th>
<th>Medical Assistance (MA), Program NM and IM</th>
<th>General Assistance Medical Care (GAMC)</th>
<th>GAMC Hospital Only (GHO)</th>
<th>Emergency Medical Assistance (EMA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Transportation</td>
<td>Emergency and special trans</td>
<td>Emergency</td>
<td></td>
<td>Emergency and special trans</td>
</tr>
<tr>
<td>Mental Health</td>
<td>X(C)</td>
<td>X(C)</td>
<td></td>
<td>Same as MA except excludes targeted case management</td>
</tr>
<tr>
<td>Nursing Home/ICF-MR Facility</td>
<td>X(C)</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Outpatient Surgical Center</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Physicians and Clinics</td>
<td>$3 copay for non-preventive services</td>
<td>X</td>
<td>Limited to physician services provided in inpatient hospital setting</td>
<td>Not covered for routine, screening or preventive services</td>
</tr>
<tr>
<td>Podiatrist</td>
<td>$3 copay</td>
<td>X</td>
<td>X</td>
<td>$3 copay</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>$3 copay on brand name</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>$1 copay on generic</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>$12 monthly copay max; no copay for anti-psychotics and contraceptives</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Preventive Visit</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Rehab Therapies (PT, OT, speech)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

The following services are not available to MHCP recipients enrolled in a health plan, but are available otherwise as noted:

(A) SED/SPMI, CW TCM, VA/DD TCM — available through the county.
(B) Bus, taxi and/or volunteer driver (paid through health plan for plan enrollees, personal mileage available through the county or through MNET depending on county of residence – see Transportation Services)
(C) ICF/MR facilities, IEP services, abortion, CW TCM, VA/DD TCM, Adult Rehab MH/Adult MH crisis services — paid fee-for-service. Nursing home stays after 90 days (180 days for MSHO) are paid fee-for-service.
(D) Covered only for prepaid health plan enrollees.

**MinnesotaCare**

MinnesotaCare is a state-subsidized health care program for people who live in Minnesota and do not have health insurance. The program is open to all Minnesota residents who meet program guidelines. MinnesotaCare is funded by recipient premiums, copays, and statewide taxes.

DHS and some local county agencies administer MinnesotaCare. MinnesotaCare applicants and enrollees who reside in participating counties can choose to have their MinnesotaCare case administered by the local county agency or by the DHS MinnesotaCare Operations Office.

All MinnesotaCare recipients are automatically enrolled in DHS contracted prepaid health plans. Refer to Prepaid Minnesota Health Care Programs (ch. 3) for additional information.
Some children enrolled in MinnesotaCare may have other health insurance in addition to their prepaid health plan.

**MinnesotaCare Application Materials**

MinnesotaCare legislation mandates that application and informational materials be made available to provider offices, local human services agencies, and community health offices. To have applications mailed to your office, contact MinnesotaCare at:

MinnesotaCare  
P.O. Box 64838  
St. Paul, Minnesota 55164-0838  
1-800-657-3672 or (651) 297-3862

**Eligibility for MinnesotaCare**

- Persons may be eligible for either MinnesotaCare or MA, but cannot have coverage from both programs at the same time, with certain time-limited exceptions (for example, certain abortion services) and must choose one. This does not apply to one-month MA retroactive eligibility, related to a hospital stay.
- MinnesotaCare recipients are no longer required to apply for MA when they are admitted to a hospital. MinnesotaCare recipients who have expenses not covered by MinnesotaCare may apply for MA if they choose.
- A person incarcerated in a correctional facility, government owned/operated halfway house, locked juvenile facility, or penal institution is not eligible for MinnesotaCare, regardless of age. A person residing in one of these facilities who is covered by MinnesotaCare will be terminated at their renewal date.
- A person cannot have simultaneous coverage under both MinnesotaCare and GAMC.
- MinnesotaCare will not reimburse providers when a recipient has gone outside of their prepaid health plan network, unless it is for family planning (including sterilization, abortion services, and pregnancy related services in conjunction with an abortion). Infertility treatment must stay within the network guidelines set by the prepaid health plan.
- MinnesotaCare-related copays are outlined.

**MinnesotaCare Benefit Sets and Benefit Limits for Inpatient Hospital**

MinnesotaCare enrollees choose one of the following five benefit set options:

1. **Expanded Benefit Set** - (Program KK or LL): Children (to age 21) and pregnant women.  
   *Inpatient Hospital Benefit Limit:* No annual inpatient hospital coverage limit; and no inpatient copays.

2. **Basic Plus Benefit Set** - (Program FF or JJ): Parents above 175% of the FPG.  
   *Inpatient Hospital Benefit Limit:* $10,000 annual inpatient hospital coverage limit; and no inpatient copays.
3. **Basic Plus One Benefit Set** - (Program BB): Adults, age 21 and older, not parents, not pregnant, and at or below 75% of the FPG.

   *Inpatient Hospital Benefit Limit:* $10,000 annual inpatient hospital coverage limit; and 10% copay for inpatient services (up to $1,000 per adult per year, $3,000 per family).

4. **Basic Plus Two Benefit Set** - (Program FF or JJ): Parents at or below 175% of the FPG.

   *Inpatient Hospital Benefit Limit:* No annual inpatient hospital coverage limit; and no inpatient copays.

5. **Limited Benefit Set** – (Program BB) Adults without children between 75% and 175% of the FPG. The MinnesotaCare Limited Benefit Set includes only:
   - Inpatient hospitalization benefits
   - Outpatient hospital care
   - Services provided by a physician, advanced practice nurse (nurse practitioner, clinical nurse specialist, nurse midwife), physician assistant, licensed independent clinical social worker, or psychologist.
   - Limited optometrist services for treatment of diseases or injuries to the eye or removal of foreign bodies in the eye
   - Drugs
   - Chiropractic services
   - Lab and radiology
   - Diabetic supplies only

   *Inpatient Hospital Benefit Limit:* $10,000 annual inpatient hospital coverage limit; and 10% copay for inpatient services (up to $1,000 per year).

**Adult Dental Care Benefits for MinnesotaCare Enrollees**

The Expanded Benefit Set includes the full MA dental benefit set; dental copays do not apply.

Enrollees in the Basic Plus One and Basic Plus Two Benefit Sets receive preventive and non-preventive services except for orthodontic services. These recipients are required to pay a 50% copay equal to 50% of the fee-for-service rate for non-preventive dental care services. The dental care provider’s office should tell the recipient about the required copay before giving treatment. The copay should be paid directly to the dental care provider.

The Basic Plus Benefit Set includes preventive and restorative dental services; dental copays do not apply.

The Limited Benefit Set does not include any dental coverage.

**MHCP Benefits by Program – Minnesota Care**

The following table summarizes covered benefits for the five MinnesotaCare benefit sets. Specific coverage policy is listed in specific provider service chapters in this manual. Recipients
and enrollees are entitled to these benefits regardless of whether they are fee-for-service or enrolled in a prepaid health plan.

Follow the guidelines for these covered services as specified in this manual.

<table>
<thead>
<tr>
<th>MinnesotaCare Programs</th>
<th>Expanded Benefit KK LL</th>
<th>Basic Plus Two FF JJ</th>
<th>Basic Plus One BB</th>
<th>Basic Plus FF JJ</th>
<th>Limited BB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Recipients</td>
<td>Pregnant women, and children</td>
<td>Parents</td>
<td>Adults without children</td>
<td>Parents</td>
<td>Adults without children</td>
</tr>
<tr>
<td>Income Limit % of Federal Poverty Guidelines (FPG)</td>
<td>≤ 275%</td>
<td>≤ 175%</td>
<td>≤ 75%</td>
<td>&gt;175% ≤ 275%</td>
<td>&gt;75% to ≤ 175%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Sets</th>
<th>Expanded Benefit KK LL</th>
<th>Basic Plus Two FF JJ</th>
<th>Basic Plus One BB</th>
<th>Basic Plus FF JJ</th>
<th>Limited BB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Mental Health Rehab/Adult Mental Health Crisis Services</td>
<td>X(A)(C)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol/Drug Treatment: Residential &amp; Outpatient (B)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td>X(A)(C)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child &amp; Teen Check-ups (C&amp;T)</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic</td>
<td>X</td>
<td>$3 copay</td>
<td>$3 copay</td>
<td>$3 copay</td>
<td>$5 copay</td>
</tr>
<tr>
<td>Common Carrier Transportation and Mileage Reimbursement</td>
<td>X(D)</td>
<td>50% copay on restorative</td>
<td>50% copay on restorative</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontia</td>
<td>Included in limited circumstances</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room</td>
<td>X</td>
<td>$6 copay on non-emergency ER visits</td>
<td>$6 copay on non-emergency ER visits</td>
<td>$6 copay on non-emergency ER visits</td>
<td>$50 copay</td>
</tr>
<tr>
<td>Eye Exams</td>
<td>X</td>
<td>$3 copay</td>
<td>$3 copay</td>
<td>$3 copay</td>
<td>$5 copay (E)</td>
</tr>
<tr>
<td>Eyeglasses</td>
<td>No co-pay</td>
<td>$25 co-pay</td>
<td>$25 co-pay</td>
<td>$25 co-pay</td>
<td></td>
</tr>
<tr>
<td>Family Planning</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Home Care</td>
<td>Includes private duty and PCA</td>
<td>Excludes private duty and PCA</td>
<td>Excludes private duty and PCA</td>
<td>Excludes private duty and PCA</td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Immunizations</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X (E)</td>
</tr>
<tr>
<td>Individual Education Plan (IEP) Services</td>
<td>X(C)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Sets</td>
<td>Expanded Benefit KK LL</td>
<td>Basic Plus Two FF JJ</td>
<td>Basic Plus One BB</td>
<td>Basic Plus FF JJ</td>
<td>Limited BB</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>------------------------</td>
<td>----------------------</td>
<td>-------------------</td>
<td>------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Inpatient Hospitalization</td>
<td>X</td>
<td>X</td>
<td>10% copay, up to $1,000. $10,000 annual limit</td>
<td>No copay, $10,000 annual limit</td>
<td>10% copay, up to $1,000; $10,000 annual limit</td>
</tr>
<tr>
<td>Interpreters (hearing, language)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Lab, X-ray and Diagnostics</td>
<td>X</td>
<td>$3 copay for diagnostics only (for example, colonoscopies)</td>
<td>$3 copay for diagnostics only (for example, colonoscopies)</td>
<td>$3 copay for diagnostics only (for example, colonoscopies)</td>
<td>$5 copay for diagnostics only (for example colonoscopies)</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Diabetic supplies only</td>
</tr>
<tr>
<td>Medical Transportation</td>
<td>Emergency and special trans</td>
<td>Emergency only</td>
<td>Emergency only</td>
<td>Emergency only</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>$5 copay (E)</td>
</tr>
<tr>
<td>Nursing Home/ICF-MR Facility</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgical Center</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Physicians and Clinics</td>
<td>X</td>
<td>$3 copay for non-preventive visits</td>
<td>$3 copay for non-preventive visits</td>
<td>$3 copay for non-preventive visits</td>
<td>$5 copay for non-preventive visit (E)</td>
</tr>
<tr>
<td>Podiatrist</td>
<td>X</td>
<td>$3 copay for non-preventive visits</td>
<td>$3 copay for non-preventive visits</td>
<td>$3 copay for non-preventive visits</td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>No copay</td>
<td>$3 copay</td>
<td>$3 copay</td>
<td>$3 copay</td>
<td>$1/3 copay; $20 monthly maximum</td>
</tr>
<tr>
<td>Preventive Visits</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X(E)</td>
</tr>
<tr>
<td>Rehab Therapies (OT, PT, Speech)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X(E)</td>
</tr>
</tbody>
</table>

The MA/GAMC copay exclusions do not apply to MinnesotaCare enrollees in health plans and are not reflected in this chart.

The following services are not available to MHCP recipients enrolled in a health plan, but are available otherwise as noted:

(A) SED/SPMI, CW TCM, VA/DD TMC -- available through the county.
(B) Alcohol and Drug Treatment—health plans are responsible for Primary Residential Inpatient care in all benefit sets; halfway house and extended care will be paid fee-for-service in all benefit sets. Outpatient CD treatment is covered in all benefit sets except the Limited Benefit set and is paid for by the health plan.
(C) Nursing home stays after 90 days, ICF/MR facilities, IEP services, abortion, CW TCM, VA/DD TCM, Adult Rehab MH services, Adult MH crisis services—paid fee-for-service.
(D) Common carrier transportation costs and personal mileage reimbursement—available through the MinnesotaCare division.
(E) In Limited Benefit, these services are covered only if provided by a physician, physician assistant, nurse practitioner or clinical nurse specialist, licensed independent clinical social worker, or psychologist. Physicians include MD specialists (e.g., psychiatrists).
Prescription Drug Program (PDP)

Some low-income Minnesota seniors were able to receive assistance in purchasing prescription drugs through the Prescription Drug Program (PDP). PDP ended December 31, 2005.

Eligibility for PDP

PDP paid prescription drug costs on a fee-for-service basis for those age 65 and older or disabled who had incomes at or below 120% of the FPG. Please note:

- PDP was not available for residents of nursing homes whose care was paid for by MA.
- Only drugs manufactured by pharmaceutical companies that had signed a PDP rebate contract with DHS were covered.
- Drug coverage information is available through the DHS NDC line at (651) 282-2599 or 1-800-657-3985.

Fees and Payments

All PDP recipients must have paid a $35 per person, per month deductible to their pharmacy provider in advance, as the expenses were incurred. Point of Sale (POS) reduced the MHCP payment to the provider by $35. The provider’s remittance advice reflected the $35 deductible with code PR1 and major program code VV.

Recipients with spenddowns may have paid the $35 deductible in advance, and treated the other spenddown amounts as usual.

Eligibility Verification

The DHS eligibility verification system identifies recipients who were enrolled in PDP, but does not indicate the $35 recipient deductible; however, POS clearly reflected the correct deductible.

For More Information

- MHCP recipients may call the DHS Member Help Desk at (651) 431-2670 or 1-800-657-3739 for assistance.
- Physicians and pharmacists with questions may call the MHCP Provider Call Center at (651) 431-2700 or 1-800-366-5411.

Waivered Services Programs

Waivered Services are programs that have received federal approval for expanded coverage of services to MA recipients that are not usually covered by MA. These programs include the:

- Elderly Waiver (EW)
- Persons with Mental Retardation or Related Conditions (MR/RC)
- Community Alternative Care (CAC) for chronically ill individuals
- Community Alternatives for Disabled Individuals (CADI)
• Traumatic Brain Injury (TBI) Waiver

Refer to HCBS Waiver Programs and the AC Program (ch. 26) for additional information about the Waivered Services programs.

Copays

Definitions

Emergency Services: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

- The recipient must be seen by the medical professional on the same day that the recipient contacted the medical professional in order for the situation to be considered an emergency.
- The situation is not considered an emergency if the recipient contacts the medical professional and is not given an appointment for the same day of the call.
- Prescheduled services are not considered an emergency.
- Services provided as follow-up to initial emergency care are not considered emergency services.

Family Planning Services: A family planning supply or health service, including screening, testing, and counseling for sexually transmitted diseases, such as HIV, when provided in conjunction with the voluntary planning of the conception and bearing of children and related to a recipient’s condition of fertility. “Family planning supply” means a prescribed drug or contraceptive device ordered by a physician or other eligible provider with prescribing authority for treatment of a condition related to a family planning service.

Medical Institution: Hospital, nursing facility, Regional Treatment Center (RTC), Institute for Mental Disease (IMD) hospital, or Intermediate Care Facility for the Mentally Retarded (ICF-MR).

Non-preventive Visit: An episode of service which is required because of a recipient’s symptoms, diagnosis, or established illness. Copays are applied to non-preventive visits.

Preventive Medicine Services: CPT codes:
- 99381 through 99429, or
- 99201 - 99215 when provided for the following diagnoses: V03 - V06.9, V20 - V20.2, V21.1 - V21.2, V70.0

Copays are not applied to preventive visits.

Eyeglasses: Complete frames and lenses. A copay does not apply if only the frames are dispensed or only the lenses are dispensed.
MHCP Copay Guidelines

- MA and GAMC recipients and MinnesotaCare enrollees are responsible to pay copays to providers.
- Providers are responsible to collect copays from recipients and enrollees.
- For MinnesotaCare, existing copays remain in effect; however, exemptions will extend only to fee-for-service MinnesotaCare recipients who have copays.
- Payment to providers will be reduced by the amount of the copay, except that payment for prescription drugs will not be reduced after a recipient has reached the monthly maximum listed on the coverage chart.
- Copays will be applied to claims after the spenddown has been met. Recipients are responsible for 100% of the spenddown.
- Providers serving recipients who are in managed care plans should contact the plan regarding the providers’ contractual requirements.

Recipient Inability to Pay MHCP-related Copays

Federally funded MA or MinnesotaCare recipients are protected from denial of service based on inability to pay as long as they inform the provider that they are unable to pay the copay. Providers must continue to accept their assertion of inability to pay.

Providers cannot deny services to recipients who are unable to pay copays. A provider must accept a recipient’s assertion that he or she is unable to pay a copay and cannot require additional documentation of inability to pay.

General Assistance Medical Care (GAMC), GAMC Hospital Only (GHO) and other state-funded MA and MinnesotaCare programs are not affected by the federal statute.

When a recipient has a copay obligation, DHS will pay only the allowable minus the copay.

Copays for MHCP Recipients Enrolled in a Prepaid Health Plan

- MA and GAMC enrollees in health plans are required to pay copays.
- The MA and GAMC copay exemptions apply to MA and GAMC enrollees in health plans.
- MinnesotaCare enrollees in health plans must pay any copays that apply in their benefit sets.
- Health plans participating in Minnesota Senior Health Options (MSHO) have chosen to waive copays for enrollees in their MSHO products only. This copay waiver does not extend to copays required under the Medicare Prescription Drug Program. Providers should contact the MSHO health plan with questions.
MA and GAMC Recipient Copays

<table>
<thead>
<tr>
<th>Type of Copay</th>
<th>MA Copays</th>
<th>GAMC Copays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-preventive visit</td>
<td>$3</td>
<td>$0</td>
</tr>
<tr>
<td>Non-preventive services provided by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, physician assistant, audiologist, optician and optometrist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyeglasses – frames and lenses</td>
<td>$3</td>
<td>$25</td>
</tr>
<tr>
<td>Non-emergency visit to a hospital-based emergency room</td>
<td>$6</td>
<td>$25</td>
</tr>
<tr>
<td>Drugs - $12 per month maximum</td>
<td>$3 for brand name</td>
<td>$3 for brand name</td>
</tr>
<tr>
<td></td>
<td>$1 for generic</td>
<td>$1 for generic</td>
</tr>
<tr>
<td>Restorative adult dental services</td>
<td>(Not applicable)</td>
<td>50% of fee-for-service allowable</td>
</tr>
<tr>
<td>Copay Limits</td>
<td>One per day per treating provider, except drugs</td>
<td>One per day per treating provider, except drugs</td>
</tr>
</tbody>
</table>

Copay Exemptions—MA/GAMC Recipients

The following MA and/or GAMC recipients are exempt from copays related to MHCP services:

- Recipients under age 21
- Pregnant woman whose pregnancy has been verified and coded in the DHS Medicaid Management Information System (MMIS)
- Recipients of major programs RM, VV (ended 12/31/05), and HH (Except pharmacy for HH)
- Persons enrolled in MSHO
- Recipients who have elected hospice care
- Recipients residing or expecting to reside for 30 days or more in a medical institution
- PDP enrollees are not subject to drug copays, but are responsible for the first $35 deductible of drug costs

The following services are exempt from MA/GAMC-related copays:

- 100% federally funded services provided by a facility of the Indian Health Service
- Antipsychotic drugs and contraceptive drugs
- Case management services
- Copays that exceed one per day per treating provider for non-preventive visits, eyeglasses, and non-emergency visits to a hospital-based emergency room
- Emergency services
- Family planning services and supplies
- Hearing aids
- Home and Community Based waivered services
• Home-based services, including home health and personal care attendant services
• Inpatient professional visits
• Lab
• Medical supplies and equipment
• Mental health services, including community mental health center services and, regardless of provider: psychotherapy, psychiatrist services, day treatment, clozaril monitoring, partial hospitalization, and adult rehabilitative mental health services (ARMHS), health and behavior assessment and intervention
• Occupational therapy, physical therapy, speech therapy
• Orthotics and prosthetics
• Preventive services as defined above
• Radiology
• Repair of eyeglasses
• Services paid by Medicare for which MA pays the coinsurance and deductible

**MinnesotaCare Copays**

Copays do not apply to children under age 21 and pregnant women (Expanded Benefit Set).

<table>
<thead>
<tr>
<th>Type of Copay</th>
<th>Basic Plus Two, Basic Plus One and Basic Plus</th>
<th>Limited Benefit enrollee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital stays</td>
<td>10% of inpatient hospital charges up to $1,000 for Basic Plus One only</td>
<td>10% per stay up to $1,000</td>
</tr>
<tr>
<td>Hospital-based emergency room visit, when the service was an emergency</td>
<td>$0</td>
<td>$50</td>
</tr>
<tr>
<td>Hospital-based emergency room visit when the service was not an emergency</td>
<td>$6</td>
<td>$50</td>
</tr>
<tr>
<td>Non-preventive visit services provided by a physician, physician assistant, advanced practice nurse, chiropractor, podiatrist, audiologist, optometrist, or optician</td>
<td>$3</td>
<td>$5</td>
</tr>
<tr>
<td>Dental restorative services (fillings, crowns, root canals, etc)</td>
<td>50% for Basic Plus Two and Basic Plus One only</td>
<td>Not covered</td>
</tr>
<tr>
<td>Mental health services</td>
<td>$0</td>
<td>$5 for health plan enrollees (Only psychologists and licensed independent social workers are covered.)</td>
</tr>
<tr>
<td>Drugs</td>
<td>$3 for each prescription</td>
<td>$3 for brand name $3 for generic $20 per month maximum</td>
</tr>
<tr>
<td>Copay Limits</td>
<td>One per day per treating provider, except drugs</td>
<td>One per day per treating provider, except drugs</td>
</tr>
<tr>
<td>Eyeglasses</td>
<td>$25 for each pair of eyeglasses</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
Copay Exemptions - MinnesotaCare Enrollees

The following MinnesotaCare enrollees are exempt from copays related to MHCP services:

- Recipients under age 21
- Pregnant women whose pregnancy has been verified and coded in the DHS Medicaid Management Information System (MMIS)
- Recipients residing or expecting to reside for 30 days or more in a medical institution*
- Recipients who have elected hospice care*

The following services are exempt from MinnesotaCare-related copays:

- 100% federally funded services provided by a facility of the Indian Health Service*
- Antipsychotic drugs and contraceptive drugs*
- Case management services
- Copays that exceed one per day per treating provider for non-preventive visits, eyeglasses, and non-emergency visits to a hospital-based emergency room
- Emergency services
- Family planning services and supplies
- Hearing aids
- Home-based services, including home health and personal care attendant services
- Inpatient visits
- Interpreter services
- Lab
- Medical supplies and equipment
- Mental health services, including community mental health center services and, regardless of provider: psychotherapy, psychiatrist services, day treatment, clozaril monitoring, partial hospitalization, and adult rehabilitative mental health services (ARMHS), health and behavior assessment and intervention*
- Occupational therapy, physical therapy, speech therapy
- Orthotics and prosthetics
- Preventive services as defined above
- Radiology
- Repair of eyeglasses

*These exclusions apply to MinnesotaCare enrollees only when they are in fee-for-service.

**Recipient MHCP ID Numbers and Cards**

When recipients are approved for MHCP, they are assigned an 8-digit MHCP ID number that is printed on their MHCP ID card.

- All recipient MHCP ID cards are issued in the same format and contain the same general, non-recipient information.
• MHCP ID numbers do not change, and follow recipients through any changes in program, eligibility or address.
• If approved for one of the health care programs, each member of a household is issued their own individual MHCP ID card.
• The MHCP ID card does not include information about current program eligibility, prepaid health plan (PPHP) or HMO enrollment, spenddown, other health insurance coverage, Medicare coverage, or recipient restriction.
• Verify eligibility each month per recipient or on the day the service is rendered:
  − By calling (651) 282-5354 or 1-800-657-3613; or
  − Online through MN–ITS
• A new version of the MHCP ID card began being distributed March 2006 (prior to that, January 2003) to new recipients, with a phase in to those currently eligible. Verify eligibility regardless of the MHCP ID card version. Recipients in the same family may have multiple versions of the card.

New Recipient MHCP ID Card (issued March 2006 to present):

Old Recipient MHCP ID Card (issued January 2003 through February 2006):
Old Recipient MHCP ID Card (issued prior to January 2003):

Covered Service Requirements for MA/GAMC/MinnesotaCare

In order to be covered by MA, GAMC and/or MinnesotaCare, a health service must be determined by prevailing community standards or customary practice and usage to be:

- Medically necessary;
- Appropriate and effective for the medical needs of the patient;
- The most cost effective health service available for the medical needs of the patient;
- Able to meet quality and timeliness standards.
- Able to represent an effective and appropriate use of program funds;
- Able to meet specific limits outlined in rules adopted by DHS and explained in this manual; and
- Personally furnished by a provider, except as specifically authorized in this manual.

Out-of-country care: MHCP does not cover non-U.S./Canada care.

Non-Covered Services for MA/GAMC/MinnesotaCare

The following services are not covered under the MA, GAMC, or MinnesotaCare programs:

- Health services paid for directly by the recipient or other source, except when the recipient made the payment for services incurred during the recipient’s retroactive eligibility period. Refer to Billing Policy (ch. 4).
- A health service, other than an emergency health service, provided to a recipient in a long term care facility that is not in the recipient’s plan of care and has not been ordered, in writing, by a physician when an order is required.
- Artificial insemination.
- Autopsies.
• Aversive procedures, including cash penalties, unless otherwise authorized under state law.
• Ear piercing.
• Environmental products, such as air filters and purification systems, humidifiers and dehumidifiers (central or room), and hypoallergenic bedding and linens.
• Health services for which a physician’s order is required but not obtained.
• Health services not documented in the recipient’s health/medical record.
• Health services not in the recipient’s plan of care, individual treatment plan, IEP, or individual service plan.
• Health services not provided directly to the recipient unless the service is identified as a covered service in this manual.
• Health services of a lower standard of quality than the prevailing community standard of the provider’s professional peers. (Providers of services that are determined to be of low quality must bear the cost of these services.)
• Health services that do not contain documentation of supervision, if supervision is required.
• Health services, other than emergency health services, provided without the full knowledge and consent of the recipient or the recipient’s legal guardian.
• Home modifications, such as: grab bars, handrails, widening of doorways, bathroom modifications, stair lifts, or ramps.
• Missed appointments. (MHCP recipients may not be billed for missed appointments.)
• More than one home visit for a particular type of home health service by a home health agency per recipient per day, except for respiratory therapy visits or skilled nurse visits as specified in the recipient’s plan of care.
• Reversal of voluntary sterilizations.
• Surgery primarily for cosmetic purposes.
• Vehicle modifications: adapted seating, door handle replacements, door widening, motorized lifts, wheelchair lifts, wheelchair securing devices.
• Vocational or educational services, including functional evaluations or employment physicals, except as provided under IEP-related services.
• Other non-covered items include:
  ▪ Adaptive furniture
  ▪ Air conditioners
  ▪ Appliances
  ▪ Bed baths
  ▪ Bedboards
  ▪ Beds (oscillating and lounge)
  ▪ Bicycles
  ▪ Blankets
  ▪ Blood glucose analyzers (reflectance colorimeter)
  ▪ Bottle washers
  ▪ Cell phones
  ▪ Cervical rolls or pillows
  ▪ Computers
  ▪ Control units and battery device adapters
  ▪ Diathermy machines
  ▪ Disinfectants
  ▪ Disposable wipes
  ▪ Electric toothbrushes/water picks
  ▪ Elevators and stair lifts
  ▪ Enuresis or bedwetting alarms
  ▪ Exercise equipment
  ▪ Feeding instruments
  ▪ Food blenders
  ▪ Home security systems
  ▪ Hot tubs
  ▪ Hygiene supplies and equipment
  ▪ Ice packs (disposable)
  ▪ Instructional materials (pamphlets and books)
  ▪ Isolation gowns
Minnesota Restricted Recipient Program (MRRP)

The purpose of the Minnesota Restricted Recipient Program (MRRP) (formerly the Health Care Designated Provider Program [HCDPP]) is to identify MHCP recipients who have used services at a frequency or amount that is not medically necessary and/or who have used health services that resulted in unnecessary costs to the program. Once identified, such recipients will be placed under the care of a primary care physician and/or other designated providers who will coordinate their care for a 24-month period.

Investigation

MRRP staff conducts investigations to determine if:
- A fraud, theft or abuse situation exists and can be supported by documentation;
- Sufficient justification exists to support restricting a recipient to a primary care physician and/or other designated providers; and/or
- Sufficient evidence exists to support the imposition of other sanctions.

Abuse: In the case of a recipient, the use of health services that results in unnecessary cost to MHCP, or in reimbursement for services that are not medically necessary. The following practices are deemed to be abuse:
- Obtaining equipment, supplies, drugs, or health services that are in excess of MHCP limitations, or that are not medically necessary and that are paid for by MHCP;
- Obtaining duplicate services for the same health condition from multiple providers. Duplicate service does not include an additional opinion that is medically necessary for the diagnosis, evaluation, or assessment of the recipient’s condition or required under MHCP rule, or a service provided by a school district as specified in the recipient’s individualized education plan under MS 256B.0625, subd. 26;
• Continuing to engage in practices that are abusive of the program after receiving a written warning from DHS that the conduct must cease;
• Altering or duplicating the MHCP ID card for the purpose of obtaining additional health services billed to MHCP;
• Using a MHCP ID card or ID number that belongs to another person, or allowing others to use their MHCP ID card or ID number to obtain services, drugs or equipment;
• Using the MHCP ID card to assist an unauthorized individual in obtaining a health service for which MHCP is billed;
• Duplicating or altering or falsifying prescriptions;
• Misrepresenting material facts as to physical symptoms for the purpose of obtaining equipment, supplies, health services, or drugs;
• Furnishing incorrect eligibility status or information to a provider;
• Furnishing false information to a provider in connection with health services previously rendered to the recipient that were billed to MHCP;
• Obtaining health service by false pretenses;
• Obtaining health services that are potentially harmful to the recipient;
• Repeatedly obtaining emergency room health services for non-emergency care; or
• Using medical transportation to obtain health services from providers located outside the local trade area when health services are available within the local area.

Grounds for Sanctions Against Recipients

MRRP may impose administrative sanctions against recipients for the use of health services that result in unnecessary costs to the health care programs or in reimbursements for services that are not medically necessary.

Sanctions Against Recipients

MRRP may impose any of the following sanctions:
• Referring the recipient to the appropriate authority for possible criminal or civil legal action;
• Recovery from the recipient, to the extent permitted by law, all amounts incorrectly paid by MHCP; and
• Restricted status: Requiring that the recipient receive health care from a designated primary care physician and other designated health service providers for a period of 24 months.

A recipient may be given an additional 24 months of restricted status if patterns of program abuse continue and are supported by documentation.

Notification and Recipient Rights to Appeal

DHS must notify recipients in writing of any sanctions to be imposed. A recipient may appeal any sanction proposed by DHS.
MCO Restriction Status

DHS and managed care organizations (MCOs) have developed universal restriction, which is put in place by either DHS or an MCO and stays in effect for the entire period of restriction, regardless of whether the recipient:

- Changes health plans;
- Moves from fee-for-service to an MCO; or
- Moves from an MCO to fee-for-service.

When an MCO restricts a recipient, the MCO must fax the following information to MRRP at (651) 431-7422:

- Name and MHCP ID number of the restricted recipient;
- Name(s) and MHCP ID number(s) of the provider(s) to whom the recipient is restricted;
- The date span of the restriction; and
- The reason codes for the restriction.

DHS created the Enrollment Reporting Form (DHS-4656) for MCOs to notify MHCP of recipients placed on restriction.

Denial, Termination or Reduction (DTR) of Benefits Notice

For recipients enrolled in an MCO, any change in service authorization or denial of a claim from a non-designated provider requires a denial, termination or reduction (DTR) notice to the recipient. Placement in MRRP is not grounds for a DTR.

Obtaining Restriction Information

Providers may obtain information about the types of services to which a recipient is restricted by verifying eligibility (phone or through MN-ITS). Typically, a recipient is restricted to one primary care physician, pharmacy, and hospital. A recipient may also be restricted to other designated providers or referred by the primary care physician to other providers, if appropriate. Recipients may receive services that are not subject to restriction from any enrolled MHCP provider. Long term care facility services are not subject to restriction.

Selection of Providers by MRRP

A recipient placed on restriction is required to select a primary care physician, hospital and an individual pharmacy to coordinate their care. The recipient may choose a primary care physician provider. If the recipient fails to choose providers, DHS will assign a physician based on considerations of geographic proximity, the recipient’s prior experience with a specific physician, and the physician’s willingness to provide health care services.
Responsibilities of the Primary Care Physician

Any physician enrolled as a general practitioner, internal medicine, or family practice physician may be selected by the recipient as his/her primary physician. The primary care physician will be asked to review each recipient’s profile of utilization, develop an appropriate care plan, and authorize referrals. To participate as primary care physician, the physician must be enrolled as an MHCP provider.

Limitations on Physician Participation

The commissioner may limit a primary care physician’s participation in MRRP based on the quality or quantity of health care services delivered or a review of sanctions previously imposed by MHCP or by the physician’s professional licensing board. The commissioner also may limit the number of recipients restricted to an individual primary care physician.

Medical Referral for Minnesota Restricted Recipient Program Recipient Form

The primary care physician must mail or fax a Medical Referral for MRRP Recipient form (DHS-2978) to the MRRP unit as soon as a recipient is referred to another physician for care. This information is necessary for the referral provider’s claim(s) to be processed in a timely manner.

Emergency Services

Emergency health care services may be provided to a MRRP recipient without the authorization of the primary care physician if these services are provided in response to a condition that, if not immediately diagnosed and treated, could cause a person serious physical or mental disability, continuation of severe pain, or death. The MRRP unit may require documentation of the emergency situation in order to determine payment of the claim.

Program Requirements

In addition to MRRP, the provider(s) must follow all MHCP requirements (such as authorization, second surgical opinion, program limitations, etc.).

Claims Reimbursement

Services provided to a MRRP recipient will be reimbursed when:

- The service is provided by the recipient’s primary care physician or his/her designee;
- The primary care physician has submitted a Medical Referral for MRRP Recipient form (DHS-2978) to DHS; or
- The service is of a provider or service type that is not listed as restricted on the recipient’s file.
Reporting Suspected Misuse of Services or Requests for Additional Information

To report actual or suspected fraud, abuse, or mis-utilization of service by recipients, or for questions regarding the MRRP, call (651) 431-2648 or 1-800-657-3674.

Legal References

MS 256B.02
MS 256B.055 to 256B.061; 256L.01 to 256L.15
MS 256B.0625; 256D.03; 256L.03
Minnesota Rules 9505.0010 to 9505.0140
Minnesota Rules 9505.0010 to 9506.0090
Minnesota Rules 9505.0170 to 9505.0475
Minnesota Rules 9505.2160 to 9505.2245
42 CFR 435 (MA Eligibility)
42 CFR 440 (MA Services)
42 CFR 456 (MA Utilization Control)