

# Health Care Programs and Services

Revised: [November 21, 2024](#)

## Overview

The Minnesota Department of Human Services (DHS) ensures basic health care coverage for low-income Minnesotans through [Minnesota Health Care Programs \(MHCP\)](#). This section outlines eligibility and coverage for these programs.

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## MHCP Member Eligibility

The following information shows the major program codes that appear in the [MN-ITS](#) eligibility verification transaction, with a brief description of the program and a link to more information. MHCP member eligibility is generally approved on a monthly basis. Verify MHCP eligibility through the secure, online MN-ITS eligibility verification transaction before providing a service (or at least once per month if billing monthly or for multiple services provided in one calendar month). Review [Billing the Member \(Recipient\)](#) for information about member cost-sharing responsibilities.

<b>Minnesota Health Care Programs (MHCP)</b>	
<b>Major Program Code</b>	Brief Description of Program When mentioned, <a href="#">MinnesotaCare</a> is the program for Minnesota residents without access to affordable health care coverage.
<b>AC</b>	<a href="#">Alternative Care Program</a> A state and federally funded cost-sharing program that provides home and community-based services to prevent and delay transitions to nursing facility level of care for eligible Minnesotans age 65 and over.
<b>BB</b>	MinnesotaCare State and federally funded coverage for adults age 19 years and older.
<b>EH</b>	<a href="#">Emergency Medical Assistance (EMA)</a> State funded and federally funded emergency assistance for some people with a medical emergency. EMA only covers services provided in an emergency department or inpatient hospital when the admission is the result of an emergency admission and some limited services under a certified care plan.

<b>FP</b>	<a href="#">Minnesota Family Planning Program (MFPP)</a> State and federally funded program that provides only pre-pregnancy family planning and related health care services for people of any age.
<b>FF</b>	MinnesotaCare State and federally funded coverage for adults age 19 years and older.
<b>HH</b>	<a href="#">HIV/AIDS</a> Federally funded program for people with HIV or AIDS who meet eligibility guidelines; <a href="#">provides support</a> for people to access case management, dental, insurance benefit, medication, mental health and nutrition services. See also <a href="#">Program HH Covered Services</a> .
<b>IM</b>	Institution for Mental Disease (IMD) State funded Medical Assistance (MA) program for people who are residing in an IMD.
<b>KK</b>	MinnesotaCare State funded coverage for children age 19 years and under.
<b>LL</b>	MinnesotaCare State and federally funded coverage for children age 19 years and under.
<b>MA</b>	<a href="#">Medical Assistance</a> Minnesota's Medicaid program with more than a million Minnesotans eligible; most enrolled in <a href="#">managed care organizations (MCOs)</a> .
<b>NM</b>	MA program that is mostly federally funded under the Children's Health Insurance Program (CHIP), which covers pregnant women and infants under age 2. NM also covers a small number of adults age 19 and over who are not covered by CHIP. Eligibility and covered services mirror MA.
<b>OO</b>	Behavioral Health Fund. State funded for Substance Use Disorder (SUD) service only.
<b>QM</b>	Medicare Savings Program that covers Medicare Part A and B copays, coinsurance, premiums and deductibles only. See <a href="#">Qualified Medicare Beneficiary (QMB) (DHS-2087E) (PDF)</a>
<b>RM</b>	<a href="#">Refugee Medical Assistance</a> Federally funded MA program available for the first 12 months after a refugee arrives in the United States. The covered services for this program are the same as MA.
<b>SL</b>	Service Limited Medicare Beneficiary Medicare Savings Program that covers Medicare Part B premiums. There is no coverage for services or Medicare copays and deductibles. See <a href="#">Service Limited Medicare Beneficiaries (DHS-2087G) (PDF)</a>
<b>UN</b>	Limited program for specified benefits that do not require MA basis of eligibility. <a href="#">Essential Community Supports (ECS)</a> <a href="#">Housing Support Supplemental Services</a>
<b>XX</b>	MinnesotaCare State funded coverage for adults age 19 years or older.

Some people may be eligible for more than one program at the same time. For these people, MHCP will pay services at the highest level of coverage. For example, if a person has QM and MA coverage, MHCP will cover the person's Medicare coinsurance and deductible based on QM coverage. However, because the person also has MA coverage, MHCP will cover services that are not covered by QM but are covered by MA. Program SL reimburses a person's Medicare premium and does not include coverage for health care services. People pending a long-term care assessment are listed as unknown until the assessment has been completed.

### **Minnesota Restricted Recipient Program (MRRP)**

MRRP identifies MHCP members (any major program code) who have used services at a frequency or amount that is not medically necessary or who have used health services that resulted in unnecessary costs to MHCP. Once identified, these people are placed under the care of a designated primary care physician or other providers who coordinate their care for a 24-month period.

The primary care provider must fax a [Medical Referral for MRRP Enrollee \(DHS-2978\) \(PDF\)](#) to the MRRP office at 651-431-7475 no later than 90 days after the date of service of the referred-to provider service. This allows MHCP to process the referred-to provider's claim. MHCP will deny claims if the referral is not received within 90 days of the referred-to provider's date of service. Emergency health care services 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 may be provided to a MRRP recipient without the authorization or referral of the primary care physician. The MRRP office may require documentation of the emergency situation to determine payment of the claim.

If you have any questions about a referral or the referral form, call MRRP at 651-431-2648 or 800-657-3674.

For members enrolled in managed care organizations (MCO), primary care providers must fax all health plan MRRP referrals to the appropriate MCO.

### **Hospital Presumptive Eligibility**

The Hospital Presumptive Eligibility (HPE) program was established by the Affordable Care Act. It allows participating hospitals and hospital clinics to determine eligibility for temporary Medical Assistance (MA) using preliminary information from applicants. HPE helps people get needed health care coverage and helps hospitals receive payments for services they provide before a full MA determination can be made.

A hospital or hospital clinic can enroll as a qualified HPE provider at any time. A qualified HPE hospital must help people it approves for HPE to complete and submit the full MA application. Qualified HPE hospitals can provide direct assistance to complete the application, or help people connect with a navigator organization or certified application counselor. A hospital qualified to determine eligibility for HPE must comply with all policies and procedures and meet the HPE performance metrics established. See the [HPE: Policies, forms and notices](#) for more information. Certified hospital personnel who have completed training and are certified by DHS can determine eligibility for HPE. No verification is required to establish eligibility for HPE. See the [HPE: Policies, forms and notices](#) for more information.

When a qualified HPE hospital approves HPE, it must provide the approved member with an approval notice on security paper that DHS provides to the hospital. The HPE approval notice serves as proof of coverage for the member until they receive their MHCP ID card. The member can go to any MHCP provider and receive services with the HPE approval notice. DHS will mail an MHCP ID card to the approved member. The card contains the member's MHCP ID number, which providers and pharmacies use to verify coverage.

A person does not need to be a patient to apply for HPE. Qualified HPE hospitals are required to process applications for a person regardless of whether the person is seeking medical treatment.

HPE coverage begins no earlier than the date on which the hospital approves the HPE application. The date of approval is entered as the "coverage begin date" on the HPE approval notice.

HPE Coverage ends:

- The date on which DHS makes an eligibility determination for MA if the person submits an application for MA during the HPE coverage period.
- The last day of the month following the month in which the person is approved for HPE if the person does not submit an application during the HPE coverage period.

A person approved for HPE is eligible to receive full MA (adult or children) benefits. This means there is no difference in covered services between HPE and regular MA.

Any MHCP provider, not just a qualified HPE hospital, is able to bill for services provided during the HPE coverage period. The billing procedures for HPE are the same as for MA.

Most people are able to receive HPE once in a twelve-month period. A pregnant woman is able to receive HPE once per pregnancy.

To make HPE determinations, a hospital must be an enrolled MHCP provider and agree to comply with the DHS HPE policy and procedures. Hospitals must sign and submit the [Hospital Presumptive Eligibility Provider Assurance Statement \(DHS-3887\) \(PDF\)](#). Hospitals must also submit to DHS the name of two members of the hospital's staff who have passed the [DHS HPE training](#).

Refer to [Hospital Presumptive Eligibility program](#) webpage for more information.

### **Applicants with Disabilities**

For MA applicants who indicate they may have a disability, the State Medical Review Team (SMRT) determines if they meet the criteria for disability status. Refer to the [FAQs about the State Medical Review Team](#) webpage for more information.

### **Waiver Services Programs**

Waiver services are programs that have received federal approval for expanded coverage to MHCP members of services not usually covered by MA. These programs include:

- [Brain Injury \(BI\) Waiver](#)
- [Community Alternative Care \(CAC\)](#) for chronically ill individuals
- [Community Access for Disability Inclusion \(CADI\)](#)
- [Developmental Disabilities \(DD\) Waiver](#)
- [Elderly Waiver \(EW\)](#)

Refer also to [HCBS Waiver Services](#) section of the MHCP Provider Manual for additional provider information about waiver and AC programs.

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

MCSHN is no longer a funding resource for children with chronic illnesses or disabilities. Staff from this program are available to help 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. Call 800-728-5420 for assistance.

### **Incarcerated Members**

In general, adults who are incarcerated in detention or correctional facilities are not eligible for MHCP. People eligible under major program RM who meet all other eligibility requirements remain eligible for RM regardless of their living arrangement.

Incarcerated individuals who meet current clinical and financial eligibility guidelines and are receiving services in 245G or tribally licensed programs are eligible for payment through the Behavioral Health Fund.

MHCP members, regardless of age, are ineligible for coverage while they reside in the following correctional facilities:

- City, county, state and federal correctional and detention facilities for adults, including, inmates who are:
  - In a work release program that requires they return to the facility during non-work hours
  - Admitted to an acute care medical hospital for medical treatment or to give birth, but required to return to the facility when treatment or convalescence is completed
  - Sent by the court or penal institution to a chemical dependency residential treatment program while serving a sentence and are required to return to the correctional facility after completing treatment
- Secure juvenile facilities licensed by the Department of Corrections (DOC) that are for holding, evaluation, and detention purposes
- State-owned and operated juvenile correctional facility
- Publicly owned and operated juvenile residential treatment and group foster care facilities licensed by the DOC with more than 25 non-secure beds

Children who are placed by a juvenile court in certain juvenile programs may be eligible depending on the type of facility.

MHCP may not receive notification that a member is incarcerated until after the person's eligibility was determined. In those cases, MHCP will retroactively close out the member's eligibility and recoup any reimbursements made to the provider for services performed during the member's dates of incarceration.

#### **Incarcerated Member's Living Arrangement (LA):**

- If the incarcerated member's LA does not show incarcerated, please contact the member's local [tribal or county](#) of residence before billing.
- If the member is no longer incarcerated, but the member's LA still shows incarcerated, please contact the member's local [tribal or county](#) of residence before billing.

#### **Incarcerated Member Billing:**

A person incarcerated in a state or local correctional facility may qualify for MA payment for hospital services. Refer to information under the [Incarceration](#) section of the Inpatient Hospital Services provider manual.

Contact the appropriate county jail or correctional facility about how to bill for the services that were provided.

#### **Applying for MHCP Coverage**

People may apply online through [MNsured.org](#), at their local [tribal or county](#) agency, or at the [MinnesotaCare](#) office at DHS for MHCP coverage.

MinnesotaCare legislation mandates that application and informational materials be made available to provider offices, local human services agencies, and community health offices. Access and print [online applications](#) or have applications mailed to your office. Find direction on which application to use on each application. Contact MinnesotaCare at:

MinnesotaCare  
P.O. Box 64838  
St. Paul, MN, 55164-0838  
651-297-3862 or 800-657-3672

### **Postpartum Coverage**

MA and CHIP-funded MA provide access to the full range of MA benefits for people who are pregnant throughout the 12-month postpartum period, with no premiums, copays or deductibles. Effective July 1, 2022, the Minnesota Legislature extended postpartum coverage from 3 months to 12 months for pregnant people enrolled in MA or CHIP-funded MA.

### **Newborn Coverage**

Children born to mothers covered by MA during the month of birth are given automatic MA newborn coverage and do not need to apply for MHCP coverage for the newborn. If these children continue to live in Minnesota (regardless with whom), the automatic MA eligibility continues through the last day of the month in which the child turns one year of age.

### **Spenddowns**

Members in MA, IM (institutions for mental disease) or EH (emergency medical assistance) may be eligible with a spenddown or waiver obligation. Some people who have more income than the MA income limit allows may become eligible by spending down to the income limit. The spenddown dollar amount, similar to an insurance deductible, becomes the member's financial responsibility before MHCP payment can be made.

- **Medical spenddown:** Members pay for medical services, including prescriptions, generally on a monthly basis
- **Institutional or long-term care (LTC) spenddown:** Members pay a portion or all of their institutional daily charges
- **Elderly waiver (EW) obligation:** Members pay a portion or all their EW service costs. For members enrolled in a senior managed care program, MCOs pay providers minus the waiver obligation and the provider bills the member. Members cannot use a designated provider for waiver obligations.

### **Spenddowns and Managed Care**

- Members eligible for MA who are enrolled in a managed care plan for families and children (F&C) and Minnesota Senior Care Plus (MSC+) cannot be eligible with a medical spenddown. Members who become eligible with a medical spenddown while enrolled in F&C or MSC+ will be disenrolled from their managed care plan. Their eligibility will be fee for service (FFS) for the next available month.
- Members cannot enroll in Minnesota Senior Health Options (MSHO) or Special Needs BasicCare (SNBC) if they have an existing medical spenddown. However, if someone was enrolled in MSHO or SNBC without a medical spenddown, and later become eligible with a medical spenddown, they can remain enrolled as long as they continue to pay their medical spenddown to DHS.
  - If a member fails to pay three months of medical spenddowns to DHS they will be disenrolled from MSHO or SNBC.
  - Once a member has been disenrolled from SNBC or MSHO, he or she has 90 days from the date of disenrollment to pay the outstanding balance to DHS and be reinstated into the health plan.
  - If it has been more than 90 days since a member has been disenrolled from the SNBC or MSHO plan, the member cannot enroll into SNBC or MSHO until he or she no longer has an

ongoing medical spenddown **and** has paid the outstanding balance of the previous spenddown.

- Members living in an institution who have a medical spenddown due to hospice care (considered a medical service) are allowed to enroll in MSHO.

### **Spenddown Payment Options**

Members may pay spenddowns in one of four different ways, depending on the program they are eligible for:

- **Potluck spenddown:** For members in FFS, the provider (or providers) who bills first, has all or a part of the medical spenddown amount deducted from their claims. The provider then bills the member for the spenddown amount that was deducted from the claims.
- **DHS spenddown:** For members in MSHO and SNBC, spenddowns are paid directly, in advance, to DHS.
- **Designated provider spenddown:** FFS members pay a specific provider, selecting the provider using the [Request for Designated Provider Agreement \(DHS-3161\) \(PDF\)](#). Designated providers agree to make sure the member's spenddown is applied to the provider's claims for each month the provider renders services to the member.
  - People enrolled in MSHO cannot have a designated provider for a medical spenddown. They must pay their spenddown to DHS. The only exception is for people living in a nursing facility with an institutional spenddown who are in hospice care (considered a medical service). The hospice provider must be listed as the designated provider when the institutional spenddown is changed to a medical spenddown. People are allowed to have designated providers with institutional spenddowns.
  - People enrolled in SNBC can have a designated provider for a medical spenddown as long as it is for services not covered by the health plan. Services covered by fee-for-service that are eligible for payment to a designated provider are Home and Community-Based Services waiver for people with disabilities, PCA, or home care nursing.

Contact the county or tribal agency if:

- The information on the form is incorrect.
- The spenddown is not applied to claims appropriately.
- The provider stops rendering services to the member named on the designated provider agreement.
- The provider no longer renders services that equal or exceed the spenddown amount reported on the monthly designated provider notice.
- The provider continues to receive the designated provider notices after it has stopped providing services.

MHCP may collect any overpayments if the provider does not take appropriate steps.

The spenddown designated provider must bill services shortly after rendering the service. The member will remain ineligible for other services until the designated provider's claim is processed.

- **Client option spenddown:** Members prepay their spenddowns to DHS. The client option spenddown is not available to people on MSHO.

Providers who are owed spenddown amounts see group and reason code PR142 on their remittance advices with a dollar amount that indicates the member's spenddown amount. See the [Billing the Member \(Recipient\)](#) section of the MHCP Provider Manual.

### **Member ID Cards and Verification**

Each member approved for MHCP is assigned an 8-digit member number that is printed on his or her ID card. Members of an eligible household receive their own ID cards, and may have different versions of the card, depending on when they became eligible.

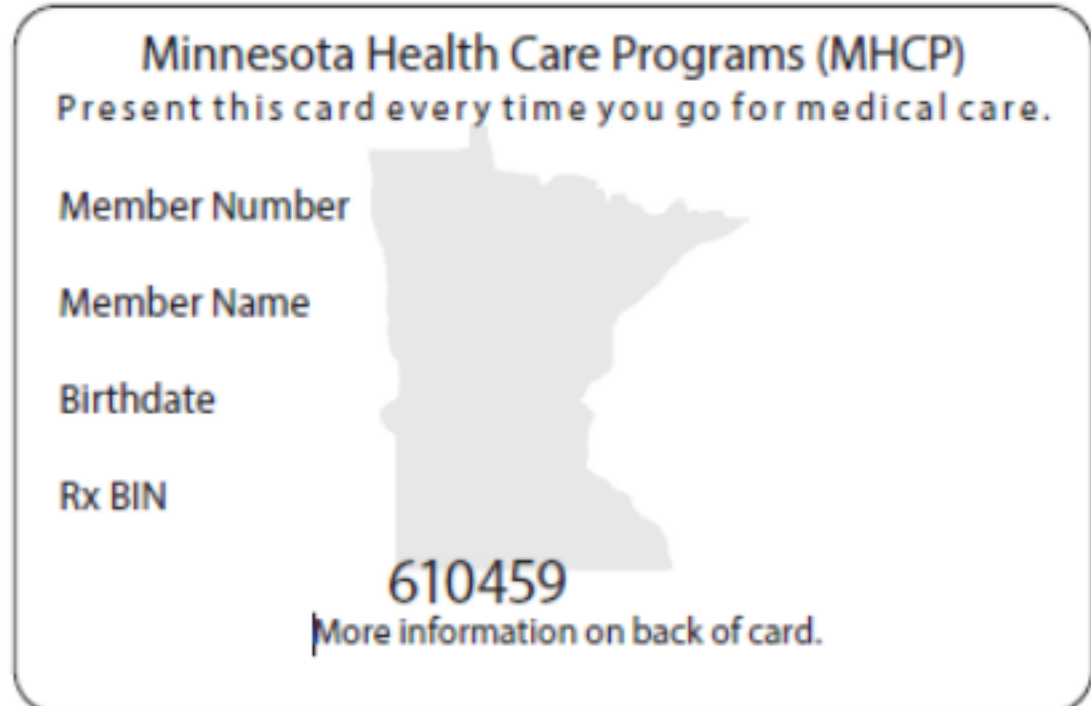
- MHCP ID numbers do not change, regardless of changes in program, eligibility or address.
- MHCP ID cards do not include eligibility information. (The look of the cards may change slightly from time to time.)

Verify eligibility before each visit through MN-ITS.

Example of MHCP Member ID cards issued April 2020 through present:

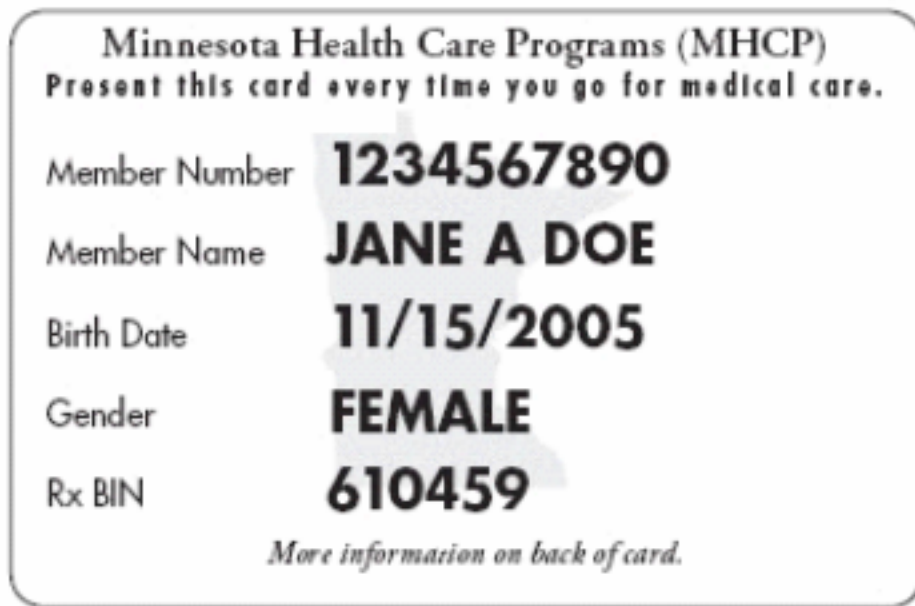
Here is your membership card. Be sure to carry it with you at all times.

Please do not store your membership card in a plastic photo holder. If you do, the ink will come off the card.

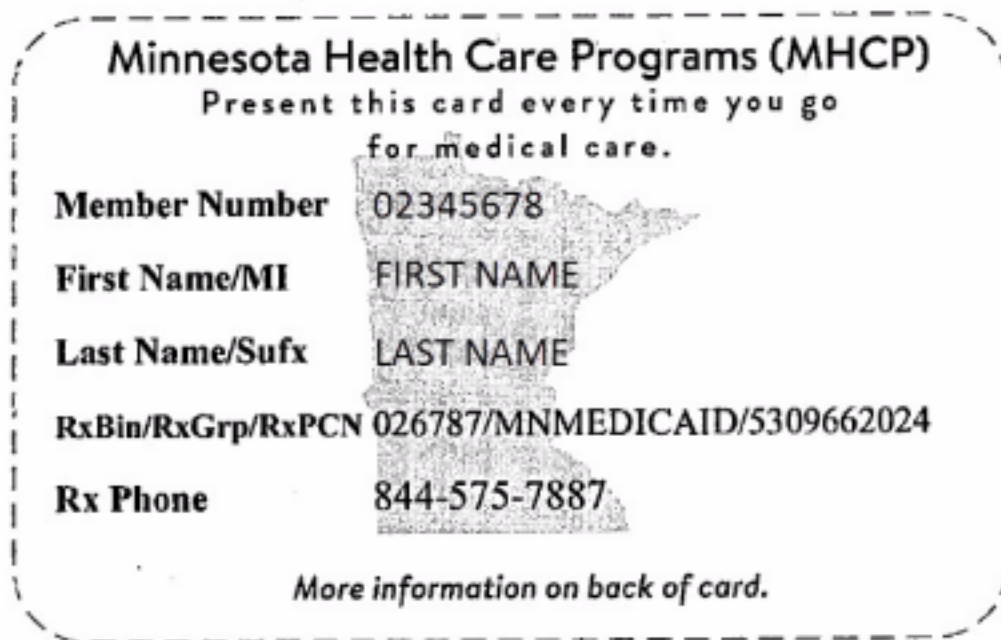


<p><b>MEMBERS:</b> If you have questions about bills, benefits, copays or authorization, call the number on your health plan member card. If you do not have a card from a health plan, call Health Care Consumer Support at: • 651-431-2670 • 800-657-3739 • TDD or TTY 7-1-1 For eligibility questions, contact your county, tribal or MinnesotaCare worker. Find MHCP providers at <a href="http://mhcpproviderdirectory.dhs.state.mn.us">http://mhcpproviderdirectory.dhs.state.mn.us</a></p>	<p><b>PROVIDERS:</b> Verify eligibility before delivering and billing for services. Verify MHCP eligibility online at: <a href="https://mn-its.dhs.state.mn.us">https://mn-its.dhs.state.mn.us</a> Or by phone at: • 651-431-4399 • 800-657-3613 Visit the provider website at <a href="http://mn.gov/dhs/mhcp/providers-policies">mn.gov/dhs/mhcp/providers-policies</a></p>
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Example of MHCP Member ID cards issued March 2006 through April 2020:



**Note:** Beginning Oct. 29, 2024, newly enrolled MHCP members will receive a redesigned member ID card. Example of the new member ID card (the back of the card remains the same):



Currently enrolled members will use their existing member ID cards until DHS sends the new card sometime in 2025. Current members do not need to request a new member ID card. We will update this manual when we know when current members will receive their new member ID cards.

### MHCP Covered Services

To be covered by MHCP, 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 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 the service-specific [MHCP Provider Manual](#) sections
- Personally rendered by a provider, except as specifically authorized in the MHCP Provider Manual

For covered services by program, refer to the [MHCP benefits at a glance chart](#).

### MHCP Noncovered Services

MHCP does not cover:

- Health services for any of the following:
  - When a physician's order is required but not obtained
  - Not documented in the member's health or medical record

- Not in the member's plan of care, individual treatment plan, IEP, or individual service plan
- Not provided directly to the member unless the service is identified as a covered service in MHCP Provider Manual
- 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)
- Other than an emergency health service, provided to a member in a long-term care facility that are not in the member's plan of care and have not been ordered, in writing, by a physician when an order is required
- Other than emergency health services, provided without the full knowledge and consent of the member or the member's legal guardian
- Paid for directly by the member or other source, except when the member made the payment for services incurred during the member's retroactive eligibility period. Refer to [Billing Policy](#) and [Billing the Member \(Recipient\)](#)
- That do not contain documentation of supervision, if supervision is required
- Missed appointments (do not bill MHCP member for missed appointments)
- Non-U.S. (out of country) care
- Reversal of voluntary sterilizations
- Surgery primarily for cosmetic purposes
- Vocational or educational services, including functional evaluations or employment physicals, except as provided under IEP-related services

Consult the appropriate section(s) of this manual for more specific information about other noncovered services.

### **Legal References**

[Minnesota Statutes, 256B.02](#) (Definitions)

[Minnesota Statutes, 256B.03](#), subdivision 4 (Prohibition on payments to providers outside of the United States)

[Minnesota Statutes, 256B.055](#), subdivision 14 (Persons detained by law)

[Minnesota Statutes, 256B.055 to 256B.061](#) (MA, Eligibility Categories, and requirements)

[Minnesota Statutes, 256B.0625](#) (Covered Services)

[Minnesota Statutes, 256D.03](#) (Responsibility to Provide General Assistance)

[Minnesota Statutes, 256L](#) (MinnesotaCare)

[Minnesota Statutes, 256B.055](#), subdivision 6 (Pregnant women; unborn child)

[Minnesota Rules, 9505.0010 to 9505.0140](#) (Health Care Programs, Medical Assistance Eligibility)

[Minnesota Rules, 9505.0170 to 9505.0475](#) (Health Care Programs, Medical Assistance Payments)

[Minnesota Rules, 9505.1960 to 9505.2245](#) (Health Care Programs, Surveillance and Integrity Review Program)

[Minnesota Rules, 9506.0010 to 9506.0400](#) (MinnesotaCare)

[Code of Federal Regulations, title 42, section 435](#) (MA Eligibility)

[Code of Federal Regulations, title 42, section 440](#) (MA Services)

[Code of Federal Regulations, title 42, section 456](#) (MA Utilization Control)