

Service Delivery

MCO Contracts

The Department of Human Services contracts with prepaid MCOs to provide covered services statewide to enrollees with PMAP and MinnesotaCare. The PMHCP MCOs must accept all enrollees who choose or are assigned to their plan, if the enrollee resides in the geographic area designated in the MCO's contract.

MCO Marketing

The Department must give prior approval to all materials sent to PMHCP enrollees and potential enrollees, including marketing materials, member handbooks evidence of coverage and notices targeted specifically to PMHCP enrollees. The MCOs marketing practices must comply with provisions of MN Statute 62D.22, Subd. 8, and rules and regulations promulgated by the Commissioners of Commerce and Health. A MCO may use mass media advertising to inform MHCP recipients of the availability of medical coverage through their MCO.

New Enrollee Materials

- The PMHCP MCOs are required to provide the following materials to all new enrollees on or before the 15th day after the enrollment data is available:
 - Evidence of Coverage (EOC) which includes: specific information on benefits, exclusions, and limitations, and a description of how enrollee grievances and appeals are resolved, including the telephone number of the department or person handling grievances and appeals, and information on how to access the State fair hearing process.
 - A description of the enrollee's rights and protections as specified in 42 CFR 438.100
 - Cost sharing if applicable
 - Notice of open access of Family Planning Services and services prescribed by Minnesota Statute, Section 62Q.14
 - Information about providing coverage for prescriptions that are dispensed as written (DAW)
 - A statement informing enrollees that upon request they can obtain a EOC in the languages specified in Minnesota Statutes, Section 256B.69, Subd. 27 (Spanish, Hmong, Russian, Somali, or Vietnamese)
 - A description of how American Indian enrollees may directly access Indian Health Services and certain tribal providers and how such enrollees shall obtain referral services.
 - A description of how enrollees may access services covered under Medical Assistance, or for all programs, but that are not provided by the MCO.
 - A description of Medical Necessity for mental health services under Minnesota Statutes, Section 62Q.53
 - A provider directory which lists the providers within the MCO's network, including primary care providers, specialty providers and hospitals. The directory shall also indicate those current contracted providers who speak a non-English language and identify any contracted provider that is not accepting new patients. The provider directory shall include a phone number where an enrollee may call to verify or receive current information.
 - Member card identifying the recipient as an MCO enrollee and which contains an MCO telephone number to contact regarding coverage, procedures and grievances and appeals. The member card shall demonstrate that the enrollee is a recipient of Minnesota Health Care Programs, either by printing the enrollee's state PMI number on the card or by other reasonable means.
 - Description of how to access services including a 24-hour telephone number for medical emergency services.
 - A toll-free telephone number for the enrollee to call regarding MCO coverage and procedures.
 - A description of the MCOs Child and Teen Checkup (C&TC) program for preventive care for children.
 - A description of grievance, appeal and State fair hearing rights and procedures, including the MCOs internal grievance system procedures, the availability of an expert medical opinion from an external organization, the ability of internal grievance, appeals, and State fair hearings to run concurrently, and the availability of a second opinion within the MCO.
 - A description of the MCOs obligation to assume financial responsibility and provide reimbursement for medical emergency services, post stabilization services and out of area urgent care.
 - General descriptions of the coverage for durable medical equipment with the criteria and procedures for any service authorizations.
 - A description of the enrollee's right to request information about Physician Incentive Plans, including whether the prepaid plan uses a physician incentive plan that affects the use of referral services.
 - A description of the enrollee's right to request the results of an external quality review study. Section 4705(a) of the Balanced Budget Act of 1997

Changes in an MCO's Provider Network

The MCO must report to the state a possible material modification in its provider network within 10 working days from the date the MCO has been notified of the possibility that a material modification could reasonably occur but not less than 120 days prior to the effective date or within two working days of becoming aware of it, whichever occurs first. A material modification means 1) a change which would result in an enrollee having only three remaining choices of a primary care clinic within 30 miles or 30 minutes; or 2) a change which results in the discontinuation of a primary care clinic which is responsible for services for 1/3 or

more of the enrollees in the applicable area; or 3) a change which involves termination of a sole source service provider where the termination is for cause.

The MCO shall not make any substantive changes in its method of provider access unless approved in advance by the state. The MCO shall provide the same network of providers for all MA and MinnesotaCare enrollees.

The MCO shall make a good faith effort to provide written notice of the termination of a contracted provider to enrollee's who received their primary care from, or were seen on a regular basis by, that contracted provider. The MCO must update their Primary Care Network List (PCNL) as necessary to maintain accuracy, but not less than on a quarterly basis. The PCNL and all revisions must be submitted to the State along with a cover letter detailing the changes in the PCNL. DHS forwards a copy of the cover letter to the county managed care contact with that month's MCO monthly enrollment totals.

Reporting of Newborns

The MCO is no longer required to report newborn births to the county or MinnesotaCare. This section was deleted from the MCO contract effective 10/1/03.

Quality Improvement

Each MCO is required to have a quality assessment and performance improvement program as outlined in their contract with the Department. The MCO shall have an ongoing quality assessment and performance improvement program for the services it furnishes to all enrollees ensuring the delivery of quality health care. The MCO must incorporate into its quality assessment and improvement program the standards as described in 42 CFR 438, Subpart D:

- Access Standards
 - Availability of services
 - Assurances of adequate capacity and services
 - Coordination and continuity of care
 - Coverage and authorization of services
- Structure and Operation Standards
 - Provider Selection
 - Enrollee information
 - Confidentiality
 - Enrollment and Disenrollment
 - Grievance Systems
 - Subcontract relationships and delegation
- Measurement and Improvement Standards
 - Practice guidelines
 - Quality assessment and performance improvement program
 - Health information systems

The MCO must conduct an annual quality assessment and performance improvement program evaluation consistent with state and federal regulations, and current NCQA "Standards for Accreditation of Managed Care Organization." This evaluation must review the impact and effectiveness of the MCO's quality assessment and performance improvement program including performance on standardized measures and the MCO's performance improvement projects.

Both the Department and CMS (formerly HCFA) have the right to conduct an external quality of care audit.

Covered Services

MCOs shall provide, or arrange to have provided to PMHCP enrollees comprehensive preventive, diagnostic, therapeutic and rehabilitative health care services (as defined in Minnesota Statutes 256B.0625 and 256D.03 and Minnesota Rules 9505.0170 to 9505.0475. All covered benefits, except for services mandated by state or federal law, are subject to determination by the MCO of medical necessity. The MCO shall have the right, in its discretion, to pay for or provide alternative or additional health services if such services are, in the judgment of the MCO, medically appropriate and cost effective. The MCO understands that the provision of such services shall not affect the calculation of capitation rates. The MCO may not, however, provide additional or alternative services to enrollees in the MinnesotaCare Limited Benefit Set.

Approval by MCO

The MCO shall be responsible for the provision and cost of health care services as described above only when such services are deemed to be medically necessary by the MCO or recommended and/or approved by the MCO's physicians or case managers, or where otherwise mandated by state or federal law. The MCO is also responsible for services that are provided as emergency, post stabilization or urgent care that is out of the plan service area. The MCO is not responsible for services received from providers outside of the United States or Canada.

Prescription Drugs and Over-the-Counter Drugs

If the MCO chooses to have a drug formulary or policies which are more restrictive than the State's drug formulary or policies, the MCO shall provide any necessary drug at its own cost to enrollee's for whom the state intervenes, following the state's review by a pharmacist and physician. Some dispense as written (DAW) name brand prescriptions may require service authorization. Check with the MCO.

Indian Health Service and Tribal Providers

American Indian MA recipients, living on or off a reservation, will have direct out-of-network access to Indian Health Service (IHS) facilities and facilities operated by a tribe or tribal organization for services that would otherwise be covered under MN § Section 256B.0625, even if such facilities are not participating providers. The MCO shall not require any service authorization or impose any condition for an American Indian to access services at such facilities.

Abortion Services

Abortion services are covered under MA/NMED/MinnesotaCare in the following circumstances. The MCOs do not provide abortion services under their contracts. Abortion services are paid through the DHS fee-for-service payment system.

- The pregnancy resulted from rape
- The pregnancy resulted from incest
- The abortion is performed to prevent substantial and irreversible impairment of a major bodily function (MinnesotaCare only).
- Continuation of pregnancy would endanger the woman's life (MinnesotaCare only).
- The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition, caused by or arising from the pregnancy itself that would place the woman in danger of death, unless the abortion is performed. (MA only)
- The abortion is provided for other health/therapeutic reasons (MA only)

Care Management

The MCO's care management system must be designed to coordinate the provision of services to its enrollees and must promote and assure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, the provision of culturally appropriate care and fiscal and professional accountability. At a minimum, the MCO's care management system must incorporate the following elements:

- Procedures for the provision of an individual needs assessment, diagnostic assessment, the development of an individual treatment plan as necessary based on the needs assessment, the establishment of treatment objectives, the monitoring of outcomes, and a process to ensure that treatment plans are revised as necessary. These procedures must be designed to accommodate the specific cultural and linguistic needs of the MCO's enrollees.
- A strategy to ensure that all enrollees and/or authorized family members or guardians are involved in treatment planning and consent to the medical treatment.
- A method for coordinating the medical needs of an individual with his/her social service needs. This may involve working with local agency social service staff or with the various community resources in the county. Coordination with the local agency social service staff will be required when the individual is in need of the following services: case management for serious and persistent mental illness or seriously emotionally disturbed children, prepetition screening, preadmission screening or elderly waiver services, extended care or halfway house services covered by the Consolidated Chemical Dependency Treatment Fund, child protection, court ordered treatment, developmental disability services, assessment of medical barriers to employment, or a state medical review team or social security disability determination. It may also involve working with local agency social service staff or county attorney staff for enrollees who are victims or perpetrators in criminal cases. Except for preadmission screening for home and community based waiver services, if the MCO determines that an assessment is required in order for the enrollee to receive these services, the MCO is responsible for payment of the assessments, unless the requested assessment has been paid for by a MCO within the previous 180 days.
- Procedures and criteria for making referrals to specialists and subspecialists.
- Capacity to implement, when indicated, care management functions such as individual needs assessment, including screening for special needs (e.g. mental health/chemical dependency problems, developmental disabilities, high risk health problems, difficulty living independently, functional problems, language or comprehension barriers); individual treatment plan development; establishment of treatment objectives; treatment follow-up; monitoring of outcomes; or revision of treatment plan. The MCO shall coordinate with local human service agencies for assessment and evaluation related to judicial proceedings.
- For MinnesotaCare enrollees who are hospitalized, the MCO's responsibility for certifying the inpatient admission must include a medical necessity review of the entire confinement, not just the portion covered by the MCO.
- Procedures for coordinating care for American Indian enrollees.
- Procedures for coordinating individualized education plans (IEP) or individualized family service plans (IFSP), and supports for school age enrollees.
- Procedures for coordinating with care coordination and services provided by children's mental health collaborative and family services collaborative.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Child and Teen Checkups (C&TC) Program

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program is a federally mandated service under Title XIX of the Social Security Act. In Minnesota, the EPSDT Program is known as the Child and Teen Checkups (C&TC) Program. Children from birth through the age of 20 enrolled in Minnesota Health Care Programs (MHCP), Medical Assistance (MA) and MinnesotaCare, are eligible for the C&TC Program. The program services include: early screening of a child's health to prevent or detect conditions, disease, and disabilities; periodic screening of a child's health at critical points in physical and mental development; screening tests and procedures to determine further examination needs of a child; diagnostic tests and procedures to determine the nature and cause of identified conditions; treatment services that control, correct or reduce physical and mental health conditions. The C&TC benefit includes comprehensive and periodic preventive health screenings through approved schedules of age-related standards for medical and dental screenings. Refer to the [Schedule of Age-Related Screening Standards \(DHS-3379\) \(PDF\)](#) and the [Schedule of Age-Related Dental Standards \(DHS-5544\) \(PDF\)](#).

The purpose of the C&TC Program is to:

- Identify potential health problems or handicapping conditions;
- Provide diagnosis and treatment of those health problems or conditions; and
- Encourage the development of good health habits.

The C&TC components, which are currently required and must be performed in accordance with program standards specified in the Minnesota Health Care Program (MHCP) Provider Manual in the Child and Teen Checkups (C&TC) Section.

The MCO must:

- Report the results of the C&TC screening and any abnormal findings,
- Report one of the four HIPAA compliant referral codes on a C&TC claim, to the State on a monthly basis.
- Notify eligible enrollees and/or their families or guardians, of the availability of C&TC screenings at least annually.
- Provide and reimburse for all required screening components.
- Provide and reimburse for all medically necessary health care, diagnostic services, treatments and other measures, to correct or ameliorate defects and physical, mental, and other illnesses and conditions discovered by screening services, which are mandatory or optional MA-covered services.

The MCO may offer additional preventive health services beyond these minimal standards.

PMAP Transportation Costs Covered by MCOs

The MCOs, with the exception of Itasca Medical Care, PrimeWest Health System, and South Country Health Alliance, shall provide common carrier transportation to its enrollees for the purpose of obtaining health care services. Transportation services provided by the MCO to or from non-emergency health care services are reimbursed on a capitation basis. Enrollees in South Country Health Alliance, PrimeWest Health System and Itasca Medical Care, should contact their county financial worker for transportation services.

MA Reimbursement for Transportation Costs by County

The county is responsible for reimbursing the MA enrollee for private automobile mileage to non-emergency covered services, and meals and lodging as necessary, following the county's access plan. The MCO shall not be responsible for providing common carrier transportation in any situation where the enrollee has access to private automobile transportation. The county remains responsible for providing non-emergency transportation to medical services located outside of MN that have been approved by the MCO. MCO enrollees should be directed to their financial worker for assistance in receiving mileage reimbursement.

MinnesotaCare Reimbursement for Transportation

Common carrier transportation is available for MinnesotaCare/MA enrollees, i.e. children up to age 21 and pregnant women. Common carrier transportation is the transport of an enrollee by bus, taxicab, by other commercial carrier or by private automobile. MinnesotaCare will reimburse transportation costs to and from medical appointments. MinnesotaCare enrollee's should contact MinnesotaCare rep for information on obtaining transportation reimbursement. Reimbursement will be based on the least expensive form of transportation available.

MinnesotaCare Inpatient

Inpatient services are an inclusive service. Included are room and board charges, lab work, other tests, rehab, drugs, and operating room charges when services are provided and billed by the hospital. All of these services would be applied to a MinnesotaCare enrollee's \$10,000 annual inpatient limit.

Services that are not billed by the hospital are not considered part of the inpatient hospital bill. These are services that are billed separately by non-hospital providers for services such as physician and surgeon services provided in the hospital setting, labs, diagnostics, etc. These services would NOT be applied to a MinnesotaCare enrollee's \$10,000 annual inpatient limit.

Second Medical Opinion

A PMHCP enrollee is allowed a second medical opinion within his/her MCO. Service authorization for this service may be necessary. If an enrollee wishes to obtain a second medical opinion from a provider outside the plan, service authorization must be received from the MCO or the enrollee must assume responsibility for payment for the out-of-plan second opinion. When an out-of-plan second opinion is ordered by a Department State fair hearing Referee, the MCO must provide the second opinion at its expense.

Mental Health

State licensed MCO's are required to pay for a second medical opinion regarding the necessity of mental health services when it has determined that MH services should not be authorized. If the MCO or its provider determines that no type of structured treatment is necessary, the enrollee has the right to obtain a second opinion by a qualified health care professional who is not affiliated with the MCO. This second opinion must be paid for by the MCO. The MCO or participating provider must consider the second opinion but is not obligated to accept the conclusion of the second opinion. Consideration of the second opinion must be documented by the MCO or participating provider. (MN Statute 62D.103)

Chemical Dependency

If an enrollee who has received a CD assessment disagrees with the level of chemical dependency care proposed by the assessor, they have the right to request a second chemical use assessment. The county or the prepaid MCO shall inform the enrollee in writing of the right to request a second assessment at the time the client is assessed for a program placement. The county or MCO shall also inform the enrollee that their request must be in writing and be received by the county or the MCO within five working days of completion of the first assessment or before the enrollee enters treatment, whichever occurs first. The county or MCO must provide a second chemical use assessment by a different qualified assessor within five working days of receipt of a request for reassessment. If the recipient agrees with the second level of care determination, the county or MCO shall place the recipient in accordance with chemical dependency placement standards (Minnesota Rule 9530.6625 to 9530.6650) and the second assessment.

Copayments

There may be copayments for some covered services based on the benefit set. The MCO may delegate to the providers of these services the responsibility to collect the copayment. MCOs may not reduce or waive the copayment as an inducement to recipients or members to enroll or continue membership in the MCO.

Exclusions and Limitations of Service

The MCO is responsible for the provision and cost of health care services as described in Section 9.02.01 only when the MCO determines services are medically necessary or for mental health services that are court ordered. A MCO may not impose exclusions or limitations of services other than those set forth in Minnesota Statutes, Section 256B.0625 and 256B.69, Minnesota Rules, parts 9505.0170 to 9505.0475, or 9500.1450 to 9500.1464 under FFS MA and those exclusions specified in each MCO's contract.

Out-of-Network Services

The MCO must cover all medically necessary out of service area or out-of-plan services received by an enrollee when one of the following occurs:

- The enrollee requires services as a result of a medical emergency.
- The enrollee is outside the service area and requires urgent care.
- The enrollee is outside the service area and in need of non-emergency medical services that are or have been prescribed, recommended that are or currently being provided by a MCO physician, except that the MCO may require service authorization for these services.
- The enrollee moves out of the service area and this is entered on MMIS after the managed care enrollment cut-off date, and a payment has been or will be made to the MCO for coverage for the enrollee for that same or next month. The MCO shall reimburse any services provided by non-participating providers during the balance of the month or the month after which the enrollee has moved. The MCO may condition reimbursement of these out-of-plan services on the enrollee requesting MCO approval or service authorization to receive such services.
- The enrollee requires Post-Stabilization Care Services, to maintain, improve or resolve the enrollee's condition. The MCO shall continue coverage until; i) an MCO provider assumes responsibility for the enrollee's care; ii) the MCO reaches an agreement with the treating provider concerning the enrollee's care; iii) the MCO has contacted the treating provider to arrange for a transfer, or iv) the enrollee is discharged.
- The MCO service authorized the services;
 - The MCO did not service authorize the services because it did not respond to the request by the provider of Post-Stabilization Care Services for service authorization within 1 hour after the MCO was asked to service authorize care;
- The MCO could not be contacted to service authorize services;
 - Pregnancy-related services received in connection with an abortion.

Non-Covered Services

Services not covered by the MCO include the following:

- Claims arising from services provided by institutions operated or owned by the federal government, a state regional treatment center, a state-owned long term care facility or an institution for mental disease unless the services are approved by the MCO or in the case of mental health services ordered by a court for a service otherwise covered.
- Cosmetic procedures or treatment. (Services necessitated by accident, injury, illness or disease, or for treatment or repair of birth abnormalities are not considered cosmetic).
- All health care services not prescribed or recommended by a participating physician, dentist, case manager, other practitioner, or approved by the MCO (except as otherwise provided under contract).
- Incidental services which are not medically necessary (i.e., television rental, barber and beauty services, guest services).
- Mental health case management for persons with serious and persistent mental illness (SPMI) according to Minnesota Rules, Parts 9520.0900 to 9520.0926 and for children with severe emotional disturbances (SED) as defined in Minnesota Rules, Parts 9505.0322.
- Waivered services provided under home-based and community-based waivers, except for MSHO enrollees, who require services provided under the Elderly Waiver program in addition to home care services.
- Fertility drugs and procedures. Fertility drugs are not covered when specifically used to enhance fertility. The following procedures are also not covered: in vitro fertilization, artificial insemination, and reversal of a voluntary sterilization.
- Autopsies. MN Rule 9505.0220, Subpart D
- Adult Rehabilitation Mental Health Services (ARMHS) and Adult Mental Health Crisis Services.
- Gender reassignment surgery and other gender reassignment medical procedures including drug therapy are not covered unless they began such services prior to 07/01/98.
- Abortion Services
- Individual Education Plans and Individual Family Service Plans. Medically Necessary MA services that would otherwise be covered by this contract, identified in an enrollee's IEP or IFSP and provided by school districts are not covered.
- Experimental or investigative services.
- Rule 5 Facility Services. Enrollees needing Residential Treatment for Emotionally Disturbed Children (Rule 5) may obtain them from the local agency. The MCO is responsible for other medical costs while the child resides in the Rule 5 facility and remains in managed care.
- Out of country care. Emergency care or other health care services received from providers located outside the United States and Canada.

Authorization Prior to Payment

The MCO is exempt from Department authorization and second medical opinion procedures under Minnesota Rules, parts 9505.5000 to 9505.5105, and from certification for admission requirements under Parts 9505.0500 to 9505.0540. The medical necessity of services authorized under these rules prior to enrollment in the MCO must be evaluated by the MCO upon enrollment. The MCO will not bear financial responsibility for provision of these services, unless they are deemed medically necessary by the MCO. The MCO has the authority under Department contract to require authorization of certain services as determined by the MCO as long as enrollees are informed of the requirements. The certificate of coverage which is given to the recipient upon enrollment defines those services that require authorization. When the Department contracts with a MCO, they delegate the authority for authorization of services to the MCO. Each MCO may determine what services require authorization. Examples of services that frequently require service authorization are:

- Inpatient hospital care
- Certain durable medical supplies or equipment
- Orthodontics
- Hearing aids
- Mental health
- Physical or occupational therapy
- Home health nursing
- Transplants

The MCO cannot deny or limit coverage of a service which the enrollee has received solely on the basis of lack of service authorization, to the extent that the service would otherwise have been covered by the MCO had service authorization been obtained (MN Statutes, Section 62D.12, Subd. 19.)

Transitional Services

The MCO is responsible for care in the following situations:

Orthodontia Care

The MA or MinnesotaCare/MA enrollee, prior to enrollment in the MCO, is receiving orthodontia care that has been service

authorized by an out of plan provider or the State, that service has an established plan of care, and that care plan has a definitive end date. Payment to the prior provider must be at least equivalent to the State MA fee-for-service rate for orthodontia care. In the alternative, the MCO may transfer the Enrollee to a MCO provider, if such a transfer would not create undue hardship on the Enrollee, and is clinically appropriate.

High Risk Pregnancy

The recipient enrolls in the MCO while in her third trimester of pregnancy, and her nonparticipating physician has reported her pregnancy as high risk on the State prenatal risk assessment form. In this situation, the MCO must authorize the care by non-participating providers for services related to prenatal care and delivery, including inpatient hospital costs for the mother and child. The MCO need not authorize payment for services by a non-participating provider if the non-participating provider does not accept from the MCO the MA rate that would be paid if the enrollee was not enrolled in the MCO. As a condition of payment, the MCO must require the non-participating provider to agree in writing to refrain from billing the enrollee for any portion of the cost of the authorized service. The MCO may not offer a non-participating provider less than the comparable MA fee-for-service payment. The MCO is not responsible for additional out-of-plan care for the mother and child after discharge from the hospital.

CD Services

Chemical Dependency (CD) Treatment Services. CD treatment services do not include detoxification (unless it is required for medical treatment).

Effective for dates of service on July 1, 2014 and going forward, the MCO shall not be responsible for the payment of room and board services provided by residential chemical dependency treatment providers. Note: Effective for dates of service (DOS) on or after July 1, 2014, Minnesota Health Care Programs (MHCP) fee-for-service (FFS) covers free standing residential room and board (R&B) charges for members enrolled in managed care organizations (MCO).

For dates of service before July 1, 2014 the MCO is responsible for all CD treatment services including room and board determined necessary by the assessment identified in Minnesota Rules, Part 9530.6615.

Notwithstanding the medical necessity standard of the model contract CD treatment services shall be provided in accordance with 42 CFR § 8.12, and Minnesota Statutes, §§ 254B.04, subd. 2a and 254B.05, subd. 1.

MCO Billing

Continue to bill the following CD Services to the MCO:

- **Inpatient hospital services** (previously referred to as "hospital-based")
- Inpatient hospital per diem (treatment/R&B)
- Inpatient hospital treatment program service
- Inpatient hospital treatment R&B component only
- **Free standing residential treatment program services only**

For MCO billing questions, contact the [MCO](#) directly.

For Additional Resources:

[Chemical Health Room & Board Billing Change for MCO Enrollees](#)

[MHCP Enrolled Providers – Alcohol and Drug Abuse](#)

Mental Health Services

At the time of initial enrollment in PMAP, the MCO is required to consider the individual enrollee's prior use of mental health services and to develop a transitional plan to assist the enrollee in changing mental health providers, should this be necessary, and to develop a plan to assure the need for continuity of care for any individual or family who is receiving ongoing mental health services. The MCO is also required to develop a transitional plan for children who have previously been excluded from PMAP because they have been involved in the child protection system, placed in foster care, or diagnosed as severely and emotionally disturbed, or placed in a juvenile corrections facility. While excluded from PMAP, a treatment regimen may be initiated for those children who are assessed as having behavioral or other mental health problems. However, because the duration of the exclusion from PMAP will vary from one child to the next, some of these children may be enrolled in the MCO before their treatment program is completed. As part of this transition plan, the MCO should assure proper communication and coordination between the local social services agency and the MCO regarding the specific needs of each child.

Services Previously Authorized

The MCO shall provide enrollees medically necessary covered services that an Out of Plan provider, another MCO, or the state had service authorized before enrollment in the MCO. The MCO may require the enrollee to receive the services from a MCO provider, if such a transfer would not create undue hardship on the enrollee, and is clinically appropriate.

Enrollee Change of Major Program

When an enrollee changes major programs, ex. MinnesotaCare to MA, and the MCO does not have the same participating providers in that county under the new major program, an enrollee may choose to continue receiving services from the participating providers from the prior enrollment with the MCO. The MCO must notify any affected enrollee of his/her right to choose to remain with their original participating providers. Pharmacy For those enrollees who have identified themselves to the MCO or have been identified to the MCO by an appropriate representative, the MCO will continue payment of all drugs an enrollee is taking upon enrollment into the MCO, under a current prescription, until such time as a transition plan can be established by the MCO or 90 days, whichever occurs first.

Services to Nursing Facility Residents

In order to ensure continuity of medical care for nursing home residents, each MCO has designed special procedures as well as specific nursing home contact people at the MCO. If a medical service has been ordered by a MCO participating physician or dentist for an enrollee residing in a nursing facility, the MCO is responsible for covering the cost of the service required by the physician's or dentist's order.

MCO Coverage for Nursing Facility Services

MSC+ and MSHO:

For any individual age 65 or older who, at the time of enrollment in MSC+ or MSHO, was residing in the community and subsequently entered a nursing facility, the MCO is responsible for nursing facility (NF) services for the first 180 days. The 180 day benefit period begins at the time of the enrollee's date of admission to a Skilled Nursing Facility (SNF) or Nursing Facility (NF).

SNBC:

For any individual who, at the time of enrollment in SNBC, was residing in the community and subsequently entered a nursing facility, the MCO is responsible for NF services for the first 100 days. The 100 day benefit period will begin at the time of the Enrollee's date of admission to a (SNF) or (NF).

After the NF benefit has been exhausted by the MCO, the NF services are paid by MA on a fee-for-services basis.

180 Day Separation Period:

The NF liability period may be applied to an individual more than once even if the MCO has already been liable for SNF/NF services. For the MCO to be liable for additional NF services, a 180 day Separation period must be met. The separation period is defined as one hundred and eighty (180) consecutive community days after the MCO has already been liable for SNF/NF. After this separation period has expired, the MCO shall be liable for a new distinct SNF/NF benefit period for any enrollee who is residing in the community and enrolled in MSHO, MSC+ or SNBC. If an Enrollee becomes institutionalized prior to the end of the separation period, no new SNF/NF benefit period is applied.

Medicare SNF days

After the NF benefit period for MSHO or the SNBC integrated product (MA17) is expended, the MCO shall retain responsibility for Medicare SNF days according to Medicare SNF benefit policy.

Chemical Dependency (CD) Services

Each MCO has its own procedures for provision of MHCP covered services. Enrollees must contact their MCO first to find out how to access CD services through their MCO.

CD treatment services does not include detoxification (unless it is required for medical treatment), halfway house care, extended care and transition care. Notwithstanding the medical necessity standard, Section 6.24.2 of the model contract, CD services shall be provided in accordance with 42 CFR 8.12, and Minnesota Rules, Part 9530.6600 to 9530.6660, and by programs and facilities licenses under Minnesota Rules, Part 9530.5000 to 9530.6400, and Part 9530.4100 to 9530.4450.

The MCO provides all MHCP covered CD services through its network of providers except for non-medical CD services, e.g., half-way house, and extended care which are not considered MA covered services and are covered under the Consolidated Chemical Dependency Treatment Fund (CCDTF). In general, the MCOs cover the costs of primary treatment. If the MCO completes the required assessment and determines extended care or halfway house is needed, the enrollee should be referred to the county for the provision of treatment. The MCO should send a copy of the Rule 25 assessment to the county. Services that have been authorized by the CCDTF prior to the client's enrollment in a MCO will continue to be reimbursed by the CCDTF through the duration of the period authorized. After the authorization period expires, the MCO will be responsible for providing all medically necessary services. For enrollees who are in an inpatient hospital or a Rule 35 facility (i.e., extended care, halfway house or free-standing residential CD treatment facility [IMD]) at the time of enrollment in the MCO, the effective date of the enrollment will be delayed until the month following the enrollee's discharge from the CD facility.

Court Ordered Treatment

Payment for Court-ordered Mental Health Services

The MCO must pay for court-ordered mental health services under the following circumstances:

- The services are otherwise covered by the plan; and
- The court's order is based on a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. This court-ordered coverage must not be subject to a separate medical necessity determination by a MCO under its utilization review procedures. The MCO must pay for the clinical evaluation used by the court if it is performed by an MCO participating provider. The MCO, however, may make a motion for a modification of the court ordered plan of care.

The MCO must provide a 24 hour telephone number answered in person that a local agency may call to get an expeditious response to situations involving the MCO's enrollees when court-ordered treatment and disability certification are involved. As soon as a county or mental health provider becomes aware that a client may need court-ordered services, the agency should contact the person's MCO. In some cases, the plan may be willing to pay for services which would not otherwise be covered if the plan determines that the services may be a cost-effective alternative to covered services. The MCO should participate in the prepetition screening and commitment process to help develop an individual treatment plan for care in the most appropriate, least restrictive environment.

Third Party Coverage

Third party coverage refers to any private health care benefits available to a PMHCP enrollee. Other coverage can be, but is not limited to:

- Hospitalization insurance (e.g., Blue Cross/Blue Shield)
- Health Maintenance Organization (HMO) (a licensed, regulated health care organization)
- A non-regulated health care organization, e.g., preferred provider organization (PPO)
- Medical and/or hospital costs for which an absent parent is legally responsible Note: An MA applicant who would normally be mandated to enroll in a MCO but has private coverage through a State certified HMO is excluded from participation in the PMHCP program. MA applicants who are excluded from the PMHCP as stated above may volunteer to participate if their private HMO is the same as their PMHCP HMO. An MA recipient with cost-effective employer sponsored private health insurance or enrolled in an individual health plan determined to be cost effective AND for whom the county or State is paying an insurance premium is excluded from participation in the PMHCP. The worker will code "HH" exclusion on the MMIS RPPH screen to indicate that a person has other HMO coverage.

Coordination of Benefits

For enrollees who have private health care coverage, the MCO must coordinate benefits in accordance with Minnesota Rules, Part 9505.0070, and Minnesota Statutes, section 62A.046. Coordination of Benefits includes paying any applicable copayments or deductibles on behalf of an enrollee, except for MinnesotaCare or Medical Assistance copays. For enrollees who are also eligible for Medicare, coordination of benefits includes paying any applicable copayments, coinsurance or deductibles on behalf of an enrollee up to the Medicare allowed amount.

The MCO will cost avoid all claims or services that are subject to third-party payment, and may deny a service to an enrollee if the MCO is assured that a third party (i.e., other insurer) will provide the service. The MCO must determine whether it is more cost-effective to provide the service, or pay copays, coinsurance and deductibles to a non-participating provider. If the MCO refers an enrollee to a third-party insurer for a service which the MCO covers, and the third-party insurer requires payment in advance of all copayments, coinsurance and deductibles, the MCO shall make such payments in advance or at the time such payments are required.

For prenatal care services, preventive pediatric services and services provided to a dependent covered by health insurance pursuant to a court order, the MCO must ensure that services are provided without regard to insurance payment issues, even if the MCO must provide the service first and then coordinate payment with the potentially liable third party.

Education of Recipients Regarding Coordination of Benefits

The county must ask consumers about private health care coverage including Medicare supplementary coverage (Medi-Gap). Workers must enter this information in the TPL Resource File which is a subsystem of MMIS. The consumer education process for recipients who will be enrolled in a PMHCP MCO and also have private health coverage, must include an explanation of Coordination of Benefits (COB).

The consumer education process should cover the following points about COB:

- Enrollees who have private health care coverage must inform both the MCO and their private insurer of their other health coverage. The PMHCP MCO will determine which network the enrollee should access service through.
- An enrollee will need to notify their worker when there is any change regarding private insurance coverage.
- The private coverage including Medicare and Medicare supplement is considered the primary coverage. The PMHCP MCO is the secondary coverage.

- The above policy also applies to enrollees who have Medicare supplement (i.e. Medi-Gap coverage). Enrollees who have Medicare supplemental coverage through a licensed HMO under Minnesota Statute 62D will be excluded from the PMHCP. Enrollees who have a Medicare supplement through a PMHCP MCO may volunteer for the PMHCP if they enroll in the same MCO as their Medicare supplementary MCO unless the supplementary policy is considered cost effective, in case they must be excluded from PMHCP.

Cost Effective Insurance

Currently the Department evaluates the cost effectiveness of Department payment of the premium for private health insurance. Cost effective insurance is coverage which provides services at a lower premium than the costs DHS would incur if the client was not enrolled in the coverage. In determining cost effectiveness, several factors are examined, including a comparison of the cost of health care services with premium costs, and the availability of coverage in the event the consumer becomes ineligible for MA. The Department uses the same criteria for determining cost effectiveness of private health care coverage for PMHCP enrollees as for FFS clients. Enrollment in a MCO rather than participation in FFS has no bearing on the Department's determination of cost effectiveness.

Provider Billing of PMAP Enrollees

Providers must verify the enrollment status of all recipients before providing non-emergency services. Providers can verify the recipient's MHCP eligibility using the Eligibility Verification System (EVS). No claims will be paid for an ineligible recipient. Enrollees who present a MCO card must be referred to providers affiliated with that plan, except in emergency situations, unless the provider has special arrangements with the MCO to serve the enrollees. If there is any doubt about an enrollee's enrollment status, providers should contact the appropriate MCO. Providers may bill MCO enrollees for health services that have been provided under the following circumstances:

Non-covered services: a provider who furnishes a recipient a non-covered service may request that the recipient pay for the non-covered service if the provider informs the recipient of their potential liability before providing the service, MN Rules 9505.0225, subpart 3 and MN Rules 9505.0190. DHS encourages providers to use a written notification form that includes the service in question, the date, and recipient's signature attesting they understand they may be billed. Non-covered services are defined:

- Services that are not covered under Minnesota Statutes 256B.0625, and MN Rules parts 9505.0170 to 9505.0475.
- Services provided to a recipient by a non-participating provider without authorization from the recipient's MCO.

Providers have the right to legally pursue payment from a PMHCP enrollee in the above situations, but if a provider obtains a legal judgment, it cannot be enforced until six months after an MA enrollee is no longer receiving public assistance, in accordance with Minnesota Statute 550.37, Subd. 14. Enrollees should be aware that:

- It is the enrollee's responsibility to establish exemption from the enforcement of a judgment against them by obtaining a letter from the responsible county which verifies the enrollee's public assistance status.
- Non-payment of a claim by a PMHCP MCO is appealable. Enrollees who are successful in their appeal may avoid civil action against them.
- Enrollees who become involved in such payment issues should be advised to seek legal assistance. An MA provider cannot request payment or attempt to collect payment in whole or in part from a PMHCP enrollee for a covered service. A covered service is defined as a service covered under Minnesota Statutes 256B.0625, parts 9505.0170 to 9505.0475, and provided to an enrollee by a participating or by a non-participating provider when authorized by the enrollee's MCO. Health care services not prescribed or recommended by a participating physician, dentist, case manager or other practitioner or approved by the MCO are considered to be non-covered services.

Provision of Services for Incarcerated Persons

Incarcerated persons are not eligible for Medical Assistance and will not be enrolled in a MCO. Medical Assistance recipients enrolled in a PMAP MCO prior to incarceration will be dis-enrolled from the PMAP MCO upon termination of MA eligibility.

MA Eligibility and MCO Enrollment

PMHCP enrollees who are placed in an Institution for Mental Disease (IMD) by the MCO or court order, and the court order is for a service covered under the MCO contract, regardless of age, remain eligible as long as they are part of a participating population. If an IMD resident becomes certified as disabled, he/she is disenrolled from the MCO on the first of the month following notification of the change in eligibility status. Otherwise, persons placed for treatment in an IMD by the MCO or court order remain eligible and remain enrolled in the MCO. PMAP enrollees who convert from MA to Program IM eligibility must be disenrolled from the prepaid MCO on the first of the month following the change in eligibility. If MA eligibility is restored after discharge from the IMD, the recipient is re-enrolled in the MCO.

MCO Coverage for IMD Services

PMAP waivers allow MCOs to cover treatment in a free standing mental health (MH) and chemical dependency (CD) facility as a cost effective alternative to treatment in an inpatient hospital setting. If a MCO places an enrollee in an IMD for treatment, the

MCO is responsible for covering treatment costs, including both treatment program costs and room and board costs, for MH and CD diagnoses.