Chapter 2

Health Care Programs and Services

The Minnesota Department of Human Services (DHS) ensures basic health care coverage for low-income Minnesotans through the major publicly subsidized health care assistance programs. IMCare is contracted with DHS to provide health care coverage through the programs listed below:

1. Medical Assistance (Medicaid)
2. MinnesotaCare
3. Minnesota Senior Care Plus (MSC+)
4. IMCare Classic (HMO SNP), IMCare's Minnesota Senior Health Options (MSHO) program for members with both Medicaid and Medicare through IMCare

This chapter outlines specifics for each major program and sub-program, including eligibility, covered services, and service limitations. This chapter also outlines Minnesota's Waivered Services Programs and the Minnesota Restricted Recipient Program (MRRP).

Definitions

Copay: A pre-determined sum for which an IMCare member is responsible to offset the overall costs for services. Copays are to be paid by the IMCare member to the provider. Copay amounts for IMCare members are determined by the Minnesota Legislature and may change. Refer to the *Spenddowns and Copays* section in Chapter 4, Billing Policy, and the *IMCare Copay Guidelines* section below for additional copay information.

Cost Sharing: Amounts an IMCare member may be responsible to pay for his/her health care services. Cost sharing amounts include deductibles and copays.

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 and/or result in serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

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

Eyeglasses: Complete frames and lenses.

Family Planning Services: A family planning supply or health service, including screening, testing, and counseling for sexually transmitted diseases, such as human immunodeficiency virus (HIV), when provided in conjunction with the voluntary planning of the conception and bearing of children and related to a member'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.

Federal Poverty Guidelines (FPG): A means by which the Federal government measures and evaluates eligibility for publicly subsidized health care and cash programs administered by each state.

Institution for Mental Disease (IMD): A residential facility with 17 or more beds that is primarily engaged in providing diagnoses, treatments, and care, including medical attention, nursing care, and related services, to those with mental diseases.

Medical Institution: A hospital, nursing facility, Regional Treatment Center (RTC), IMD hospital, or Intermediate Care Facility for the Developmentally Disabled (ICF/DD).

Non-Preventive Visit: An episode of service which is required because of a member's symptoms, diagnosis, or established illness.

Preventive Medicine Services: Services that help members stay healthy. These include the following Current Procedural Terminology (CPT) codes:
1. 99381 – 99429; or
2. 99201 – 99215

Spenddown: Some people who have more income than the Medical Assistance (Medicaid) 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 IMCare payment can be made. Refer to the *Spenddowns and Copays* section of Chapter 4, Billing Policy, for additional information.

Or

"Spenddown" means the process by which a person who has income in excess of the income standard allowed under MN Rules part 9505.0065, subp. 1 becomes eligible for Medical Assistance (Medicaid) as a result of incurring medical expenses that are not covered by a liable third party and that reduce the excess income to zero (MN Rules part 9505.0015, subp. 44).

Medical Assistance (Medicaid)

Medical Assistance (Medicaid) is the largest of Minnesota's publicly funded health care programs, providing coverage for people with low incomes, people age 65 or over, and people who have disabilities.

People apply for Medical Assistance (Medicaid) through their local county human service offices or MNSure. Most of those enrolled get their health care through health plans. The remaining get care on a fee-for-service basis, under which providers bill the State directly for services provided.

Medical Assistance is Minnesota's Medicaid program. It is jointly funded with State and Federal funds. DHS oversees the program statewide. The Federal Centers for Medicare & Medicaid Services (CMS) oversees Medicaid nationally.

Eligibility for Minnesota Senior Care Plus (MSC+)

Managed care members ages 65 or over who do not choose or qualify for enrollment into Minnesota Senior Health Options are eligible for MSC+. Most seniors enrolled in Medical Assistance (Medicaid) managed care receive their health care through MSC+ health plans. MSC+ includes all Medicaid benefits, as well as Elderly Waiver (EW) services and coverage of 180 days of nursing home care.

To see benefits by member group, refer to the Evidence of Coverage documents.

Eligibility for IMCare Classic (HMO SNP) (MSHO)

Enrollment is voluntary. People who are eligible for Medical Assistance (Medicaid) may enroll in IMCare Classic if they meet all of the following:

1. Are age 65 or over
2. Are Medical Assistance (Medicaid)-eligible
3. Have both Parts A and B Medicare
4. Reside within the service area

To see benefits by member group, refer to the Evidence of Coverage documents.

MinnesotaCare

MinnesotaCare is a publicly subsidized program for Minnesota residents who do not have access to affordable health care coverage.

Most enrollees pay a monthly premium, determined by a sliding-fee scale based on family size and income.

All health care services are provided through health plans. People can choose their health plan from those serving MinnesotaCare enrollees in their county.

Applications can be sent to the State MinnesotaCare office or certain county offices that also administer the program, or filled out on the MNSure website.

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
PO Box 64838
Saint Paul, MN 55164-0838

Phone: **1-800-657-3672** (toll free) or **1-651-297-3862**

Eligibility for MinnesotaCare

1. People may be eligible for **either** MinnesotaCare or Medical Assistance (Medicaid), but **cannot** have coverage from **both** programs at the **same** time, with certain time-limited exceptions (for example, certain abortion services). This does not apply to one-month Medical Assistance (Medicaid) retroactive eligibility related to a hospital stay.
2. MinnesotaCare members are no longer required to apply for Medical Assistance (Medicaid) when they are admitted to a hospital. MinnesotaCare members who have expenses not covered by MinnesotaCare may apply for Medical Assistance (Medicaid) if they choose.
3. A Service Authorization is required before reimbursement. IMCare may not reimburse providers when a member has gone outside of the IMCare network, unless it is for family planning services (including sterilization, abortion services, and pregnancy related services in conjunction with an abortion).

MinnesotaCare Benefit Sets and Benefit Limits for Inpatient Hospital

MinnesotaCare enrollees receive one of the following two benefit set options:
1. **MinnesotaCare Child** (Program LL): Children (to age 21). Some procedures/hospitalizations require Service Authorization
2. **MinnesotaCare (Program BB, FF, or JJ): Adults without children, parents, and caretakers.**

To see benefits by member group, refer to the

Incarcerated Members

In general, adults who are incarcerated in detention or correctional facilities are not eligible for IMCare.

IMCare members, regardless of age, are ineligible for coverage while they reside in the following correctional facilities:
1. City, county, State and Federal correctional and detention facilities for adults, including, inmates who are:
   a. In a work release program that requires they return to the facility during non-work hours
   b. 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
   c. Sent by the court or penal institution to a chemical dependency (CD) residential treatment program while serving a sentence and are required to return to the correctional facility after completing treatment
2. Secure juvenile facilities licensed by the Department of Corrections (DOC) that are for holding, evaluation, and detention purposes
3. State-owned and operated juvenile correctional facility
4. 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.

Notification that a member is incarcerated may not be received by IMCare until after the member's eligibility was determined. In those cases, IMCare will notify the county financial worker and eligibility will be updated for the next month as needed.

When an incarcerated member is covered by other health insurance, the health care provider must bill that insurance before submitting the bill to the appropriate county or DOC for reimbursement. If the member is enrolled in IMCare on the date of service, bill the Minnesota Department of Human Services (DHS) for inpatient services. See Chapter 14, Hospital Services, for details on billing these services. Providers should contact the appropriate county jail or correctional facility regarding how to bill for any outpatient services that were provided.

Waivered Services Programs (Available to MSC+ and IMCare Classic Members Only)

Waivered Services are programs that have received Federal approval for expanded coverage of services to Medical Assistance (Medicaid) members that are not usually covered by Medical Assistance (Medicaid). IMCare provides services under the EW program for eligible members ages 65 and over.

Services included under EW are:

1. Adult Day Care
2. Adult Day Care Bath
3. Customized Living (CL)
4. 24-Hour CL
5. Caregiver Training and Education
6. Case Management
7. Case Management Aide
8. Consumer-Directed Community Supports (CDCS)
9. Chore Services
10. Companion Services – Adult
11. Corporate Foster Care (Monthly)
12. Environmental Modifications/Adaptations
13. Family Foster Care (Monthly)
14. Home Delivered Meals
15. Homemaker Services
16. Modification & Adaptations
17. Non-Medical Transportation
18. Residential Care
19. Respite Care
20. Specialized Supplies & Equipment
21. Transitional Supports

Refer to Chapter 26, Home and Community Based Services (HCBS) Elderly Waivers for additional information about the Waivered Services programs.

Complex Case Management

Case management is a support service offered to eligible IMCare members and refers to the coordination of health services on behalf of a member. IMCare contracts case management to the Itasca county Public Health and Human Services agency. Case managers play an important role in a member's health; they may be nurses or social workers and may accompany members to their health care provider appointments. They can also assist members with the following:

- Arranging for, getting, and coordinating assessments, tests, and health and continuing care services
- Developing and updating member care plans
- Communicating with a variety of agencies and people
- Disease management programs
- Other services as outlined in member care plans

Case managers are automatically assigned to members age 65 and over and to members enrolled in IMCare Classic (HMO SNP), one of our programs for people with disabilities. However, members always have the right to refuse case management. To find out if a member has case management or to contact his/her county case manager, call our Member Services at **1-800-843-9536** (toll free).

Care Coordination

Care coordination is a process that links members to services and resources in a coordinated effort to provide members with optimal health care.

If you know a member who would benefit from care coordination services, please call our Member Services at **1-800-843-9536** (toll free).

Copays

IMCare Copay Guidelines

1. Medical Assistance (Medicaid) and MinnesotaCare members are responsible to pay copays to providers.
2. Providers are responsible to collect copays from IMCare members.
3. Payment to providers will be reduced by the amount of the copay, except that payment for prescription

drugs will not be reduced after a member has reached the monthly maximum listed on the coverage chart.
4. Providers serving IMCare members should contact IMCare regarding the providers' contractual requirements.

The following chart applies to adults with Minnesota Care coverage:

Service	Copay Amount
Non-preventive office visit	$15
Ambulatory Surgery	$50
Emergency room visit	$50
Eyeglasses	$25
Inpatient hospital	$150 per admission
Outpatient hospital service	$25 per visit
Radiology (one copay per visit, regardless of the number of procedures)	$25 per visit

Prescriptions	Copay Amount
Generic drugs	$6 per prescription
Brand name drugs	$20 per prescription
Maximum out of pocket for prescription drugs (includes both generic and brand name drugs)	$60 combined maximum per month

Inpatient hospital admission copays include both mental health and chemical health admissions. The copay limit includes 1 copay per admission, per recipient, per treating provider.

Any emergency room visit will be assessed a copay. There is no longer a distinction between non-emergency services and emergency services.

Copay limits for all services follow the same general rule of one copay per day, per recipient, per treating provider. For example, if a recipient had an X-ray performed at a non-preventive office visit within the same day, the $25 (radiology) copay and the $15 (non-preventive visit) copay would be assessed.

Copays are **not** required for the following services:
1. Preventive services
2. Chemical dependency treatment
3. Mental health office visits
4. Dental services
5. Family planning services
6. Certain prescriptions used to treat mental illness
7. Services provided to American Indians through the Indian Health Services (IHS), an Indian health care provider contracted with IHS, an Indian tribe, a tribal organization, or an urban Indian organization

Copays for IMCare Members Enrolled in a Prepaid Health Plan

1. IMCare Medical Assistance (Medicaid) and MSC+ members may be required to pay copays.
2. IMCare MinnesotaCare members must pay any copays that apply in their benefit sets.

Member Inability to Pay IMCare Copays

Federally funded Medical Assistance (Medicaid) members 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 members who are unable to pay copays. A provider must accept a member's assertion that he/she is unable to pay a copay and cannot require additional documentation of inability to pay.

Providers must allow members time to pay their copays.

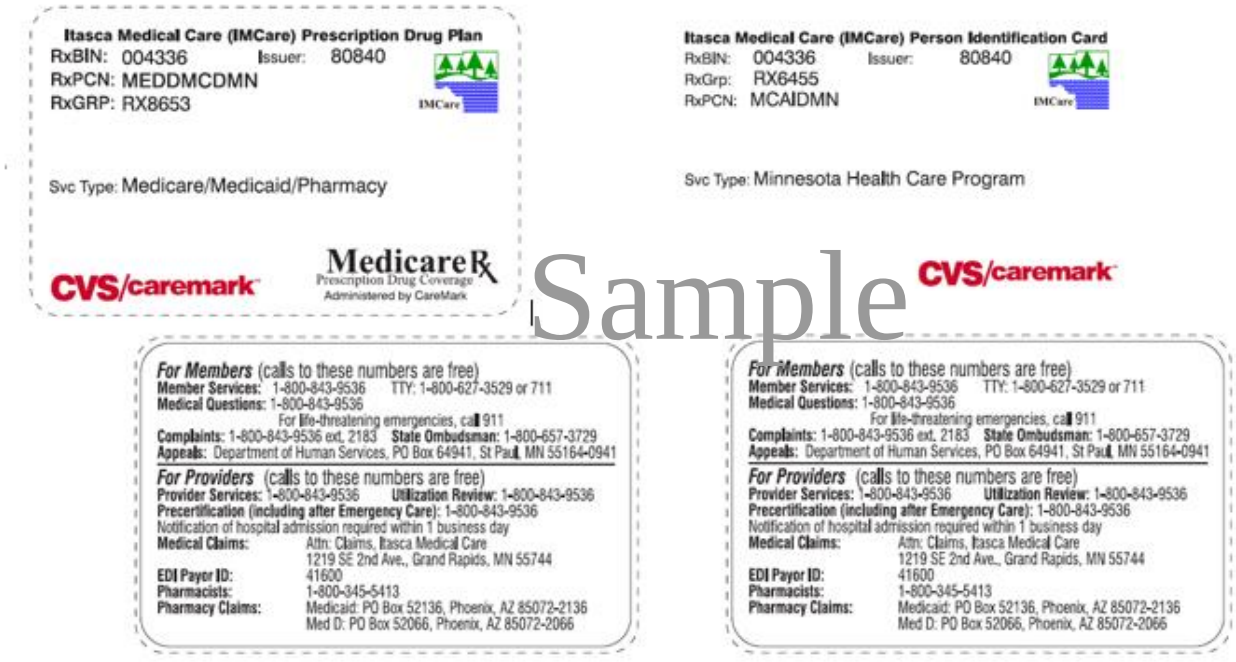
When a member has a copay obligation, IMCare will pay only the allowable minus the copay.

Member IMCare Identification (ID) Numbers and Cards

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

1. All member IMCare ID cards are issued in the same format and contain the same general information.
2. IMCare ID numbers do not change and follow members through any changes in program, eligibility, or address.
3. If approved for one of the health care programs, each member of a household is issued his/her own individual IMCare ID card.
4. The IMCare ID card does not include information about spenddowns, other health insurance coverage, Medicare coverage, or member restriction.
5. Verify eligibility each month for each member or on the day service is rendered
   A. HealthX. Prior registration is required using by calling 1-800-843-9536, extension 2157
   B. IMCare Provider Contact Center: **1-800-843-9536, ext 2133** (toll free) DHS Minnesota Information Transfer System (MN-ITS) web portal
   C. DHS Enrollment Verification System (EVS) Line: 1-651-431-2700 or 1-800-657-3613 (toll free)
6. Members within the same family may have multiple versions of the card.

IMCare Identification (ID) card



Covered Service Requirements

In order to be covered, a health service must be determined by prevailing community standards or customary practice and usage to be all of the following:

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

To see benefits by member group, refer to the Evidence of Coverage documents.

For information regarding out-of-country care, refer to Chapter 5, Service Authorization.

Minnesota Restricted Recipient Program (MRRP)

The purpose of the Minnesota Restricted Recipient Program (MRRP) is to identify IMCare members 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 members 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

The IMCare case manager/care coordinator conducts investigations to determine if:

1. A fraud, theft or abuse situation exists and can be supported by documentation;
2. Sufficient justification exists to support restricting a member to a primary care physician and/or other designated providers; and/or
3. Sufficient evidence exists to support the imposition of other sanctions.

Abuse: In the case of a member, the use of health services that results in unnecessary cost to IMCare or in reimbursement for services that are not medically necessary. The following practices are deemed to be abuse:

1. Obtaining equipment, supplies, drugs, or health services that are in excess of IMCare limitations, or that are not medically necessary and that are paid for by IMCare
2. 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 member's condition or required under IMCare rule, or a service provided by a school district as specified in the member's individualized education plan under MN Stat. sec. 256B.0625, subd. 26.
3. Continuing to engage in practices that are abusive of the program after receiving a written warning from IMCare that the conduct must cease
4. Altering or duplicating the IMCare ID card for the purpose of obtaining additional health services billed to IMCare
5. Using a IMCare ID card or ID number that belongs to another person, or allowing others to use their IMCare ID card or ID number to obtain services, drugs, or equipment
6. Using the IMCare ID card to assist an unauthorized individual in obtaining a health service for which IMCare is billed
7. Duplicating or altering or falsifying prescriptions
8. Misrepresenting material facts as to physical symptoms for the purpose of obtaining equipment, supplies, health services, or drugs

9. Furnishing incorrect eligibility status or information to a provider
10. Furnishing false information to a provider in connection with health services previously rendered to the member that were billed to IMCare
11. Obtaining health service by false pretenses
12. Obtaining health services that are potentially harmful to the member
13. Repeatedly obtaining emergency room (ER) health services for non-emergency care
14. 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 Members

The IMCare case manager/care coordinator may impose administrative sanctions against members for the use of health services that result in unnecessary costs to IMCare or in reimbursements for services that are not medically necessary.

Sanctions against Members

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

A member may be given an additional 36 months of restricted status if patterns of program abuse continue and are supported by documentation.

Notification and Member Rights to Appeal

IMCare must notify members in writing of any sanctions to be imposed. A member may Appeal any sanction proposed by IMCare.

Managed Care Organization (MCO) Restriction Status

IMCare and DHS have developed universal restriction, which is put in place by either IMCare or DHS and stays in effect for the entire period of restriction, regardless of whether the member:
1. Changes health plans;
2. Moves from fee-for-service to IMCare; or
3. Moves from IMCare to fee-for-service.

When IMCare restricts a member, IMCare must fax the following information to MRRP at **1-651-431-7422**:
1. Name and IMCare ID number of the restricted member;
2. Name(s) and IMCare ID number(s) of the provider(s) to whom the member is restricted;
3. The date span of the restriction; and
4. The reason codes for the restriction.

Denial, Termination, or Reduction (DTR) of Benefits Notice

For members enrolled in IMCare, 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 member. Placement in MRRP is not grounds for a DTR.

Obtaining Restriction Information

Providers may obtain information about the types of services to which a member is restricted by verifying eligibility (by phone at **1-800-843-9536** [toll free], through HealthX the provider web portal, or through MN–ITS). Typically, a member is restricted to one primary care physician, pharmacy, and hospital. A member may also be restricted to other designated providers or referred by the primary care physician to other providers, if appropriate. Members may receive services that are not subject to restriction from any enrolled IMCare provider. Long-term care facility (LTCF) services are not subject to restriction.

Selection of Providers by MRRP

A member placed on restriction is required to select a primary care physician, hospital, and a pharmacy to coordinate his/her care. If the member fails to choose providers, IMCare will assign providers based on considerations of geographic proximity, the member's prior experience with a specific physician, and the physician's willingness to provide health care services.

Members may be restricted to physician assistants (PAs) and nurse practitioners (NPs); however, if a member is restricted to a PA, IMCare will restrict the member to the primary care provider the PA works under. IMCare can restrict the member to an NP if the NP has privileges at the member's assigned hospital.

Responsibilities of the Primary Care Physician

Any physician enrolled as a general practitioner, internal medicine, or family practice physician may be selected by the member as his/her primary physician. The primary care physician will be asked to review each member's profile of utilization, develop an appropriate care plan, and authorize referrals. To participate as a primary care physician, the physician must be enrolled as an IMCare 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 IMCare or by the physician's professional licensing board. The commissioner also may limit the number of members restricted to an individual primary care physician.

Medical Referral for the Minnesota Restricted Recipient Program (MRRP)

The primary care physician must complete a ***IMCare Authorization Request*** form as soon as a member is referred to another physician for care. This information is necessary for the referring provider's claim(s) to be processed in a timely manner.

Emergency Services

Emergency health care services may be provided to a IMCare member 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. IMCare 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 IMCare requirements (such as authorization, second surgical opinion, program limitations, etc.).

Claims Reimbursement

Services provided to a IMCare member will be reimbursed when:
1. The service is provided by the member's primary care physician or his/her designee;
2. The primary care physician has submitted a IMCare Authorization Request form as soon as a recipient is referred to another physician for care; or
3. The service is of a provider or service type that is not listed as restricted on the member's file.

Discharging an IMCare Member

If a provider chooses to discontinue care for an IMCare member, the provider must notify IMCare and the member in writing, providing a 30-day notice that includes the effective date and reason. IMCare is obligated to ensure that members have access to medical care. IMCare will furnish the member with names, addresses, and telephone numbers of other participating providers in the same area of medical specialty, and an IMCare case manager/care coordinator will assist the member in locating a new medical home.

A provider may discharge a member for any of the following reasons:
1. The member behaves in a manner that seriously impairs the provider or the provider's ability to furnish health care services to the member or to other members
2. The member is uncooperative or abusive toward the provider
3. The member incurred unpaid bills before enrollment with IMCare

Reporting Suspected Misuse of Services or Requests for Additional Information

To report actual or suspected fraud, abuse, or misutilization of service by an IMCare member, or for questions regarding IMCare's Restricted Recipient Program (RRP), call **1-800-843-9536** (toll free).

For other questions regarding MRRP, call **1-651-431-2648** or **1-800-657-3674** (toll free).

Legal References

MN Stat. sec. 256B.02 – Definitions
MN Stat. secs. 256B.055 – 256B.061 – Medical Assistance for Needy Persons: Eligibility
MN Stat. sec. 256B.0625 – Covered Services
MN Stat. sec. 256B.0625, subd. 26 – Covered Services: Special education services
MN Stat. sec. 256B.0631 – Medical Assistance Co-Payments
MN Stat. secs. 256L.01 – 256L.15 – MinnesotaCare
MN Stat. sec. 256L.03 – Covered Health Services
MN Rules parts 9505.0010 – 9505.0140 – Medical Assistance Eligibility
MN Rules part 9505.0065, subp. 1 – Income
MN Rules parts 9505.0170 – 9505.0475 – Medical Assistance Payments
MN Rules parts 9505.2160 – 9505.2245 – Surveillance and Integrity Review Program
Title 42 Code of Federal Regulations (CFR) Part 435 – Eligibility in the States, District of Columbia, the Northern Mariana Islands, and American Samoa
42 CFR 440 – General Provisions
42 CFR 456 – Utilization Control