

NOTE: Due to the State of Minnesota's legislation, coverage for General Assistance Medical Care (GAMC) is switching from Health Plan coverage to Fee-For-Service coverage on April 1, 2010.

Chapter 16

Restricted Recipient Program

Program Overview

The Restricted Recipient Program (RRP) is a program developed by the Minnesota Department of Human Services for recipients who have failed to comply with the requirements within the Minnesota Rule 64. Placement in the RRP does not apply to services in long term care facilities and/or members covered by Medicare.

RRP identifies members who have used services at a frequency or amount that is not medically necessary and may be deemed as abusing the system and/or accessing medical services that are potentially harmful to the recipient.

Initially, members may be placed in the RRP for a period not to exceed 24 months of enrollment to a Minnesota Health Care Program (MHCP). During this period of time the member's health services will be limited to a designated primary care provider or other designated health service provider, including pharmacy and hospital, except in an emergency service need. After the initial 24 months of restriction, members will be reviewed and may be continued in RRP for an additional 36 months.

Misuse of Medical Services

Abuse of medical services is defined by the Department of Human Services as the use of health services that result in unnecessary costs to the programs or in reimbursements for services that are not medically necessary.

Members' behavior based on statute 9505-2165 subp. 2 Part B

- Obtaining equipment, supplies, drugs, or health services that are in excess of program limitations or that are not medically necessary and that are paid for through the program.
- Obtaining duplicate or comparable services for the same health condition from a multiple number of vendors, such as going to multiple pharmacies or physicians. Duplicate or comparable services do not include an additional opinion that is medically necessary for the diagnosis, evaluation, or assessment of the recipient's condition or required under program rules, or a service provided by a school district as specified in the recipient's individualized education plan under Minnesota Statutes, section 256B.0625, subdivision 26:
- Continuing to engage in abusive practices after receiving a written warning.
- Altering or duplicating the medical identification card for purpose of obtaining additional health services or aiding another person to obtain such services.
- Using a medical identification card belonging to another person.

- Using an identification card to assist an unauthorized individual in obtaining a health service for which a program is billed.
- Duplicating or altering prescriptions.
- Misrepresenting material facts as to physical symptoms for the purpose of obtaining equipment, supplies, health services, or drugs.
- Furnishing incorrect eligibility status or information to a vendor.
- Furnishing false information to a vendor in connection with health services previously rendered to the recipient which were billed to a program.
- Obtaining health services by false pretenses.
- Repeatedly obtaining health services that are potentially harmful to the recipient.
- Repeatedly obtaining emergency room health services for nonemergency care.
- Repeatedly using medical transportation to obtain health services from providers located outside the local trade area when health services appropriate to the recipient's physical or mental health needs can be obtained inside the local trade area. For purposes of this sub-item, "local trade area" has the meaning given in part 9505.0175, subpart 22; or
- Repeatedly arranging for services and then canceling services in order to circumvent the spend-down requirement.
- Obtaining medical services from a physician without an authorization from the recipient's designated primary care provider when restricted.
- Obtaining emergency room services for nonemergency care.
- Obtaining prescriptions from a pharmacy other than the designated pharmacy when restricted.
- Obtaining health services from a non-designated provider when the recipient has been required to designate a provider.

Member identification

Members will be identified for the RRP through various mechanisms, including, but not limited to:

- Analysis of medical and pharmacy claims data.
- Referral from SCHA contracted providers including practitioners, pharmacies, county public health and human service agencies.
- Referral from SCHA third party administrator (TPA) and SCHA staff.
- Members who refuse care coordination or case management.
- Members identified by another managed care organization or DHS.
- Behaviors by a member that could be deemed as abuse.

Review of Referred Members

- Prior to placing a member on the RRP, a full investigation will be conducted by the Utilization Review Coordinator and the RRP Case Manager.

- SCHA may contact the member in an attempt to change the behavior leading to the recommendation.
- SCHA staff may also refer member to appropriate health counseling service to correct inappropriate or dangerous use of health service.
- The review will include documentation, utilization data, and communication with involved providers and correlate medical records when appropriate. Identified situations must be supported by documentation.
- SCHA staff will prepare a case summary for review by the Director of Medical Services or a medical consultant chosen by the Director of Medical Services.
- The case summary will include any recommendations for restriction. The SCHA Medical Director will review the case for approval of member placement in the RRP or will continue to monitor member. A decision must be reached within 30 days.
- For members who are being monitored, data will be pulled and reviewed at least every 3 months for review.

Placement in RRP

- The period of time a member is initially placed on restriction cannot exceed the 24 months of enrollment in a MHCP. Months during which the member is not enrolled in a MHCP do not count toward the 24 month total. Individuals who continue on the Restricted Recipient Program will be enrolled for an additional 36 months.
- The Restricted Recipient Program is universal and stays in place regardless of whether a recipient:
 - Changes health plans
 - Moves from fee-for-service to a health plan
 - Moves from the health plan to fee-for-service
- SCHA will provide a member who is about to be placed on restriction with a 30-day written notice that complies with DHS contract requirements. The notice will include:
 - Explanation that placement in the RRP will not result in loss of eligibility for Medicaid.
 - Explanation that placement in the RRP will not result in denial, reduction or termination of benefits.
 - A 30-day notification period prior to the effective date of the proposed sanction.
 - Factual basis of the allegations against the member.
 - Requirements of the Restricted Recipient Plan: choosing a designated primary care physician, hospital and pharmacy by completing the Provider Selection Form, or if the member does not choose, being assigned to a designated provider(s). Member input regarding choice of providers to supervise the restriction will be considered in the selection of providers available to the member.

- The right of the member to appeal placement in the RRP with SCHA and also the process to appeal to the State Fair Hearing at the Department of Human Services.
- The member will have the right to appeal the decision under Minnesota Statutes, section 256.045 and part 9505.0130.

Provider Responsibilities

- Any physician enrolled as a general practitioner, internal medicine, pediatric, or family practice physician may be selected by the recipient as his or her primary physician.
- Providers designated to act as a primary care provider for a restricted member will be contacted and agree to the requirements of that role as specified in the Restricted Recipient plan. Providers who sign the MRRP Provider agreement enable their clinic to receive an additional \$100 per month for that member.
- If the recipient fails to choose providers, SCHA [or MMSI] will assign a physician based on considerations of geographic proximity, the recipient's prior experience with a specific physician, and the physician's willingness to provide health care services.
- Primary care physicians will be notified in writing of a member's restricted status and of the designated RRP case manager.
- Primary care physicians are responsible to direct patient care and may authorize specialists or other providers to also provide medical services to members by completing a Managed Care Referral Form.
- Emergency health services provided to a restricted recipient by a provider other than their designated providers shall be authorized for payment by SCHA if the service provided is otherwise eligible for payment by the program.

Changing Providers

- Restricted Recipients are allowed to change providers if:
 - The current provider is unable to provide services.
 - The recipient moves more than forty miles from their current provider.
 - The provider and member agree that a change would be in the member's best interest or the provider notifies SCHA that they will no longer provide medical services to the member.
 - SCHA determines that one of the member's providers cannot manage the member's health care needs.
- 90 days after restriction, members are allowed two changes per year for reasons other than those listed.

Non Designated Providers

- If a member's primary care physician does not complete a referral for a member's claim for non-emergent care, the medical claim will be denied

unless authorized by the Director of Health Services. Providers who are not designated providers and who have treated recipients may request reconsideration of their claims. To request reconsideration, the provider must send to SCHA's Restricted Recipient Program staff the medical records of the recipient for the date of service being reconsidered. An emergency is defined by Minnesota rule 9505.0175 as: "Emergency" means a condition including labor and delivery that if not immediately diagnosed and treated could cause a person serious physical or mental disability, continuation of severe pain, or death. If the care provided was in response to an emergency, the staff will request that the denial be overridden and the claim paid. If the health service provided was not an emergency, the claim will not be paid.

Removal from the restriction

- **Member will be moved from active list to watch list if compliant over the course of restriction. Claims will be pulled and reviewed at 3 months and again at 6 months.**
 - DHS will remove the restriction lock after the initial period of 24 months unless notified by SCHA that an additional 36 month restriction is in effect due to non compliance.
- A restriction may be removed mid-cycle only when the designated primary care provider requests a review of the member's restriction status and the Medical Director recommends that the member no longer qualifies for the restriction.