Department of Health

Adopted Permanent Rules Relating to Health Maintenance Organizations

Rules as Adopted

DEFINITIONS

4685.0100 DEFINITIONS.

[For text of subps 1 and 2, see M.R.]

Subp. 3. **Act.** "Act" means the Health Maintenance Act of 1973, Minnesota Statutes, chapter 62D.

Subp. 3a. **Ancillary services.** "Ancillary services" means laboratory services, radiology services, durable medical equipment, pharmacy services, rehabilitative services, and similar services and supplies dispensed by order or prescription of the primary care physician, specialty physician, or other provider authorized to prescribe those services.

[For text of subps 4 and 4a, see M.R.]

Subp. 5. **Comprehensive health maintenance service.** "Comprehensive health maintenance service" means a group of services which includes at least all of the types of services defined below:

A. "Emergency care" means medically necessary care which is immediately necessary to preserve life, prevent serious impairment to bodily functions, organs or parts, or prevent placing the physical or mental health of the enrollee in serious jeopardy.

[For text of items B to E, see M.R.]

[For text of subps 6 to 8, see M.R.]

Subp. 8a. [See repealer.]

[For text of subps 9 and 9a, see M.R.]

Subp. 9b. **Medically necessary care.** "Medically necessary care" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's diagnosis or condition, and diagnostic testing and preventive

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services. Medically necessary care must:

A. be consistent with generally accepted ~~principles of~~ practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and

B. help restore or maintain the enrollee's health; or

C. prevent deterioration of the enrollee's condition; or

D. prevent the ~~possible~~ reasonably likely onset of a health problem or detect an incipient problem.

Subp. 9c. **Member.** "Member" means enrollee, as defined by Minnesota Statutes, section 62D.02, subdivision 6. "Member" also means "subscriber," and the terms may be used interchangeably.

[For text of subps 10 to 12, see M.R.]

Subp. 12a. **Primary care physician.** "Primary care physician" means a licensed physician, either employed by or under contract with the health maintenance organization, who is in general practice, or who has special education, training, or experience, or who is board-certified or board-eligible and working toward certification in a board approved by the American Board of Medical Specialists or the American Board of Osteopathy in family practice, pediatrics, internal medicine, or obstetrics and gynecology.

Subp. 12b. **Primary care provider.** "Primary care provider" means a primary care physician as defined in subpart 12a or a licensed practitioner such as a licensed nurse, optometrist, or chiropractor who, within that practitioner's scope of practice as defined under the relevant state licensing law, provides primary care services.

[For text of subp 13, see M.R.]

Subp. 13a. **Referral.** "Referral" means a prior written authorization from the health maintenance organization or an authorized provider that ~~directs~~ allows an enrollee to have one or more appointments with a health care provider, for consultation, diagnosis, or treatment of a medical condition, to

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be covered as a benefit under the enrollee's health maintenance organization contract.

Subp. 13b. **Specialty physician.** "Specialty physician" means a licensed physician, ~~other than a primary care physician,~~ either employed by or under contract with the health maintenance organization, who has specialized education, training, or experience, or who is board-certified or board-eligible and working toward certification in a specialty board approved by the American Board of Medical Specialists or the American Board of Osteopathy ~~from the major areas of clinical services~~.

[For text of subps 14 and 15, see M.R.]

Subp. 16. **Urgently needed care.** "Urgently needed care" means medically necessary care which does not meet the definition of emergency care but is needed as soon as possible, usually within 24 hours.

ACCESSIBILITY OF SERVICES

4685.1010 AVAILABILITY AND ACCESSIBILITY.

Subpart 1. **Definitions.** For the purpose of this part, the terms in items A and B have the meanings given them.

A. "Referral centers ~~of excellence~~" means medical facilities that provide specialized medical care such as organ transplants and coronary artery bypass surgery. Examples of criteria the health maintenance organization may use in designating a facility as a referral center ~~of excellence~~ are volume of services provided annually and the case mix and severity adjusted mortality and morbidity rates. Referral centers ~~of excellence~~ may be located within or outside the health maintenance organization's service area.

B. "Service area" means the geographic locations in which the health maintenance organization is approved by the commissioner to sell its health maintenance organization products. Geographic locations shall be identified according to recognized political subdivisions such as cities, counties, and townships.

Subp. 2. **Basic services.** The health maintenance

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organization shall have available, either directly or through arrangements, appropriate and sufficient personnel, physical resources~~,~~ and equipment to meet the projected needs of its enrollees for covered health care services. The health maintenance organization shall develop and implement written standards or guidelines which address the assessment of provider capacity to provide timely access to health care services in accordance with subpart 6.

A. Primary care ~~physician~~ services.

(1) Primary care physician services shall be available and accessible 24 hours per day, seven days per week within the health maintenance organization's service area. The health maintenance organization shall fulfill this requirement through written standards for:

(a) regularly scheduled appointments during normal business hours;

(b) after hours clinics;

(c) use of a 24-hour answering service with standards for maximum allowable call-back times based on what is medically appropriate to each situation;

(d) back-up coverage by another participating primary care physician; and

(e) referrals to urgent care centers, where available, and to hospital emergency care.

(2) The health maintenance organization shall provide or contract with a sufficient number of primary care physicians to meet the projected needs of its enrollees for primary care physician services.

(3) The health maintenance organization shall ensure that there are a number of primary care physicians with hospital admitting privileges at one or more participating general hospitals within the health maintenance organization's service area so that necessary admissions are made on a timely basis consistent with generally accepted ~~principles of~~ practice parameters.

(4) To the extent that primary care services are

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provided through primary care providers other than physicians, and to the extent permitted under applicable scope of practice in state licensing laws for a given provider, these services shall be available and accessible as required by subitems (1) to (3).

B. Specialty physician services.

(1) The health maintenance organization shall provide directly, contract for, or otherwise arrange for specialty physician services which are covered benefits and to which enrollees have continued access in the health maintenance organization's service area. These services shall be available and accessible 24 hours per day, seven days per week. The health maintenance organization shall fulfill this requirement through written standards for:

(a) regularly scheduled appointments during normal business hours;

(b) after hours clinics;

(c) use of a 24-hour answering service with standards for maximum allowable call-back times based on what is medically appropriate to each situation;

(d) back-up coverage by another participating specialty physician; and

(e) referrals to urgent care centers, where available, and to hospital emergency care.

(2) Specialty physician services to which enrollees do not have continued access, for example referrals for consultation or second opinions, shall be provided by the health maintenance organization through contracts or other arrangements with specialty physicians.

(3) The health maintenance organization shall ensure that there are a number of specialty physicians with hospital admitting privileges so that necessary admissions are made on a timely basis consistent with generally accepted ~~principles of~~ practice parameters.

C. Services of facilities licensed as general hospitals under chapter 4640 (general hospital services) shall

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be provided through contracts between the health maintenance organization and hospitals. These services shall be available and accessible, on a timely basis consistent with generally accepted ~~principles of~~ practice parameters, 24 hours per day, seven days per week within the health maintenance organization's service area. Services of facilities licensed as specialized hospitals under chapter 4640 (specialized hospital services), including chemical dependency and mental health services, shall be provided through contracts between the health maintenance organization or its contracted providers and hospitals, either within or outside the health maintenance organization's service area. These services shall be available during normal business hours consistent with generally accepted ~~principles of~~ practice parameters.

D. The health maintenance organization shall contract with or employ sufficient numbers of providers of ancillary services to meet the projected needs of its enrollees. The services shall be available during normal daytime business hours consistent with generally accepted ~~principles of~~ practice parameters.

E. The health maintenance organization shall contract with or employ sufficient numbers of qualified providers of outpatient mental health and chemical dependency services to meet the projected needs of its enrollees consistent with generally accepted ~~principles of~~ practice parameters.

(1) Services for people with alcohol and other chemical dependency problems shall be provided by outpatient treatment programs licensed by the Minnesota Department of Human Services under parts 9530.5000 to 9530.6500 or by hospitals licensed under chapter 4640.

(2) Outpatient chemical dependency treatment programs serving adolescents must meet all of the requirements of the Minnesota Department of Human Services contained in part 9530.6400.

(3) Outpatient mental health services shall be provided by licensed psychiatrists, psychologists, social

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workers, marriage and family therapists, and psychiatric nurses, as appropriate in each case, and by mental health centers and mental health clinics licensed by the Minnesota Department of Human Services under chapter 9520.

(4) The health maintenance organization, either directly or through its contracted mental health or chemical dependency provider, shall have available services that are culturally specific or appropriate to a specific age, gender, or sexual preference, to the extent reasonably possible. If any of these services cannot be provided by licensed providers and programs, the health maintenance organization shall file a request for an exception to the requirements of subitems (1) to (4). A request for an exception shall be considered a filing under part 4685.3300. The health maintenance organization shall submit specific data in support of its request.

F. The health maintenance organization shall provide directly, contract for, or otherwise arrange for residential treatment programs licensed by the Department of Human Services under parts 9530.4100 to 9530.4450 to provide services to people with alcohol and other chemical dependency problems.

G. The health maintenance organization shall provide directly, contract for, or otherwise arrange for emergency care and urgently needed care to be available and accessible within the health maintenance organization's service area 24 hours per day, seven days per week. Contracts may be with hospitals, urgent care centers, and after hours clinics. Emergency care and urgently needed care provided by noncontracted providers shall be covered in accordance with subpart 7.

~~G.~~ H. If a specific health maintenance organization provider refuses to continue to provide care to a specific health maintenance organization enrollee, the health maintenance organization shall furnish the enrollee with the name, address, and telephone number of other participating providers in the same area of medical specialty. Examples of reasons for refusal to continue to provide care to an enrollee are: unpaid bills incurred by that individual before enrollment in the health

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maintenance organization; unpaid copayments or coinsurance incurred by the enrollee after enrollment in the health maintenance organization; an enrollee who is uncooperative or abusive toward the provider; and the inability of the enrollee and the provider to agree on a course of treatment.

~~H.~~ I. The health maintenance organization is responsible for implementing a system that, to the greatest possible extent, assures that routine referrals, either by the health maintenance organization or by a participating provider, are made to participating providers. An enrollee cannot be held liable if the health maintenance organization provider, in error, gives a referral to a nonparticipating provider. This issue may be addressed in contracts between the health maintenance organization and its providers.

Subp. 3. **Geographic accessibility.**

A. The maximum travel distance or time within the health maintenance organization's service area to the nearest provider of primary care services or to the nearest general hospital provider shall be the lesser of 30 miles or 30 minutes. The health maintenance organization shall designate which method is used. The commissioner shall grant an exception to this requirement, as provided in subpart 4, if the health maintenance organization can demonstrate with specific data that the 30-mile or 30-minute requirement is not feasible in a particular service area or part of a service area.

B. The maximum travel distance or time within the health maintenance organization's service area to the nearest provider of specialty physician services, ancillary services, specialized hospital services, and all other health services shall be the lesser of 60 miles or 60 minutes. The health maintenance organization shall designate which method is used. The commissioner shall grant an exception to this requirement, as provided in subpart 4, if the health maintenance organization can demonstrate with specific data that the 60-mile or 60-minute requirement is not feasible in a particular service area or part of a service area.

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C. The provisions of items A and B do not apply when enrollees are referred to referral centers ~~of excellence~~ for health care services, or when enrollees have chosen a health plan with full knowledge that the health plan has no participating providers within 30 miles or 30 minutes of the enrollee's place of residence, or to service areas approved prior to the effective date of parts 4685.0100 to 4685.3300.

Subp. 4. **Exceptions for access to care and geographic accessibility.** A request for an exception to the requirements of subparts 2 and 3 shall be considered a filing under part 4685.3300. The health maintenance organization shall submit specific data in support of its request. The commissioner shall consider the factors in items A to C in granting an exception if the health maintenance organization is unable to meet the requirements of subparts 2 and 3 in a particular service area or part of a service area:

A. the utilization patterns of the existing health care delivery system or the health maintenance organization's reasonably justified projections of utilization of health care services in the proposed service area;

B. the financial ability of the health maintenance organization to pay charges for health care services that are not provided under contract or by employees of the health maintenance organization. The commissioner shall determine what information must be submitted by the health maintenance organization in order to demonstrate its financial ability to pay charges and may require an analysis of the impact on minimum loss ratio requirements; and

C. the health maintenance organization's system of documentation of authorized referrals to nonparticipating providers. This system of documentation of authorized referrals shall explain how, under certain circumstances, enrollees will be given referrals to nonparticipating providers, either by the health maintenance organization or by a provider acting on behalf of the health maintenance organization.

Subp. 5. **Coordination of care.**

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A. The health maintenance organization shall provide the services of primary care ~~physicians~~ providers, either directly or through contracts or other arrangements, to provide initial and basic care to enrollees. In plans in which referrals to specialty physicians and ancillary services are required, the primary care ~~physicians~~ providers or the health maintenance organization shall initiate the referrals. The health maintenance organization shall inform its primary care ~~physicians~~ providers of their responsibility to provide written referrals and any specific procedures that must be followed in providing referrals. If requested by an enrollee, or if determined necessary because of a pattern of inappropriate utilization of services, an enrollee's health care may be supervised and coordinated by the primary care ~~physician~~ provider. An enrollee who is dissatisfied with the assigned or selected primary care ~~physician~~ provider shall be allowed to change primary care ~~physicians~~ providers in accordance with the health maintenance organization's procedures and policies.

B. The health maintenance organization shall provide for the coordination and continuity of care for enrollees given a referral to specialty physicians and, where possible, provide this coordination through the enrollee's primary care ~~physician~~ provider.

Subp. 6. **Timely access to health care services.**

A. The health maintenance organization, either directly or through its provider contracts, shall arrange for covered health care services, including referrals to participating and nonparticipating specialty physicians, to be accessible to enrollees on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted ~~principles of~~ practice parameters.

B. The health maintenance organization or its participating providers shall have appointment scheduling guidelines based on type of health care service. Examples of types of health care services include well baby and well child examinations, prenatal care appointments, routine physicals,

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follow up appointments for chronic conditions such as high blood pressure, and diagnosis of acute pain or injury.

Subp. 7. **Access to emergency care.**

A. In accordance with the requirements of Minnesota Statutes, section 62D.07, the health maintenance organization shall inform its enrollees, through the evidence of coverage or contract, as well as through other forms of communication, how to obtain emergency care.

B. The health maintenance organization may require enrollees to notify it of nonreferred emergency care, including mental health and chemical dependency care, as soon as possible after emergency care is initially provided, and no later than 48 hours after becoming physically or mentally able to give notice. However, the health maintenance organization shall make exceptions in situations in which:

(1) the enrollee is physically or mentally unable to give notice within 48 hours; and

(2) emergency care would have been covered under the contract had notice been provided within the 48-hour time period.

C. Emergency care shall be covered whether provided by participating or nonparticipating providers.

D. Emergency care shall be covered whether provided within or outside the health maintenance organization's service area.

E. In determining whether care is reimbursable as emergency care, the health maintenance organization shall take the following factors into consideration:

(1) a reasonable person's belief that the circumstances required immediate medical care that could not wait until the next working day or next available clinic appointment;

(2) the time of day and day of week the care was provided;

(3) the presenting symptoms, to ensure that the decision to reimburse as emergency care shall not be made solely

on the basis of the actual diagnosis;

(4) the enrollee's efforts to follow the health maintenance organization's established procedures for obtaining emergency care; and

(5) any circumstances which precluded use of the health maintenance organization's established procedures for obtaining emergency care.

In processing the claim, the health maintenance organization shall obtain sufficient information from the provider of emergency care, including the presenting symptoms, to enable the health maintenance organization to make an informed determination as to whether reimbursement as emergency care is appropriate.

Subp. 8. **Continuity of care in the event of contract termination.**

A. The health maintenance organization shall prepare a written plan that provides for continuity of care in the event of contract termination between the health maintenance organization and any of its contracted primary care providers or general hospital providers, or in the event of site closings involving a primary care provider with more than one location of service.

B. The written plan shall explain how:

(1) if the health maintenance organization has received at least 120 days' prior notice of the termination or site closing, the health maintenance organization will inform the affected enrollees about the termination or site closing at least 30 days before the termination or closing is effective. The health maintenance organization will also inform the affected enrollees what other participating providers are available to assume their care; and

(2) the health maintenance organization will facilitate an orderly transfer of its enrollees from the terminating provider or closing provider site to the new provider so that continuity of care is maintained.

C. The written plan shall explain the procedures by

which enrollees will be transferred to other participating providers unless special circumstances require them to be transferred to nonparticipating providers.

D. The written plan shall explain who will identify enrollees with special medical needs or at special risk and what criteria will be used for this determination.

E. The written plan shall explain how continuity of care will be provided for enrollees identified as having special medical needs or at special risk. The health maintenance organization can assign this responsibility to its contracted primary care providers.

F. The written plan shall explain how, if the contract termination was not for cause, enrollees will be informed that they can request a referral to the terminating provider if medical circumstances warrant. The health maintenance organization can require medical records and other supporting documentation in support of the requested referral. Each request for referral to a terminating provider shall be considered by the health maintenance organization on a case-by-case basis.

G. The written plan shall explain how, if the contract termination was for cause, enrollees will be notified of the change and transferred to participating providers in a timely manner so that health care services remain available and accessible to the affected enrollees. If the contract was terminated by the health maintenance organization for cause, the health maintenance organization shall not be required to refer an enrollee back to the terminating provider.

QUALITY ASSURANCE

4685.1115 ACTIVITIES.

[For text of subpart 1, see M.R.]

Subp. 2. **Scope.** The components of the health maintenance organization subject to evaluation include the following:

[For text of item A, see M.R.]

B. Organizational components which are the aspects of

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the health plan that affect accessibility, availability, comprehensiveness, and continuity of health care, and which include the following:

(1) referrals;

(2) case management;

(3) discharge planning;

(4) appointment scheduling and waiting periods for all types of health care services;

(5) second opinions, as applicable;

(6) prior authorizations, as applicable;

(7) provider reimbursement arrangements; and

(8) other systems, procedures, or administrative requirements used by the health maintenance organization that affect delivery of care.

[For text of item C, see M.R.]

4685.3300 PERIODIC FILINGS.

[For text of subps 1a to 8, see M.R.]

Subp. 9. **Service area expansion.** The filing of a request to expand a service area must be accompanied by sufficient supporting documentation including the following:

[For text of items A to G, see M.R.]

H. any other information relating to documentation of service area, facility, and personnel availability and accessibility to allow a determination of compliance with part 4685.1010.

[For text of subps 10 to 11, see M.R.]

REPEALER. Minnesota Rules, parts 4685.0100, subpart 8a; and 4685.1000, are repealed.

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