CHAPTER 62Q

REQUIREMENTS FOR HEALTH PLAN COMPANIES

62Q.145 ABORTION AND SCOPE OF PRACTICE.

Health plan company policies related to scope of practice for allied independent health providers as defined in section 62Q.095, subdivision 5, midlevel practitioners as defined in section 144.1501, subdivision 1, and other nonphysician health care professionals must comply with the requirements governing the performance of abortions in section 145.412, subdivision 1.

History: *1Sp2003 c 14 art 7 s 88*

62Q.19 ESSENTIAL COMMUNITY PROVIDERS.

Subdivision 1. **Designation.** (a) The commissioner shall designate essential community providers. The criteria for essential community provider designation shall be the following:

(1) a demonstrated ability to integrate applicable supportive and stabilizing services with medical care for uninsured persons and high-risk and special needs populations, underserved, and other special needs populations; and

(2) a commitment to serve low-income and underserved populations by meeting the following requirements:

(i) has nonprofit status in accordance with chapter 317A;

(ii) has tax exempt status in accordance with the Internal Revenue Service Code, section 501(c)(3);

(iii) charges for services on a sliding fee schedule based on current poverty income guidelines; and

(iv) does not restrict access or services because of a client's financial limitation;

(3) status as a local government unit as defined in section 62D.02, subdivision 11, a hospital district created or reorganized under sections 447.31 to 447.37, an Indian tribal government, an Indian health service unit, or a community health board as defined in chapter 145A;

(4) a former state hospital that specializes in the treatment of cerebral palsy, spina bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling conditions; or

(5) a sole community hospital. For these rural hospitals, the essential community provider designation applies to all health services provided, including both inpatient and outpatient services. For purposes of this section, "sole community hospital" means a rural hospital that:

(i) is eligible to be classified as a sole community hospital according to Code of Federal Regulations, title 42, section 412.92, or is located in a community with a population of less than 5,000 and located more than 25 miles from a like hospital currently providing acute short-term services;

(ii) has experienced net operating income losses in two of the previous three most recent consecutive hospital fiscal years for which audited financial information is available; and

(iii) consists of 40 or fewer licensed beds.

(b) Prior to designation, the commissioner shall publish the names of all applicants in the State Register. The public shall have 30 days from the date of publication to submit written comments to the commissioner on the application. No designation shall be made by the commissioner until the 30-day period has expired.

(c) The commissioner may designate an eligible provider as an essential community provider for all the services offered by that provider or for specific services designated by the commissioner.

(d) For the purpose of this subdivision, supportive and stabilizing services include at a minimum, transportation, child care, cultural, and linguistic services where appropriate.

Subd. 2. **Application.** (a) Any provider may apply to the commissioner for designation as an essential community provider by submitting an application form developed by the commissioner. Except as provided in paragraphs (d) and (e), applications must be accepted within two years after the effective date of the rules adopted by the commissioner to implement this section.

(b) Each application submitted must be accompanied by an application fee in an amount determined by the commissioner. The fee shall be no more than what is needed to cover the administrative costs of processing the application.

(c) The name, address, contact person, and the date by which the commissioner's decision is expected to be made shall be classified as public data under section 13.41. All other information contained in the application form shall be classified as private data under section 13.41 until the application has been approved, approved as modified, or denied by the commissioner. Once the decision has been made, all information shall be classified as public data unless the applicant designates and the commissioner determines that the information contains trade secret information.

(d) The commissioner shall accept an application for designation as an essential community provider until June 30, 2001, from:

(1) one applicant that is a nonprofit community health care facility, certified as a medical assistance provider effective April 1, 1998, that provides culturally competent health care to an underserved Southeast Asian immigrant and refugee population residing in the immediate neighborhood of the facility;

(2) one applicant that is a nonprofit home health care provider, certified as a Medicare and a medical assistance provider that provides culturally competent home health care services to a low-income culturally diverse population;

(3) up to five applicants that are nonprofit community mental health centers certified as medical assistance providers that provide mental health services to children with serious emotional disturbance and their families or to adults with serious and persistent mental illness; and

(4) one applicant that is a nonprofit provider certified as a medical assistance provider that provides mental health, child development, and family services to children with physical and mental health disorders and their families.

(e) The commissioner shall accept an application for designation as an essential community provider until June 30, 2003, from one applicant that is a nonprofit community clinic located in Hennepin County that provides health care to an underserved American Indian population and that is collaborating with other neighboring organizations on a community diabetes project and an immunization project.

[For text of subds 2a to 7, see M.S.2002]

History: *2003 c 100 s 1; 1Sp2003 c 14 art 7 s 22,23*

62Q.675 HEARING AIDS; PERSONS 18 OR YOUNGER.

A health plan must cover hearing aids for individuals 18 years of age or younger for hearing loss due to functional congenital malformation of the ears that is not correctable by other covered procedures. Coverage required under this section is limited to one hearing aid in each ear every three years. No special deductible, coinsurance, co-payment, or other limitation on the coverage under this section that is not generally applicable to other coverages under the plan may be imposed.

History: *1Sp2003 c 14 art 7 s 24*

62Q.71 NOTICE TO ENROLLEES.

Each health plan company shall provide to enrollees a clear and concise description of its complaint resolution procedure, if applicable under section 62Q.68, subdivision 1, and the procedure used for utilization review as defined under chapter 62M as part of the member handbook, subscriber contract, or certificate of coverage. If the health plan company does not issue a member handbook, the health plan company may provide the description in another written document. The description must specifically inform enrollees:

(1) how to submit a complaint to the health plan company;

(2) if the health plan includes utilization review requirements, how to notify the utilization review organization in a timely manner and how to obtain certification for health care services;

(3) how to request an appeal either through the procedures described in sections 62Q.69 and 62Q.70 or through the procedures described in chapter 62M;

(4) of the right to file a complaint with either the commissioner of health or commerce at any time during the complaint and appeal process;

(5) of the toll-free telephone number of the appropriate commissioner; and

(6) of the right to obtain an external review under section 62Q.73 and a description of when and how that right may be exercised.

History: *2003 c 2 art 1 s 8*