62K.10 GEOGRAPHIC ACCESSIBILITY; PROVIDER NETWORK ADEQUACY.

Subdivision 1. **Applicability.** (a) This section applies to all health carriers that either require an enrollee to use or that create incentives, including financial incentives, for an enrollee to use, health care providers that are managed, owned, under contract with, or employed by the health carrier. A health carrier that does not manage, own, or contract directly with providers in Minnesota is exempt from this section, unless it is part of a holding company as defined in section 60D.15 that in aggregate exceeds ten percent in either the individual or small group market in Minnesota.

(b) Health carriers renting provider networks from other entities must submit the rental agreement or contract to the commissioner of health for approval. In reviewing the agreements or contracts, the commissioner shall review the agreement or contract to ensure that the entity contracting with health care providers accepts responsibility to meet the requirements in this section.

Subd. 1a. **Health care provider system access.** For those counties in which a health carrier actively markets an individual health plan, the health carrier must offer, in those same counties, at least one individual health plan with a provider network that includes in-network access to more than a single health care provider system. This subdivision is applicable only for the year in which the health carrier actively markets an individual health plan.

Subd. 2. **Primary care; mental health services; general hospital services.** The maximum travel distance or time shall be the lesser of 30 miles or 30 minutes to the nearest provider of each of the following services: primary care services, mental health services, and general hospital services.

Subd. 3. **Other health services.** The maximum travel distance or time shall be the lesser of 60 miles or 60 minutes to the nearest provider of specialty physician services, ancillary services, specialized hospital services, and all other health services not listed in subdivision 2.

Subd. 4. **Network adequacy.** Each designated provider network must include a sufficient number and type of providers, including providers that specialize in mental health and substance use disorder services, to ensure that covered services are available to all enrollees without unreasonable delay. In determining network adequacy, the commissioner of health shall consider availability of services, including the following:

(1) primary care physician services are available and accessible 24 hours per day, seven days per week, within the network area;

(2) a sufficient number of primary care physicians have hospital admitting privileges at one or more participating hospitals within the network area so that necessary admissions are made on a timely basis consistent with generally accepted practice parameters;

(3) specialty physician service is available through the network or contract arrangement;

(4) mental health and substance use disorder treatment providers are available and accessible through the network or contract arrangement;

(5) to the extent that primary care services are provided through primary care providers other than physicians, and to the extent permitted under applicable scope of practice in state law for a given provider, these services shall be available and accessible; and

(6) the network has available, either directly or through arrangements, appropriate and sufficient personnel, physical resources, and equipment to meet the projected needs of enrollees for covered health care services.

Subd. 5. **Waiver.** A health carrier or preferred provider organization may apply to the commissioner of health for a waiver of the requirements in subdivision 2 or 3 if it is unable to meet the statutory requirements. A waiver application must be submitted on a form provided by the commissioner and must:

(1) demonstrate with specific data that the requirement of subdivision 2 or 3 is not feasible in a particular service area or part of a service area; and

(2) include information as to the steps that were and will be taken to address the network inadequacy.

The waiver shall automatically expire after four years. If a renewal of the waiver is sought, the commissioner of health shall take into consideration steps that have been taken to address network adequacy.

Subd. 5a. **Appeal of waiver of network adequacy requirements.** (a) If a health carrier receives a waiver under subdivision 5 applicable to a health plan's provider network, a provider who is in the service area served by the health plan and who is aggrieved by the issuance of the waiver may appeal the commissioner's decision using the contested case procedures in sections 14.57 to 14.62. A contested case proceeding must be initiated within 60 days after the date on which the commissioner grants a waiver, except that a proceeding regarding a waiver in effect as of January 1, 2017, must be initiated within 60 days after the effective date of this subdivision. The commissioner must provide timely notice of an appeal under this subdivision to the health carrier that received the waiver that is subject to the appeal. After considering the appeal, the administrative law judge must either uphold or nullify the waiver of network adequacy requirements. The prevailing party in the contested case proceeding may seek an award of expenses and fees from the nonprevailing party by applying to the administrative law judge using the procedure in section 15.472, paragraph (b). The administrative law judge shall award fees and expenses to the prevailing party if the administrative law judge finds that the position of the nonprevailing party was not substantially justified. For purposes of this paragraph, "substantially justified" has the meaning given in section 15.471, subdivision 8.

(b) The decision of the administrative law judge constitutes the final decision regarding the waiver. A party aggrieved by the administrative law judge's decision may seek judicial review of the decision as provided in chapter 14. If the waiver is nullified and no judicial review is sought, the health carrier must comply with the network adequacy requirements in subdivisions 2, 3, and 4, within 30 days after the deadline for seeking judicial review in section 14.63.

(c) This subdivision expires December 31, 2018.

Subd. 6. **Referral centers.** Subdivisions 2 and 3 shall not apply if an enrollee is referred to a referral center for health care services. A referral center is a medical facility that provides highly specialized medical care, including but not limited to organ transplants. A health carrier or preferred provider organization may consider the volume of services provided annually, case mix, and severity adjusted mortality and morbidity rates in designating a referral center.

Subd. 7. **Essential community providers.** Each health carrier must comply with section 62Q.19.

Subd. 8. **Enforcement.** The commissioner of health shall enforce this section.

History: *2013 c 84 art 2 s 11,17; 2017 c 2 art 2 s 11; 2017 c 13 art 2 s 1*