

Summary of HMO Network Adequacy Statutes and Rules

[MN Statute § 62.D 124] Within the health maintenance organization's service area, 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: primary care services, mental health services, and general hospital services. The maximum travel distance or time shall be the lesser of 60 miles or 60 minutes to the nearest provider of specialty services. HMOs unable to meet these requirements must provide data demonstrating that the requirement is unfeasible in some part of the service area.

[MN Statute § 62.D 121, Subd. 7] If the Minnesota Department of Health (MDH) determines that there are not sufficient providers within the approved service area, they may institute a corrective action plan with the health maintenance organization. This corrective action plan may include but not be limited to requiring HMO to pay nonparticipating providers, reducing the HMO service area, or limiting new enrollment to those areas with sufficient provider availability.

Minnesota Rules 4685.1010:

1. The HMO shall have appropriate and sufficient personnel, physical resources, and equipment to meet the projected need for covered services. The HMO shall develop written standards or guidelines to assess the capacity of each network to provide timely access to care.
2. Primary and specialty physician services and emergency and urgent care shall be available 24 hours a day within the HMO service area;
 - a. HMO must have standards for regularly scheduled appointments; after hour clinics; 24 hour answering service; back up coverage; referrals to ER and urgent care; and
 - b. HMO must contract with or provide a sufficient number of providers to meet projected need and ensure a number of PCPs have admitting privileges.
3. Services of facilities licensed as general hospitals must be available on a timely basis 24 hours a day in accordance with generally accepted practice patterns.
4. HMOs must contract with or provide sufficient numbers of mental health and substance abuse providers to meet the projected need of enrollees either inside or outside the service area; and
 - a. HMOs must make available a full range of licensed mental health and chemical dependency providers.
5. The HMO shall provide for the coordination of care for enrollees given a referral. Wherever possible, this care should be coordinated through an enrollee's primary care physician.
6. HMOs must arrange for covered services including referrals to nonparticipating and specialty providers to be accessible to enrollees on a timely basis in accordance with medically appropriate guidelines. The organization must also, in conjunction with providers, develop and implement written appointment scheduling guidelines based on the type of health care services.
7. HMOs must implement a system for routine referrals and include a description of referral procedures in an enrollee's evidence of coverage.
8. An HMO must notify enrollees how to obtain emergency care. Where circumstances warrant emergency care, such care must be covered whether provided in or out of network.