62Q.56 CONTINUITY OF CARE.

Subdivision 1. **Change in health care provider; general notification.** (a) If enrollees are required to access services through selected primary care providers for coverage, the health plan company shall prepare a written plan that provides for continuity of care in the event of contract termination between the health plan company and any of the contracted primary care providers, specialists, or general hospital providers. The written plan must explain:

(1) how the health plan company will inform affected enrollees about termination at least 30 days before the termination is effective, if the health plan company or health care network cooperative has received at least 120 days' prior notice;

(2) how the health plan company will inform the affected enrollees about what other participating providers are available to assume care and how it will facilitate an orderly transfer of its enrollees from the terminating provider to the new provider to maintain continuity of care;

(3) the procedures by which enrollees will be transferred to other participating providers, when special medical needs, special risks, or other special circumstances, such as cultural or language barriers, require them to have a longer transition period or be transferred to nonparticipating providers;

(4) who will identify enrollees with special medical needs or at special risk and what criteria will be used for this determination; and

(5) how continuity of care will be provided for enrollees identified as having special needs or at special risk, and whether the health plan company has assigned this responsibility to its contracted primary care providers.

(b) For purposes of this section, contract termination includes nonrenewal.

Subd. 1a. **Change in health care provider; termination not for cause.** (a) If the contract termination was not for cause and the contract was terminated by the health plan company, the health plan company must provide the terminated provider and all enrollees being treated by that provider with notification of the enrollees' rights to continuity of care with the terminated provider.

(b) The health plan company must provide, upon request, authorization to receive services that are otherwise covered under the terms of the health plan through the enrollee's current provider:

(1) for up to 120 days if the enrollee is engaged in a current course of treatment for one or more of the following conditions:

(i) an acute condition;

(ii) a life-threatening mental or physical illness;

(iii) pregnancy beyond the first trimester of pregnancy;

(iv) a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or

(v) a disabling or chronic condition that is in an acute phase; or

(2) for the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of 180 days or less.

For all requests for authorization to receive services under this paragraph, the health plan company must grant the request unless the enrollee does not meet the criteria provided in this paragraph.

(c) The health plan company shall prepare a written plan that provides a process for coverage determinations regarding continuity of care of up to 120 days for enrollees who request continuity of care with their former provider, if the enrollee:

(1) is receiving culturally appropriate services and the health plan company does not have a provider in its preferred provider network with special expertise in the delivery of those culturally appropriate services within the time and distance requirements of section 62D.124, subdivision 1; or

(2) does not speak English and the health plan company does not have a provider in its preferred provider network who can communicate with the enrollee, either directly or through an interpreter, within the time and distance requirements of section 62D.124, subdivision 1.

The written plan must explain the criteria that will be used to determine whether a need for continuity of care exists and how it will be provided.

Subd. 1b. **Change in health care provider; termination for cause.** If the contract termination was for cause, enrollees must 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. The health plan company is not required to refer an enrollee back to the terminating provider if the termination was for cause.

Subd. 2. **Change in health plans.** (a) If an enrollee is subject to a change in health plans, the enrollee's new health plan company must provide, upon request, authorization to receive services that are otherwise covered under the terms of the new health plan through the enrollee's current provider:

(1) for up to 120 days if the enrollee is engaged in a current course of treatment for one or more of the following conditions:

(i) an acute condition;

(ii) a life-threatening mental or physical illness;

(iii) pregnancy beyond the first trimester of pregnancy;

(iv) a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or

(v) a disabling or chronic condition that is in an acute phase; or

(2) for the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of 180 days or less.

For all requests for authorization under this paragraph, the health plan company must grant the request for authorization unless the enrollee does not meet the criteria provided in this paragraph.

(b) The health plan company shall prepare a written plan that provides a process for coverage determinations regarding continuity of care of up to 120 days for new enrollees who request continuity of care with their former provider, if the new enrollee:

(1) is receiving culturally appropriate services and the health plan company does not have a provider in its preferred provider network with special expertise in the delivery of those culturally appropriate services within the time and distance requirements of section 62D.124, subdivision 1; or

(2) does not speak English and the health plan company does not have a provider in its preferred provider network who can communicate with the enrollee, either directly or through an interpreter, within the time and distance requirements of section 62D.124, subdivision 1.

The written plan must explain the criteria that will be used to determine whether a need for continuity of care exists and how it will be provided.

(c) This subdivision applies only to group coverage and continuation and conversion coverage, and applies only to changes in health plans made by the employer.

Subd. 2a. **Limitations.** (a) Subdivisions 1, 1a, 1b, and 2 apply only if the enrollee's health care provider agrees to:

(1) accept as payment in full the lesser of the health plan company's reimbursement rate for in-network providers for the same or similar service or the enrollee's health care provider's regular fee for that service;

(2) adhere to the health plan company's preauthorization requirements; and

(3) provide the health plan company with all necessary medical information related to the care provided to the enrollee.

(b) Nothing in this section requires a health plan company to provide coverage for a health care service or treatment that is not covered under the enrollee's health plan.

Subd. 2b. **Request for authorization.** The health plan company may require medical records and other supporting documentation to be submitted with the requests for authorization made under subdivision 1, 1a, 1b, or 2. If the authorization is denied, the health plan company must explain the criteria it used to make its decision on the request for authorization. If the authorization is granted, the health plan company must explain how continuity of care will be provided.

Subd. 3. **Disclosure.** Information regarding an enrollee's rights under this section must be included in member contracts or certificates of coverage and must be provided by a health plan company upon request of an enrollee or prospective enrollee.

History: *1997 c 237 s 12; 1Sp2001 c 9 art 16 s 7; 2002 c 379 art 1 s 113*