SENATE
STATE OF MINNESOTA
NINETY-THIRD SESSION

S.F. No. 2382

(SENATE AUTHORS: HOFFMAN)

DATE	D-PG	OFFICIAL STATUS
03/02/2023	1266	Introduction and first reading
		Referred to Commerce and Consumer Protection
03/22/2023		Comm report: To pass as amended and re-refer to Health and Human Services

A bill for an act

relating to commerce; establishing a Mental Health Parity and Substance Abuse Accountability Office in the Department of Commerce; appropriating money; amending Minnesota Statutes 2022, section 62K.10, subdivisions 2, 4, 8; proposing coding for new law in Minnesota Statutes, chapter 62Q.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2022, section 62K.10, subdivision 2, is amended to read:

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 and substance disorder services, and general hospital services, provided that a health carrier only meets this standard if the nearest provider has the availability to see an enrollee, new or existing, within ..... days.

Sec. 2. Minnesota Statutes 2022, section 62K.10, subdivision 4, is amended to read:

Subd. 4. **Network adequacy.** (a) 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.

(b) In determining whether a designated provider network described in paragraph (a) includes a sufficient number and type of providers that specialize in mental health and substance use disorder treatment to ensure that covered services are available to all enrollees without unreasonable delay, and in determining whether such providers are available and accessible through the network or contract arrangement, the commissioner shall request, and a health carrier must submit, on an annual basis comparative data regarding access to mental health and substance use disorder care and access to medical and surgical care, which shall include information, reported separately for adults versus children and adolescents, on the ability of enrollees to:

(1) access initial appointments with physicians specializing in the treatment of mental health conditions or substance use disorders;

(2) access follow-up appointments with physicians specializing in the treatment of mental health conditions or substance use disorders;

(3) access initial appointments with physicians specializing in the treatment of medical or surgical conditions;

(4) access follow-up appointments with physicians specializing in the treatment of medical or surgical conditions;

(5) access initial appointments with mental health and licensed alcohol and drug counselors with prescriptive authority specializing in the treatment of mental health conditions or substance use disorders;

(6) access follow-up appointments with mental health practitioners and licensed alcohol and drug counselors with prescriptive authority specializing in the treatment of mental health conditions or substance use disorders;

(7) access initial appointments with mental health practitioners and licensed alcohol and drug counselors with prescriptive authority specializing in the treatment of medical or surgical conditions;

(8) access follow-up appointments with mental health practitioners and licensed alcohol and drug counselors with prescriptive authority specializing in the treatment of medical or surgical conditions;

(9) access initial appointments with mental health practitioners and licensed alcohol and drug counselors specializing in the treatment of mental health conditions or substance use disorders;

(10) access follow-up appointments with mental health practitioners and licensed alcohol and drug counselors specializing in the treatment of mental health conditions or substance use disorders;

(11) access initial appointments with mental health practitioners and licensed alcohol and drug counselors specializing in the treatment of medical or surgical conditions; and

(12) access follow-up appointments with mental health practitioners and licensed alcohol and drug counselors specializing in the treatment of medical or surgical conditions.

The commissioner shall prescribe the method of and format for health carriers to submit the data required in clauses (1) to (12).

(c) The commissioner shall calculate the average number of days an enrollee must wait before accessing the respective provider and appointment types identified in paragraph (b), clauses (1) to (12), and a health carrier shall provide the commissioner with any requested data or information needed for the commissioner to perform such calculations. The commissioner, in collaboration with each health carrier, shall use reasonable assumptions related to statistics and research methods to identify representative samples for analysis to complete the calculations described in this paragraph and other such methods as the commissioner determines appropriate.

(d) The average number of days calculated in paragraph (c), based on the provider and appointment types identified in paragraph (b), shall be compared as follows:

(1) the average day wait result identified for paragraph (b), clause (3), shall be divided by the average day wait result identified for paragraph (b), clause (1);

(2) the average day wait result identified for paragraph (b), clause (4), shall be divided by the average day wait result identified for paragraph (b), clause (2);

(3) the average day wait result identified for paragraph (b), clause (7), shall be divided by the average day wait result identified for paragraph (b), clause (5);

(4) the average day wait result identified for paragraph (b), clause (8), shall be divided by the average day wait result identified for paragraph (b), clause (6);

(5) the average day wait result identified for paragraph (b), clause (11), shall be divided by the average day wait result identified for paragraph (b), clause (9); and

(6) the average day wait result identified for paragraph (b), clause (12), shall be divided by the average day wait result identified for paragraph (b), clause (10).

(e) The ratios established under paragraph (d) for 2023 shall establish a baseline for potential improvement for a health carrier in subsequent years. For years subsequent to 2023, a health carrier shall:

(1) not be required to take any action to improve any ratio that is 1.0 or higher;

(2) improve any ratio that is lower than 0.9 but higher than 0.6 so that in the succeeding year the ratio is at least 0.9;

(3) improve any ratio that is lower than 0.6 but higher than 0.3 so that in the immediate succeeding year the ratio is at least 0.6 and in the next subsequent year the ratio is at least 0.9; and

(4) improve any ratio that is lower than 0.3 so that in the immediate succeeding year the ratio is at least 0.3 and in the next subsequent year the ratio is at least 0.6 and in the next following year the ratio is at least 0.9.

Sec. 3. Minnesota Statutes 2022, section 62K.10, subdivision 8, is amended to read:

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

(b) With respect to subdivision 4, paragraph (e), the commissioner may impose a civil penalty not to exceed $10,000 per violation for each day the violation continues.

Sec. 4. **[62Q.465] MENTAL HEALTH PARITY AND SUBSTANCE ABUSE ACCOUNTABILITY OFFICE.**

(a) The Mental Health Parity and Substance Abuse Accountability Office is established within the Department of Commerce to create and execute effective strategies for implementing the requirements under:

(1) Minnesota Statutes, section 62Q.47;

(2) the federal Mental Health Parity Act of 1996, Public Law 104-204;

(3) the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Public Law 110-343, division C, sections 511 and 512;

(4) the Affordable Care Act, as defined under section 62A.011, subdivision 1a; and

(5) amendments made to, and federal guidance or regulations issued or adopted under, the acts listed under clauses (2) to (4).

(b) The office may oversee compliance reviews, conduct and lead stakeholder engagement, review consumer and provider complaints, and serve as a resource for ensuring health plan compliance with mental health and substance abuse requirements.

Sec. 5. **APPROPRIATION.**

$500,000 in fiscal year 2024 and $500,000 in fiscal year 2025 are appropriated from the general fund to the commissioner of commerce to create and operate the Mental Health Parity and Substance Abuse Accountability Office.