State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FIRST SESSION

H. F. No. 551

01/31/2019 Authored by Liebling, Schultz, Hausman, Moran and Mann
The bill was read for the first time and referred to the Committee on Health and Human Services Policy
03/13/2019 Adoption of Report: Amended and re-referred to the Committee on Commerce
03/18/2019 Adoption of Report: Amended and re-referred to the Committee on Ways and Means

A bill for an act

relating to human services; modifying provisions governing network adequacy and provider network notifications; imposing administrative penalties; establishing network access standards based on appointment wait times for managed care and county-based purchasing plans; amending Minnesota Statutes 2018, sections 62D.124, subdivision 3, by adding subdivisions; 62D.17, subdivision 1; 62K.075; 62K.10, subdivision 5; 256B.69, by adding a subdivision; 256L.121, subdivision 3; proposing coding for new law in Minnesota Statutes, chapter 62K.

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

Section 1. Minnesota Statutes 2018, section 62D.124, subdivision 3, is amended to read:

Subd. 3. **~~Exception~~ Waiver.** ~~The commissioner shall grant an exception to the requirements of this section according to Minnesota Rules, part 4685.1010, subpart 4, if the health maintenance organization can demonstrate with specific data that the requirement of subdivision 1 or 2 is not feasible in a particular service area or part of a service area.~~ (a) A health maintenance organization may apply to the commissioner of health for a waiver of the requirements in subdivision 1 or 2 if it is unable to meet those requirements. A waiver application must be submitted on a form provided by the commissioner, must be accompanied by an application fee of $1,000 per county, for each application to waive the requirements in subdivision 1 or 2 for one or more provider types in that county, and must:

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

(2) include specific information as to the steps that were and will be taken to address network inadequacy, and for steps that will be taken prospectively to address network inadequacy, the time frame within which those steps will be taken.

(b) Using the guidelines and standards established under section 62K.10, subdivision 5, paragraph (b), the commissioner shall review each waiver request and shall approve a waiver only if:

(1) the standards for approval established by the commissioner are satisfied; and

(2) the steps that were and will be taken to address the network inadequacy and the time frame for implementing these steps satisfy the standards established by the commissioner.

(c) If, in its waiver application, a health maintenance organization demonstrates to the commissioner that there are no providers of a specific type or specialty in a county, the commissioner may approve a waiver in which the health maintenance organization is allowed to address network inadequacy in that county by providing for patient access to providers of that type or specialty via telemedicine, as defined in section 62A.671, subdivision 9.

(d) A waiver shall automatically expire after four years and cannot be renewed. Upon or prior to expiration of a waiver, a health maintenance organization unable to meet the requirements in subdivision 1 or 2 must submit a new waiver application under paragraph (a) and must also submit evidence of steps the organization took to address the network inadequacy. When the commissioner reviews a waiver application for a network adequacy requirement which has been waived for the organization for the most recent four-year period, the commissioner shall also examine the steps the organization took during that four-year period to address network inadequacy, and shall only approve a subsequent waiver application if it satisfies the requirements in paragraph (b), demonstrates that the organization took the steps it proposed to address network inadequacy, and explains why the organization continues to be unable to satisfy the requirements in subdivision 1 or 2.

(e) Application fees collected under this subdivision shall be deposited in the state government special revenue fund in the state treasury.

Sec. 2. Minnesota Statutes 2018, section 62D.124, is amended by adding a subdivision to read:

Subd. 6. **Complaints alleging violation of network adequacy requirements; investigation.** Enrollees of a health maintenance organization may file a complaint with the commissioner that the health maintenance organization is not in compliance with the requirements of subdivision 1 or 2, using the process established under section 62K.105, subdivision 1. The commissioner shall investigate all complaints received under this subdivision and may use the program established under section 62K.105, subdivision 2, to investigate complaints.

Sec. 3. Minnesota Statutes 2018, section 62D.124, is amended by adding a subdivision to read:

Subd. 7. **Provider network notifications.** A health maintenance organization must provide on the organization's website the provider network for each product offered by the organization, and must update the organization's website at least once a month with any changes to the organization's provider network, including provider changes from in-network status to out-of-network status. A health maintenance organization must also provide on the organization's website, for each product offered by the organization, a list of the current waivers of the requirements in subdivision 1 or 2, in a format that is easily accessed and searchable by enrollees and prospective enrollees.

Sec. 4. Minnesota Statutes 2018, section 62D.17, subdivision 1, is amended to read:

Subdivision 1. **Administrative penalty.** The commissioner of health may, for any violation of statute or rule applicable to a health maintenance organization, or in lieu of suspension or revocation of a certificate of authority under section 62D.15, levy an administrative penalty in an amount up to $25,000 for each violation. In the case of contracts or agreements made pursuant to section 62D.05, subdivisions 2 to 4, each contract or agreement entered into or implemented in a manner which violates sections 62D.01 to 62D.30 shall be considered a separate violation. The commissioner shall impose an administrative penalty of at least $..... per day that a provider network in a county violates section 62D.124, subdivision 1 or 2, and may take other enforcement action authorized in law but shall not also impose an administrative penalty under section 62K.105, subdivision 3, for a violation. In determining the level of an administrative penalty, the commissioner shall consider the following factors:

(1) the number of enrollees affected by the violation;

(2) the effect of the violation on enrollees' health and access to health services;

(3) if only one enrollee is affected, the effect of the violation on that enrollee's health;

(4) whether the violation is an isolated incident or part of a pattern of violations; and

(5) the economic benefits derived by the health maintenance organization or a participating provider by virtue of the violation.

Reasonable notice in writing to the health maintenance organization shall be given of the intent to levy the penalty and the reasons therefor, and the health maintenance organization may have 15 days within which to file a written request for an administrative hearing and review of the commissioner of health's determination. Such administrative

hearing shall be subject to judicial review pursuant to chapter 14. If an administrative penalty is levied, the commissioner must divide 50 percent of the amount among any enrollees affected by the violation, unless the commissioner certifies in writing that the division and distribution to enrollees would be too administratively complex or that the number of enrollees affected by the penalty would result in a distribution of less than $50 per enrollee.

Sec. 5. Minnesota Statutes 2018, section 62K.075, is amended to read:

62K.075 PROVIDER NETWORK NOTIFICATIONS.

(a) A health carrier must provide on the carrier's website the provider network for each product offered by the carrier, and must update the carrier's website at least once a month with any changes to the carrier's provider network, including provider changes from in-network status to out-of-network status. A health carrier must also provide on the carrier's website, for each product offered by the carrier, a list of the current waivers of the requirements in section 62K.10, subdivision 2 or 3, in a format that is easily accessed and searchable by enrollees and prospective enrollees.

(b) Upon notification from an enrollee, a health carrier must reprocess any claim for services provided by a provider whose status has changed from in-network to out-of-network as an in-network claim if the service was provided after the network change went into effect but before the change was posted as required under paragraph (a) unless the health carrier notified the enrollee of the network change prior to the service being provided. This paragraph does not apply if the health carrier is able to verify that the health carrier's website displayed the correct provider network status on the health carrier's website at the time the service was provided.

(c) The limitations of section 62Q.56, subdivision 2a, shall apply to payments required by paragraph (b).

Sec. 6. Minnesota Statutes 2018, section 62K.10, subdivision 5, is amended to read:

Subd. 5. **Waiver.** (a) 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, must be accompanied by an application fee of $1,000 for each application to waive the requirements in subdivision 2 or 3 for one or more provider types per county, 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 specific information as to the steps that were and will be taken to address the network inadequacy, and for steps that will be taken prospectively to address network inadequacy, the time frame within which those steps will be taken.

(b) The commissioner shall establish guidelines for evaluating waiver applications, standards governing approval or denial of a waiver application, and standards for steps that health carriers or preferred provider organizations must take to address the network inadequacy and allow the health carrier or preferred provider organization to meet network adequacy requirements within a reasonable time period. The commissioner shall review each waiver application using these guidelines and standards and shall approve a waiver application only if:

(1) the standards for approval established by the commissioner are satisfied; and

(2) the steps that were and will be taken to address the network inadequacy and the time frame for taking these steps satisfy the standards established by the commissioner.

(c) If, in its waiver application, a health carrier or preferred provider organization demonstrates to the commissioner that there are no providers of a specific type or specialty in a county, the commissioner may approve a waiver in which the health carrier or preferred provider organization is allowed to address network inadequacy in that county by providing for patient access to providers of that type or specialty via telemedicine, as defined in section 62A.671, subdivision 9.

(d) The waiver shall automatically expire after four years and cannot be renewed. ~~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.~~ Upon or prior to expiration of a waiver, a health carrier or preferred provider organization unable to meet the requirements in subdivision 2 or 3 must submit a new waiver application under paragraph (a) and must also submit evidence of steps the carrier or organization took to address the network inadequacy. When the commissioner reviews a waiver application for a network adequacy requirement which has been waived for the carrier or organization for the most recent four-year period, the commissioner shall also examine the steps the carrier or organization took during that four-year period to address network inadequacy, and shall only approve a subsequent waiver application that satisfies the requirements in paragraph (b), demonstrates that the carrier or organization took the steps it proposed to address network inadequacy,

and explains why the carrier or organization continues to be unable to satisfy the requirements in subdivision 2 or 3.

(e) Application fees collected under this subdivision shall be deposited in the state government special revenue fund in the state treasury.

Sec. 7. **[62K.105] NETWORK ADEQUACY COMPLAINTS AND INVESTIGATIONS.**

Subdivision 1. **Complaints.** The commissioner shall establish a clear, easily accessible process for accepting complaints from enrollees regarding health carrier or preferred provider organization compliance with section 62K.10, subdivision 2, 3, or 4. Using this process, an enrollee may file a complaint with the commissioner that a health carrier or preferred provider organization is not in compliance with the requirements of section 62K.10, subdivision 2, 3, or 4. The commissioner shall investigate all complaints received under this subdivision.

Subd. 2. **Commissioner investigations of provider networks.** The commissioner shall establish a program to examine health carrier and preferred provider organization compliance with the requirements in section 62K.10, subdivisions 2, 3, and 4. Under this program, department employees or contractors shall seek to make appointments with a range of provider types in a carrier's or organization's designated provider network to determine whether covered services are available to enrollees without unreasonable delay, and shall examine whether the carrier's or organization's network complies with the maximum distance or travel time requirements for specific provider types. The commissioner shall develop a schedule to ensure that all health carriers and preferred provider organizations are periodically examined under this program, and shall also use this program to investigate enrollee complaints filed under subdivision 1.

Subd. 3. **Administrative penalties.** The commissioner shall impose on a health carrier or preferred provider organization an administrative penalty of at least $..... per day that a provider network violates section 62K.10, subdivision 2, 3, or 4, in a county. The commissioner may also take other enforcement actions authorized in law for a violation, except that if the commissioner imposes an administrative penalty under this subdivision, the commissioner shall not also impose an administrative penalty under section 62D.17, subdivision 1. The commissioner shall use the factors in section 62D.17, subdivision 1, to determine the amount of the administrative penalty, and the procedures in section 62D.17, subdivision 1, apply to administrative penalties imposed under this subdivision.

Sec. 8. Minnesota Statutes 2018, section 256B.69, is amended by adding a subdivision to read:

Subd. 6e. **Access standards; appointment wait times.** (a) Managed care and county-based purchasing plans must comply with the access standards for appointment wait times specified in this subdivision.

(b) Appointment wait times for primary care services must not exceed 45 days from the date of an enrollee's request for routine and preventive care and 24 hours for urgent care.

(c) Appointment wait times for specialty care services must be in accordance with the time frame appropriate for the needs of the enrollee or the generally accepted community standards.

(d) Appointment wait times for dental, optometry, lab, and x-ray services must not exceed 60 days for regular appointments and 48 hours for urgent care. For purposes of this paragraph, regular appointments for dental care means preventive care and initial appointments for restorative visits.

EFFECTIVE DATE. This section is effective for managed care and county-based purchasing contracts entered into on or after January 1, 2020.

Sec. 9. Minnesota Statutes 2018, section 256L.121, subdivision 3, is amended to read:

Subd. 3. **Coordination with state-administered health programs.** The commissioner shall coordinate the administration of the MinnesotaCare program with medical assistance to maximize efficiency and improve the continuity of care. This includes, but is not limited to:

(1) establishing geographic areas for MinnesotaCare that are consistent with the geographic areas of the medical assistance program, within which participating entities may offer health plans;

(2) requiring, as a condition of participation in MinnesotaCare, participating entities to also participate in the medical assistance program;

(3) complying with sections 256B.69, subdivision 3a; 256B.692, subdivision 1; and 256B.694, when contracting with MinnesotaCare participating entities;

(4) providing MinnesotaCare enrollees, to the extent possible, with the option to remain in the same health plan and provider network, if they later become eligible for medical assistance or coverage through MNsure and if, in the case of becoming eligible for medical

assistance, the enrollee's MinnesotaCare health plan is also a medical assistance health plan in the enrollee's county of residence; ~~and~~

(5) establishing requirements and criteria for selection that ensure that covered health care services will be coordinated with local public health services, social services, long-term care services, mental health services, and other local services affecting enrollees' health, access, and quality of care~~.~~; and

(6) complying with the appointment wait time standards specified in section 256B.69, subdivision 6e.

EFFECTIVE DATE. This section is effective for managed care, county-based purchasing, and participating entity contracts entered into on or after January 1, 2020.