Evaluation of HF XXXX – Coverage for Coordinated Specialty Care and Assertive Community Treatment

Report to the Minnesota Legislature Pursuant to Minn. Stat. § 62J. 26

01/27/2026

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As requested by Minnesota Statute § 3.197: This report cost approximately $7,986.63 to prepare, including staff time, printing and mailing expenses.

Upon request, this material will be made available in an alternative format such as large print, Braille or audio recording. Printed on recycled paper. A 508 compliant version of this report is forthcoming.

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Introduction

In accordance with Minn. Stat. § 62J.26, the Minnesota Department of Commerce (Commerce), in consultation with the Minnesota Department of Health (MDH) and Minnesota Management and Budget (MMB), performs a detailed evaluation of all relevant benefit mandate proposals. For evaluation criteria and required evaluation components, please review the Evaluation Report Methodology, available at https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/.

Bill Requirements

This House bill is sponsored by Rep. Bierman. At the time Commerce received the request for evaluation, the bill had not yet been introduced.

If enacted, this bill would require health issuers providing health insurance for "alcoholism, mental health, or chemical dependency benefits" to also provide coverage for services delivered through the Coordinated Specialty Care (CSC) model for early episode psychosis treatment and the Assertive Community Treatment (ACT) model. This proposed mandate would exclude education and employment support components of the CSC model and would require coverage for CSC to be coded and paid for as a bundle of services, as opposed to individual services.

This proposed mandate would include the following requirements for CSC delivery:

- Providers can only deliver CSC if they have been recognized by the Department of Human Services' Division of Behavioral Health.
- The credentialing of the psychiatrist or the licensed clinical leader of an early episode psychosis treatment team qualifies all members of the team to be credentialed with the issuer.

For the purpose of this bill and its evaluation:

- "Coordinated specialty care" or "CSC" is an evidence-based model for treating psychosis resulting from a serious mental illness. This model was developed by the National Institute of Mental Health and evaluated in the Recovery After an Initial Schizophrenia Episode (RAISE) research initiative.
- "Assertive community treatment" or "ACT" means intensive nonresidential treatment and rehabilitative mental health services provided according to the ACT model. ACT provides a single, fixed point of responsibility for treatment, rehabilitation, and support for individuals in a community-based setting with services offered 24 hours a day, seven days per week.

This proposed mandate would apply to fully insured small and large group commercial health plans, individual market plans, Medicare supplemental policies, and the State Employee Group Insurance Program (SEGIP). This would not apply to self-insured employer plans or grandfathered plans. While this proposed mandate, as written, does not apply to Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare), licensed health maintenance organizations (HMOs) are required to meet 62Q requirements of coverage if services are not already covered under Medical Assistance.

This bill would amend Minnesota Statutes 2024, section 62Q.47.

Related Health Conditions and Associated Services

Psychosis refers to a collection of symptoms where perception, sense of reality, and thoughts may be disrupted.[1] Symptoms and clinical manifestations can differ between individuals and episodes of psychosis, but can include hallucinations, delusions, depression, behavioral changes, and anxiety. While psychosis is considered a symptom of a serious mental illness, it can occur without an identifiable diagnosis. Associated serious mental illnesses include but are not limited to:[2]

- Schizophrenia;
- Mood disorders (e.g., bipolar and major depressive disorder);
- Anxiety disorders; and
- Post-traumatic stress disorder.

CSC is a multi-component, evidence-based early intervention for individuals who are experiencing early episode psychosis. CSC is recovery-oriented, team-based approach for treating early episode psychosis.[3] CSC programs can include:[3]

- Medication management;
- Psychotherapy;
- Family education and support; and
- Case management.

ACT is a community-based service delivery model designed for individuals diagnosed with a serious mental illness. ACT involves a multidisciplinary team that provides comprehensive care for individuals in their community 24 hours a day, 7 days a week.[4] ACT programs can include:[4]

- Medication management;
- Care coordination; and
- Housing and employment assistance.

Public Comments Summary

Commerce solicited public input on the potential health benefit mandate through a request for information (RFI) posted to Commerce's website and the Minnesota State Register. The summary below represents only the opinions and input of the organizations who responded to the RFI.

Key Stakeholder Comment Themes

For this proposed mandate, Commerce received RFI responses from three commercial health issuers.

Current Coverage. Respondents indicated they currently provide coverage for some, but not all, of the services required under the CSC and ACT models as specified in the bill. One respondent noted that CSC and ACT models are traditionally associated with Minnesota Health Care Programs coverage and suggested the models may not be in alignment with the health care experiences and needs of a commercial group population.

Interaction with Other Requirements. One respondent expressed a concern related to a provision in the bill that permits all members of a CSC treatment team to receive a credential from an issuer if the psychiatrist or licensed clinical leader of the team is credentialed with that issuer. The respondent indicated this provision conflicts with the respondent's credentialing policy and with National Committee for Quality Assurance (NCQA) standards, which require credentialing of all licensed independent practitioners to ensure the safety and quality of the care members receive. The respondent indicated it is unable to grant credentialing to unlicensed providers or to a provider based on the qualifications of another person. Another respondent expressed a concern about a possible negative impact on value-based agreements with bundled services. The same respondent also suggested that Commerce evaluate how this mandate aligns with mental health parity requirements.

Clarity of Bill Language. One respondent requested further clarification on the definition of "daily rate" and how services are bundled. The respondent stated it was unclear whether the daily rate applies for each day a member is enrolled, each day a service is delivered, or only when all services are delivered.

Cost Estimates Provided in Stakeholder Comments

Stakeholders and MMB provided the following cost estimates related to the proposed benefit mandate:

- MMB's health plan administrators estimated the average state fiscal impact of the proposed mandate to be $0.16 per member per month (PMPM), as the bill would expand current healthcare coverage of services required in the CSC and ACT models (see State Fiscal Impact section).
- Respondents suggested they would expect at least some cost increase due to coverage of additional services that are not currently covered. One respondent estimated that, if passed, the approximate cost increases would range between $5.45 and $7.70 PMPM. Another respondent indicated they were unable to determine a premium impact at this time.

Stakeholders' results may or may not reflect generalizable estimates for this mandate, depending on the methodology, data sources, and assumptions used for analysis.

Evaluation Limitations

The evaluation of the potential public health and economic impacts for this mandate was limited by several factors. The specific treatment codes associated with the mandated coverage became active as of 2023 and therefore would not be present in the available historical claims for those specific services due to a data lag in the Minnesota All Payer Claims Database. In order to conduct a representative actuarial analysis to assess the

potential economic impact of the proposed mandate, at least two years of consistent codes must be available to determine utilization, cost, and trends.

Additionally, it would not be feasible within the scope of the 62J evaluation process to assess the potential economic impact of the bundled payment approach, as these claims are currently spread across inpatient care episodes and outpatient care journeys. While there is some literature to address the clinical and economic implications of the mandated coverage, the literature has limitations given that this model is new and the specific elements of the treatment model (e.g., bundled payments) do not have sufficient evidence for review.

State Fiscal Impact

The potential state fiscal impact of this legislation includes the estimated cost to SEGIP as assessed by MMB in consultation with health plan administrators, the cost to defray benefit mandates as understood under the Patient Protection and Affordable Care Act (ACA), and the estimated cost to Minnesota Health Care Programs.

- MMB estimates the cost of this legislation for the state plan to be $127,680 for partial Fiscal Year 2027 (FY 2027) and $268,128 for FY 2028.
- Commerce has determined that this proposed mandate would not require defrayal under the ACA.
- While the proposed mandate, as written, does not explicitly apply to Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare), licensed HMOs that participate in the programs as managed care organizations (MCOs) are required to meet the requirements of coverage in chapter 62Q.

Fiscal Impact Estimate for SEGIP

MMB provided SEGIP's fiscal impact analysis, which is based on SEGIP psychiatric prevalence, Medical Assistance data, and an economic evaluation for CSC services. MMB's analysis predicted a PMPM fiscal impact of $0.06 PMPM for the CSC treatment model and $0.10 PMPM for the ACT treatment model, combining to a total of $0.16 PMPM. MMB noted the impact is due to increased credentialing requirements, bundling services, and additional services under each model that are not already covered. The partial fiscal year impact of the proposed legislation on SEGIP is estimated to be $127,680 for partial FY 2027 ($0.16 PMPM medical cost x 133,000 members x 6 months). The estimated impact for FY 2028 equals $268,128, and the amount is estimated to increase by 5% annual inflation factor each of the following years due to the increasing cost of medical services.

Affordable Care Act Mandate Impact and Analysis

States may require qualified health plan issuers to cover benefits in addition to the 10 essential health benefits (EHBs) defined by the ACA but must defray the costs, either through payments to individual enrollees or directly to issuers, and can partially defray the costs of proposed mandates if some of the care, treatment, or services are already covered in the state's benchmark plan or mandated by federal law, pursuant to section 1311(d)(3)(b) of the ACA. For further defrayal requirements and methodology, please visit https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/.

If enacted, Commerce assumes this bill would not constitute an additional benefit mandate, as it does not relate to any new requirements for specific care, treatment, or services that are not already covered by Minnesota's EHB Benchmark Plan. The Minnesota EHB Benchmark Plan includes coverage for mental/ behavioral health outpatient and inpatient services which broadly covers services and treatments included in the CSC and ACT models.

Fiscal Impact of State Public Programs

While the proposed mandate, as written, does not explicitly apply to Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare), licensed HMOs that participate in the programs as MCOs are required to meet the requirements of coverage in chapter 62Q. This proposed mandate may have a cost as Minnesota Health Care Programs may already cover some of the component services, but not the CSC treatment model specifically, so costs may be incurred from the specific coverage requirements. However, a fiscal estimate has not yet been completed on this proposed mandate.

Appendix A. Bill Text

62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY SERVICES.

(a) All health plans, as defined in section 62Q.01, that provide coverage for alcoholism, mental health, or chemical dependency services, must comply with the requirements of this section.

(b) Cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency and alcoholism services, except for persons seeking chemical dependency services under section 245G.05, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services.

(c) Cost-sharing requirements and benefit or service limitations for inpatient hospital mental health services, psychiatric residential treatment facility services, and inpatient hospital and residential chemical dependency and alcoholism services, except for persons seeking chemical dependency services under section 245G.05, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

(d) A health plan company must not impose an NQTL with respect to mental health and substance use disorders in any classification of benefits unless, under the terms of the health plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health and substance use disorders in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL with respect to medical and surgical benefits in the same classification.

(e) All health plans must meet the requirements of the federal Mental Health Parity Act of 1996, Public Law 104-204; Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; the Affordable Care Act; and any amendments to, and federal guidance or regulations issued under, those acts.

(f) The commissioner may require information from health plan companies to confirm that mental health parity is being implemented by the health plan company. Information required may include comparisons between mental health and substance use disorder treatment and other medical conditions, including a comparison of prior authorization requirements, drug formulary design, claim denials, rehabilitation services, and other information the commissioner deems appropriate.

(g) Regardless of the health care provider's professional license, if the service provided is consistent with the provider's scope of practice and the health plan company's credentialing and contracting provisions, mental health therapy visits and medication maintenance visits shall be considered primary care visits for the purpose of applying any enrollee cost-sharing requirements imposed under the enrollee's health plan.

(h) All health plan companies offering health plans that provide coverage for alcoholism, mental health, or chemical dependency benefits shall provide reimbursement for the benefits delivered through the psychiatric Collaborative Care Model, which must include the following Current Procedural Terminology or Healthcare Common Procedure Coding System billing codes:

(1) 99492;

(2) 99493;

(3) 99494;

(4) G2214; and

(5) G0512.

This paragraph does not apply to managed care plans or county-based purchasing plans when the plan provides coverage to public health care program enrollees under chapter 256B or 256L.

(i) The commissioner of commerce shall update the list of codes in paragraph (h) if any alterations or additions to the billing codes for the psychiatric Collaborative Care Model are made.

(j) "Psychiatric Collaborative Care Model" means the evidence-based, integrated behavioral health service delivery method described at Federal Register, volume 81, page 80230, which includes a formal collaborative arrangement among a primary care team consisting of a primary care provider, a care manager, and a psychiatric consultant, and includes but is not limited to the following elements:

(1) care directed by the primary care team;

(2) structured care management;

(3) regular assessments of clinical status using validated tools; and

(4) modification of treatment as appropriate.

(k) All health plan companies offering health plans that provide coverage for alcoholism, mental health, or chemical dependency benefits shall provide reimbursement for the benefits delivered through the coordinated specialty care model for early episode psychosis treatment and assertive community treatment services as defined in section 256B.0622.

(l) Coordinated specialty care means the evidence-based model conducted by the National Institute of Mental Health in the Recovery After an Initial Schizophrenia Episode (RAISE) for psychosis resulting from a serious mental illness, but excluding the components of the treatment model related to education and employment support. Only providers recognized by the Department of Human Services' Division of Behavioral Health to deliver coordinated specialty care for early episode psychosis treatment shall be permitted to provide such treatment in accordance with this section and such providers must adhere to the fidelity of the treatment model. Insurers shall use a bundled treatment approach to determine a coding solution that allows for these bundled treatment models to be coded and paid for as a bundle of services, similar to intensive outpatient treatment where multiple services are covered under one billing code or a bundled set of billing codes. For purposes of credentialing the mental health professionals and other medical professionals that are part of a coordinated specialty care for early episode psychosis treatment team, the credentialing of the psychiatrist or the licensed clinical leader of the treatment team shall qualify all members of the treatment team to be

credentialed with the insurer.

~~(k)~~ (m) By June 1 of each year, beginning June 1, 2021, the commissioner of commerce, in consultation with the commissioner of health, shall submit a report on compliance and oversight to the chairs and ranking minority members of the legislative committees with jurisdiction over health and commerce. The report must:

(1) describe the commissioner's process for reviewing health plan company compliance with United States Code, title 42, section 18031(j), any federal regulations or guidance relating to compliance and oversight, and compliance with this section and section 62Q.53;

(2) identify any enforcement actions taken by either commissioner during the preceding 12-month period regarding compliance with parity for mental health and substance use disorders benefits under state and federal law, summarizing the results of any market conduct examinations. The summary must include:

(i) the number of formal enforcement actions taken;

(ii) the benefit classifications examined in each enforcement action; and

(iii) the subject matter of each enforcement action, including quantitative and nonquantitative treatment limitations;

(3) detail any corrective action taken by either commissioner to ensure health plan company compliance with this section, section 62Q.53, and United States Code, title 42, section 18031(j); and

(4) describe the information provided by either commissioner to the public about alcoholism, mental health, or chemical dependency parity protections under state and federal law.

The report must be written in nontechnical, readily understandable language and must be made available to the public by, among other means as the commissioners find appropriate, posting the report on department websites. Individually identifiable information must be excluded from the report, consistent with state and federal privacy protections.

Works Cited

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