State of Minnesota

HOUSE OF REPRESENTATIVES

NINETIETH SESSION

H. F. No. 3641

03/12/2018 Authored by Gruenhagen
The bill was read for the first time and referred to the Committee on Health and Human Services Reform

A bill for an act

relating to human services; establishing the family medical account program; proposing coding for new law in Minnesota Statutes, chapter 256B.

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

Section 1. **[256B.695] FAMILY MEDICAL ACCOUNT (FMA) PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of human services shall establish the family medical account program by January 1, 2019, or upon federal approval, whichever is later. For purposes of this section, "financial institution" has the meaning given in section 47.59, subdivision 1, paragraph (k).

Subd. 2. **General criteria.** (a) The program must provide participants with medical assistance benefits, consisting of: (1) coverage of all medical assistance medical goods and services, after an annual deductible has been met; and (2) contributions into a family medical account, which may be used to pay for medical goods and services subject to the deductible.

(b) The program must provide enrollment counseling to program participants by:

(1) providing incentives for patients to seek preventive health services;

(2) providing enrollment counseling and related information;

(3) requiring that transactions involving family medical accounts be conducted electronically; and

(4) providing participants with access to negotiated provider payment rates.

(c) The program must provide ongoing education to program participants by:

(1) educating patients on the high cost of medical care;

(2) reducing the inappropriate use of health care services; and

(3) enabling patients to take responsibility for health care outcomes.

(d) The commissioner shall provide for retrospective medical billing as allowed under medical assistance guidelines.

Subd. 3. **Eligible persons.** (a) Persons eligible for medical assistance and having an income of 138 percent or less of the federal poverty level under section 256B.055, subdivisions 3a, 9, 10, 15, and 16, may elect to participate in the program. Beneficiaries in Medicaid-managed care organizations may elect to enroll in the FMA program at annual re-enrollment and at any other re-enrollment time determined by the commissioner.

(b) The commissioner shall fully inform eligible persons of the availability of the program and the comparative attributes of the FMA program and other programs.

(c) Enrollment is effective for a period of 12 months and may be extended for additional 12-month periods. Enrollment in the program is subject to the individual maintaining eligibility for medical assistance.

(d) A person, who, for any reason, except fraud, is disenrolled from the program shall have the FMA funds vested one year after enrollment and placed in a state approved investment account for the person's use for medical goods and services.

Subd. 3a. **Excluded persons.** Individuals who, when applying, have a disability or are 65 years of age or older. Disability as used in this subdivision has the meaning provided in United States Code, title 42, section 12102.

Subd. 4. **Medical assistance benefits.** (a) Participants in the program shall receive the following medical assistance benefits:

(1) coverage for medical expenses for medical goods and services for which benefits are otherwise provided under medical assistance, after the annual deductible specified in paragraph (c) has been met; and

(2) contributions into an FMA. Use of an FMA is limited to outpatient and emergency room goods and services.

(b) Notwithstanding section 256B.0631, any outpatient treatment service is limited to a $300 co-pay per service occurrence.

(c) The amount of the annual deductible shall be 100 percent of the annualized amount of contributions to the FMA.

(d) The following services are not subject to the annual deductible:

(1) preventive services as specified by the commissioner;

(2) prescription drugs prescribed for the treatment of diabetes, high blood pressure, high cholesterol, epilepsy, respiratory diseases, and other health conditions as determined by the commissioner;

(3) life saving devices needed for the treatment of anaphylaxis;

(4) medical equipment necessary for the treatment of respiratory diseases; and

(5) inpatient hospital care and services at surgery centers. No FMA emergency room charge is deducted if the participant is admitted to inpatient care.

(e) After a person has satisfied the annual deductible, medical assistance benefits for that person shall consist of the benefits that would otherwise be provided to that person under medical assistance had the individual not been enrolled in the program. Program participants shall be subject to all medical assistance cost-sharing requirements.

(f) The commissioner shall contract directly with health care providers as defined in section 62A.63, subdivision 2, to provide the medical assistance benefits specified in paragraph (a), clause (1), and may purchase reinsurance for the cost of providing these medical assistance benefits.

Subd. 5. **Operation of family medical accounts.** (a) The state shall contribute an annual amount into the FMA funds owned by each participating person. For the first calendar year of the program, the prefund for the FMA debit card for children is $1,500, for adults with children is $2,500, and for adults without children is $4,000. The commissioner shall annually adjust the amount to meet 50 percent of CMS annual enrollee costs using data from the Department of Human Services. The commissioner shall pay in either monthly or biweekly increments as long as the participant is eligible. There is no accrual limit for family medical accounts.

(b) The commissioner shall contract with a third-party administrator to administer and coordinate family medical accounts. The third-party administrator shall be audited annually by an independent auditor under parameters determined by the commissioner. A health plan company, or a financial institution under contract under paragraph (c), may not serve as a third-party administrator.

(c) The commissioner shall contract with a financial institution to establish investment accounts for program participants owning FMA funds at the end of the calendar year. Investment accounts do not have a dollar cap. The commissioner shall negotiate, as part of the contract, the amount of any administrative fee to be paid by the financial institution to

the third-party administrator on behalf of program participants and the interest rate to be paid by the financial institution to program participants.

(d) The commissioner may contract for private bank services.

(e) Amounts in, or contributed to, an FMA shall not be counted as income or assets for purposes of determining medical assistance eligibility.

(f) All payments shall be made by the state or third-party administrator directly to providers of medical goods and services.

(g) The commissioner shall create a process to coordinate care for high-cost chronically ill individuals with any medical illness, addiction, mental illness, dental care needs, or high medical costs due to prolonged acute illness or injury. The use of patient personal clinical data for this process requires each patient's authorized release of information. As used in this paragraph, "chronically ill individual" has the meaning given in United States Code, title 26, section 7702B, (c)(2)(A).

Subd. 5a. **Data.** All data under the FMA program including protected patient identified data is available to the commissioner of human services. All data except protected health information is available to any party pursuant to chapter 13, the Government Data Practices Act, and no such data may be declared protected data or trade secret by the commissioner of human services.

Subd. 6. **Incentives for preventive care.** (a) The commissioner may develop and provide positive incentives for individuals enrolled in the program to obtain prenatal care and other appropriate preventive care. In developing these incentives, the commissioner may consider various rewards for individuals demonstrating healthy prevention practices and may consider providing positive incentives for accessing preventive services.

(b) The commissioner may provide additional payments to providers who coordinate care for enrollees.

Subd. 7. **Using money in the family medical account.** (a) Except as provided in subdivision 10, money in an FMA may be used only for paying for medical care, as defined in section 213(d) of the Internal Revenue Code of 1986.

(b) Money in an FMA may not be used to pay providers for medical goods and services unless: (1) the providers are licensed or otherwise authorized under state law to provide the goods or services; and (2) the provider meets medical assistance program standards and complies with medical assistance prohibitions related to fraud and abuse.

(c) The commissioner shall establish procedures to: (1) penalize or disenroll from the program persons and providers who make nonqualified withdrawals from an FMA; and (2) recoup costs that derive from nonqualified withdrawals.

(d) The use of FMA funds after age 65 shall be governed by federal health savings account rules and state Medicaid payment rates for medical goods and services that do not apply unless the person remains on Medicaid. For those persons no longer in the FMA program, use of FMA money for medical goods and services are not subject to Medicaid payment rates.

Subd. 8. **Electronic transactions required.** The commissioner shall require all withdrawals and payments from FMAs to be made electronically. The method developed or selected for the program must include photo identification and electronic locks to prevent unauthorized use and must provide real-time, encounter-level payment to health care providers. The method used must: (1) allow information from a patient's medical record to be stored and accessed by the patient and health care providers; (2) be capable of storing and transferring for analysis the encounter-level data for both provider- and enrollee-specific and aggregate health care quality measurement and monitoring; and (3) enable the provider to confirm that the electronic means accurately identifies the participant.

Subd. 9. **Access to negotiated provider payment rates.** The commissioner shall allow participants who are subject to a deductible or co-pay to obtain medical goods and services from providers who choose to serve program participants at payment rates that do not exceed the medical assistance payment rates.

Subd. 10. **Maintaining an FMA for persons who become ineligible; vesting.** (a) If a participant becomes ineligible for medical assistance, the state shall make no further contributions to the participant's FMA.

(b) Following application of paragraph (a), money in the account shall remain available to the account holder for one year from the date on which the individual became ineligible for medical assistance, under the same terms and conditions that would apply had the individual remained eligible for the program, except that the money in the FMA may also be used as provided in paragraph (c).

(c) For those participants no longer enrolled in the program, money in the FMA may be used to purchase medical goods and services from health care providers. Money used for this purpose must be transferred by the state or third-party administrator directly from the account to the medical provider of goods and services or from an investment account of which the use is limited to the provision of medical goods and services. In the event of the

person's death, the amount in the investment account shall be distributed to the primary beneficiary of the estate or, if there is no named beneficiary, to the estate.

(d) The funds in the FMA are not recoverable by the state.

Subd. 11. **Commissioner duties.** (a) The commissioner shall provide enrollment counselors and ongoing education for program participants. The counseling and education must be designed to meet the program goals specified in subdivision 2, paragraphs (b) and (c); provide participants with assistance accessing providers and obtaining negotiated provider payment rates; and provide participants with information on the benefits of maintaining continuity of care both before and after meeting the required deductible.

(b) The commissioner shall make the services of the Office of Ombudsman available to program participants and shall require the office to address access, service, and billing problems related to providing medical assistance benefits under subdivision 4.

(c) The commissioner shall provide FMA enrollees a monthly report detailing transactions including FMA balances.

(d) The commissioner shall implement a streamlined medical assistance renewal process for program participants. This process must include:

(1) requiring eligibility renewals every 12 months;

(2) allowing passive renewal, under which individuals receive from the commissioner a completed renewal form; and

(3) providing to the commissioner updated information or a signed statement attesting that the individual's eligibility information has not changed.

(e) The commissioner may adopt rules under chapter 14 to establish criteria for the operation of family medical accounts and may establish conditions limiting the use of money in an account to include a deduction of $25 from the participant's FMA account if the participant does not contact the nurse hotline before going to the emergency room. If the medical event requires hospitalization, this deduction does not apply. Except for necessary emergency services that do not result in hospitalization, an enrollee in FMA shall be charged an ambulance co-pay charge if the enrollee is not admitted to the hospital.

(f) To ensure access, the commissioner shall recruit willing Medicaid providers and shall publish monthly updated provider listings, including location and ordinary office call and procedure prices that Medicaid pays for health care services based on common actuarial rates related to the expenses.

(g) The commissioner shall present annual progress reports on the program to the legislature, beginning October 1, one year after implementation of the program and each October 1 thereafter. The commissioner shall include in the progress reports recommendations for any changes in law necessary to improve operation of the program or to comply with federal requirements. The commissioner shall include in the report due October 1, 2023, recommendations on whether the program should be expanded to include additional participants.

Subd. 12. **Federal approval.** The commissioner shall seek all federal approvals necessary to establish and implement the family medical account program.