State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-SECOND SESSION

H. F. No. 1984

03/08/2021 Authored by Gruenhagen
The bill was read for the first time and referred to the Committee on Human Services Finance and Policy

A bill for an act

relating to human services; establishing the family medical account program; providing rulemaking authority; requiring reports; 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 PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of human services shall establish the family medical account (FMA) program by January 1, 2022, or upon federal approval, whichever is later.

Subd. 2. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given.

(b) "Chronically ill individual" has the meaning given in United States Code, title 26, section 7702B, (c)(2)(A).

(c) "Disability" has the meaning given in United States Code, title 42, section 12102.

(d) "Financial institution" has the meaning given in section 47.59, subdivision 1, paragraph (k).

(e) "Participant" means an individual enrolled in the FMA program.

Subd. 3. **General criteria.** (a) The FMA program must provide participants with medical assistance benefits according to subdivision 6.

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

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

(2) providing enrollment counseling and related information;

(3) requiring that transactions involving FMAs be conducted electronically; and

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

(c) The FMA program must provide ongoing education to 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. 4. **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 FMA 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 FMA program and the comparative attributes of the FMA program and other programs.

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

(d) FMA funds vest one year after enrollment. If a person is disenrolled from the FMA program for any reason other than fraud, the commissioner must place the funds in a state-approved investment account for the person's use for medical goods and services.

Subd. 5. **Excluded persons.** Individuals who, when applying, have a disability or are 65 years of age or older are excluded persons.

Subd. 6. **Medical assistance benefits.** (a) Participants shall be deemed consumers and 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 (d) has been met; and

(2) contributions into an FMA.

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

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

(d) The amount of the annual deductible is 100 percent of the annualized amount of contributions to the FMA.

(e) 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) lifesaving 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.

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

(g) 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 through open national bids for the cost of providing these medical assistance benefits.

Subd. 7. **Operation of an FMA.** (a) The state shall contribute an annual amount into the FMA funds owned by each participant. For the first calendar year of the FMA 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 $2,700. 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 FMAs. 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), must not serve as a third-party administrator.

(c) The commissioner shall contract with a financial institution to establish investment accounts for 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 participants and the interest rate to be paid by the financial institution to 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 shall include each patient's authorized release of information, except that no patient approval is required for release of information if the chronic illness severity requires that the patient be transferred to the Department of Human Services fee-for-service program.

Subd. 8. **Data.** All data under the FMA program including protected patient identified data is available to the commissioner. 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.

Subd. 9. **Incentives for preventive care.** (a) The commissioner may develop and provide positive incentives for participants 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 participants.

Subd. 10. **Using money in an FMA.** (a) Except as provided in subdivision 13, 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 must 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, except there shall be no mandated electronic health records and report requirement for cash clinics, and the provider complies with medical assistance prohibitions related to fraud and abuse.

(c) The commissioner shall establish procedures to:

(1) penalize or disenroll from the FMA 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 is 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. 11. **Electronic transactions required.** The commissioner shall require all withdrawals and payments from FMAs to be made electronically. The method developed or selected for the FMA 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. 12. **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, including cash only clinics, individual clinics, and individual mental health clinics, who choose to serve participants at payment rates that do not exceed the medical assistance payment rates.

Subd. 13. **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 remains 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 FMA program, except that the money in the FMA may also be used as provided in paragraph (c).

(c) For those individuals no longer enrolled in the FMA 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. 14. **Commissioner duties.** (a) The commissioner shall provide enrollment counselors and ongoing education for participants. The counseling and education must be designed to:

(1) meet the FMA program goals specified in subdivision 3, paragraphs (b) and (c);

(2) provide participants with assistance accessing providers and obtaining negotiated provider payment rates; and

(3) 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 participants and shall require the office to address access, service, and billing problems related to providing medical assistance benefits under subdivision 6.

(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 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 FMAs 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, a participant shall be charged an ambulance co-pay charge if the participant 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 FMA program to the legislature, beginning October 1, one year after implementation of the FMA 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 FMA program or to comply with federal requirements. The commissioner shall include in the report due October 1, 2026, recommendations on whether the FMA program should be expanded to include additional participants.

Subd. 15. **Federal approval.** The commissioner shall seek all federal approvals necessary to establish and implement the FMA program.