SENATE
STATE OF MINNESOTA
NINETY-THIRD SESSION

S.F. No. 3621

(SENATE AUTHORS: GRUENHAGEN)

DATE	D-PG	OFFICIAL STATUS
02/15/2024		Introduction and first reading Referred to Health and Human Services

A bill for an act

relating to human services; establishing Family Medical Account service delivery model; 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 SERVICE DELIVERY MODEL.**

Subdivision 1. **Establishment.** The commissioner of human services shall establish the Family Medical Account (FMA) service delivery model under this section. The commissioner shall place all new and reenrolling medical assistance enrollees eligible under subdivision 4, and not excluded by subdivision 5, on an FMA service delivery model beginning January 1, 2025.

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) "Enrollee" means an individual enrolled in the FMA service delivery model.

Subd. 3. **General criteria.** (a) The FMA service delivery model must provide enrollees with medical assistance benefits according to subdivision 6.

(b) The FMA service delivery model must provide enrollment counseling to enrollees by providing enrollees:

(1) incentives to seek preventive health care services;

(2) with individual guidance regarding the enrollment process and related information; and

(3) with access to negotiated provider payment rates.

(c) The FMA service delivery model must provide ongoing education to enrollees on:

(1) the high cost of medical care;

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

(3) taking individual enrollee responsibility for health care outcomes.

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

Subd. 4. **Participation requirements.** (a) The commissioner must require any new or reenrolling medical assistance enrollee who meets all the following qualifications to receive medical assistance in the FMA service delivery model:

(1) the person is eligible for medical assistance under section 256B.055, subdivisions 3a, 9, 10, 15, and 16;

(2) the person has an income of 138 percent or less of the federal poverty guideline;

(3) the person would otherwise receive medical assistance services under a managed care organization or a similar service delivery model; and

(4) the person is not excluded under subdivision 5.

(b) Individuals enrolled in the FMA service delivery model may opt out and elect to enroll in medical assistance under a managed care organization or a similar service delivery model at annual reenrollment and at any other reenrollment time determined by the commissioner.

(c) The commissioner shall fully inform eligible persons of the comparative attributes of the FMA service delivery model and other service delivery models.

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

Subd. 5. **Excluded persons.** (a) A person who, when applying, has a disability or is 65 years of age or older is excluded from enrollment in the FMA service delivery model.

(b) A medical assistance enrollee subject to a federal waiver that requires a specific delivery service model is excluded from enrollment in the FMA service delivery model.

(c) A medical assistance enrollee receiving services under a delivery service model other than a managed care organization or a similar service delivery model is not required to newly enroll or reenroll in the FMA service delivery model.

Subd. 6. **Medical assistance benefits.** (a) Enrollees in the FMA service delivery model must be deemed consumers and must 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, including monthly fees for direct primary care.

(c) Any outpatient treatment service is limited to a $300 co-payment per service occurrence.

(d) Notwithstanding section 256B.0631, subdivision 1a, the amount of the annual deductible for an enrollee in the FMA service delivery model 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. The commissioner must not deduct an FMA emergency room charge if the enrollee is admitted to inpatient care.

(f) After an enrollee has met the annual deductible, medical assistance benefits for that enrollee consist of the benefits that would otherwise be provided to that enrollee under medical assistance had the enrollee not enrolled in the FMA service delivery model.

(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 commissioner shall contribute an annual amount into the FMA of each enrollee. Enrollees must use an FMA debit card to pay for benefits under the program.

(b) For the initial calendar year of the FMA service delivery model, the prefund amount for the FMA debit card is:

(1) $1,500 for children;

(2) $2,500 for adults with children; and

(3) $2,500 for adults without children.

(c) The commissioner shall pay the entire yearly prefund amount on January 1 each year as long as the enrollee is eligible.

(d) The commissioner shall annually adjust the amount under paragraph (b) to meet 40 percent of Centers for Medicare and Medicaid Services annual enrollee costs as determined using data available to the commissioner.

(e) Remaining FMA service delivery model prefund money vests one year after enrollment. Any money remaining from the yearly prefund amount under paragraph (b) must be placed into an investment account according to paragraph (h). Accumulated money transferred to an investment account must not be counted toward the enrollee meeting the prefund deductible in the subsequent year.

(f) If an enrollee is disenrolled from the FMA service delivery model or otherwise becomes ineligible for any reason other than fraud, the operation of the FMA and any associated investment account is controlled by subdivision 13.

(g) The commissioner shall contract with a third-party administrator to administer and coordinate FMAs. The third-party administrator must 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 (h), must not serve as a third-party administrator.

(h) The commissioner shall contract with a financial institution to establish investment accounts for enrollees with unused FMA money at the end of the calendar year. FMA service delivery model investment accounts do not have a dollar maximum. The commissioner shall negotiate, as part of the contract, the interest rate to be paid by the financial institution to an enrollee.

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

(j) The commissioner shall not count amounts in or contributed to an FMA as income or assets for purposes of determining medical assistance eligibility.

(k) All payments must be made by the commissioner or the third-party administrator directly to providers of medical goods and services.

(l) All payments to providers of medical goods and services for medical assistance must be made at levels equivalent to the federal Medicare service fee rates.

(m) The commissioner shall create a process to coordinate care for high cost, chronically ill enrollees with any medical illness, addiction, mental illness, dental care needs, or high medical costs due to prolonged acute illness or injury. The use of enrollee personal clinical data for this process must include each enrollee's authorized release of information, except that no enrollee approval is required for release of information if the chronic illness severity requires that the enrollee be transferred to a fee-for-service delivery model.

Subd. 8. **Data.** All data under the FMA service delivery model, including protected enrollee identified data, is available to the commissioner. All data except protected health information is available to any party pursuant to chapter 13, 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 enrollees to obtain prenatal care and other appropriate preventive care. In developing these incentives, the commissioner may consider various rewards for enrollees demonstrating healthy prevention practices.

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

Subd. 10. **Using money in an FMA.** (a) Except as provided in subdivision 13, enrollees must only use money in an FMA for paying for medical care, as defined in section 213(d) of the Internal Revenue Code of 1986.

(b) Enrollees must not use money in an FMA 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;

(2) the provider meets medical assistance program standards, except there must be no mandated electronic health records or report requirement for cash clinics; and

(3) 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 service delivery model enrollees and providers who make nonqualified withdrawals from an FMA; and

(2) recoup costs that derive from nonqualified withdrawals.

(d) Enrollee use of FMA money after age 65 is governed by federal health savings account rules.

(e) Medical assistance payment rates for medical goods and services do not apply unless the enrollee remains on medical assistance. For those individuals no longer enrolled in the FMA service delivery model, use of FMA money for medical goods and services is not subject to medical assistance payment rates.

Subd. 11. **Electronic transactions required.** The commissioner shall require all withdrawals and payments from FMAs be made electronically. The method developed or selected for the FMA service delivery model 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 an enrollee's medical record to be stored and accessed by the enrollee and health care providers;

(2) allow storage and transfer of encounter-level data for analysis 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 identify the enrollee.

Subd. 12. **Access to negotiated provider payment rates.** The commissioner shall allow enrollees who are subject to a deductible or co-payment to obtain medical goods and services from providers, including cash only clinics, individual clinics, and individual mental health

clinics, that choose to serve enrollees at payment rates that do not exceed the medical assistance payment rates.

Subd. 13. **Maintaining an FMA for enrollees who become ineligible; vesting.** (a) If an enrollee becomes ineligible for medical assistance, the commissioner must make no further contributions to the individual's FMA.

(b) If an enrollee becomes ineligible for medical assistance, money in the FMA 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 service delivery model, 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 service delivery model, 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 commissioner or the third-party administrator directly from the FMA 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.

(d) In the event of the individual's death, the amount in the investment account must be distributed to the primary beneficiary of the estate or, if there is no named beneficiary, to the estate.

(e) The money in the FMA investment account is not recoverable by the state.

Subd. 14. **Commissioner duties.** (a) Notwithstanding section 256B.0631, subdivision 1a, the commissioner shall establish and publish co-payment amounts for the benefits provided to an enrollee under the FMA service delivery model.

(b) The commissioner shall provide enrollment counselors and ongoing education for enrollees. The counseling and education must be designed to:

(1) meet the FMA service delivery model requirements specified in subdivision 3, paragraphs (b) and (c);

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

(3) provide enrollees with information on the benefits of maintaining continuity of care both before and after meeting the deductible.

(c) The commissioner shall make the services of the Office of Ombudsperson for Public Managed Health Care Programs available to enrollees in the FMA service delivery model and shall require the office to address access, service, and billing problems related to providing medical assistance benefits under subdivision 6.

(d) The commissioner shall provide FMA service delivery model enrollees a monthly report detailing transactions, including FMA balances.

(e) The commissioner shall implement a streamlined medical assistance renewal process for FMA service delivery model enrollees. This process must include:

(1) requiring eligibility renewals every 12 months;

(2) allowing for passive renewal in which an enrollee receives a completed renewal form from the commissioner; and

(3) allowing enrollees to provide to the commissioner updated information or a signed statement attesting that the enrollee's eligibility information has not changed.

(f) The commissioner may adopt rules under chapter 14 to establish criteria for the operation of the FMA service delivery model and may establish conditions limiting the use of money in an account, including but not limited to a deduction of $25 from the enrollee's FMA if the enrollee does not contact the nurse hotline before going to the emergency room. If the medical event requires hospitalization, this deduction must not apply. Except for necessary emergency services that do not result in hospitalization, the commissioner must charge an enrollee an ambulance co-payment.

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

(h) In implementing the FMA service delivery model, the commissioner shall also raise all service fees for medical assistance provided under the FMA service delivery model to levels equivalent to the federal Medicare service fee rates.

(i) The commissioner shall present progress reports on the FMA service delivery model to the legislative committees with jurisdiction over health and human services finance and policy by October 1, 2025, and October 1, 2026. The commissioner shall include in the progress reports recommendations for any changes in law necessary to improve operation of the FMA service delivery model or to comply with federal requirements.

EFFECTIVE DATE. This section is effective the day following final enactment.