A bill for an act

relating to human services; allowing medical assistance providers to repackage and reprice services; establishing a health opportunity account demonstration project for medical assistance enrollees; requiring the commissioner of human services to develop and seek federal approval for a medical assistance reform demonstration project; establishing a MinnesotaCare voucher demonstration project; requiring the commissioner of human services to develop proposals and a timetable for the reform and restructuring of state health care programs; amending Minnesota Statutes 2008, section 256B.0754, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapters 256B; 256L.

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

Section 1. Minnesota Statutes 2008, section 256B.0754, is amended by adding a subdivision to read:

Subd. 3. **Repackaging and repricing services.** Beginning January 1, 2010, the commissioner shall regularly request proposals from health care providers serving fee-for-service medical assistance enrollees to repackage and reprice their services. The commissioner shall accept proposals for repackaging and repricing services if:

(1) the repriced, repackaged services do not increase total spending by the state;

(2) the quality of care received by patients will not decline; and

(3) the health care provider proposes a method to measure cost and quality to ensure that the requirements of clauses (1) and (2) are met. The commissioner shall coordinate the implementation of repackaged and repriced services with the implementation of the payment reform provisions of sections 62U.02 to 62U.05.

Sec. 2. **[256B.0755] HEALTH OPPORTUNITY ACCOUNTS.**

Subdivision 1. **Demonstration project.** The commissioner shall establish a health opportunity account demonstration project that meets the criteria specified in section

6082 of the Deficit Reduction Act of 2005, (Public Law 109-171). Enrollment in the demonstration project is voluntary and limited to 14,000 individuals. The commissioner shall implement the demonstration project effective January 1, 2010, or upon federal approval, whichever is later. The term of the demonstration project is five years.

Subd. 2. **Project goals and requirements.** (a) The demonstration project must provide participants with alternative benefits, consisting of coverage of:

(1) all medical assistance services, after an annual deductible has been met; and

(2) contributions into a health opportunity account, which may be used to pay for services subject to the deductible.

(b) The demonstration project must:

(1) create patient awareness of the high cost of medical care;

(2) provide incentives for patients to seek preventive health services;

(3) reduce the inappropriate use of health care services;

(4) enable patients to take responsibility for health care outcomes;

(5) provide enrollment counselors and ongoing education activities;

(6) require transactions involving health opportunity accounts to be conducted electronically; and

(7) provide participants with access to negotiated provider payment rates.

Subd. 3. **Eligible persons.** (a) Participation in the demonstration project is limited to families and children who are eligible for medical assistance under section 256B.055, subdivisions 3, 3a, 9, 10, and 10b. Individuals who are disabled, age 65 or older, or pregnant, and others excluded under section 1938(b) of the Social Security Act, are not eligible to participate in the demonstration project.

(b) Participation in the demonstration project is voluntary. Enrollment is effective for a period of 12 months, and may be extended for additional 12-month periods with the consent of the individual. Enrollment in the demonstration project is subject to the individual maintaining eligibility for medical assistance.

(c) An individual who, for any reason, is disenrolled from the demonstration project is not permitted to re-enroll before the end of the one-year period that begins on the effective date of disenrollment.

Subd. 4. **Alternative benefits.** (a) Participants in the demonstration project are entitled to the following alternative benefits:

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

(2) contributions into a health opportunity account.

(b) The amount of the annual deductible must be 100 percent of the annualized amount of contributions to the health opportunity account. Preventive services, as defined by the commissioner, are not subject to the annual deductible.

(c) After an individual has satisfied the annual deductible, alternative benefits for that individual shall consist of the benefits that would otherwise be provided to that individual under medical assistance, including cost sharing related to those benefits, had the individual not been enrolled in the demonstration project. Each individual shall obtain alternative benefits under this paragraph from the managed care plan or county-based purchasing plan in which the individual was enrolled prior to entering the demonstration project. The per capita payment for the provision of alternative services under the demonstration project must not exceed the per capita payment under the prepaid medical assistance program, adjusted for the deductible and any differences in the use of health care services by the population served under the demonstration project.

Subd. 5. **Account contributions and administration.** (a) Contributions into a health opportunity account may be made by the state and by other persons and entities such as charitable organizations. The state shall contribute an annual amount into the health opportunity account of each participating individual. For the calendar year 2009, the amount contributed by the state must equal $2,765 for each eligible adult and $1,106 for each eligible child. For future calendar years, these amounts must be increased by the change in the medical component of the Consumer Price Index for all urban consumers (CPI-U).

(b) The commissioner shall contract with a third-party administrator to administer health opportunity accounts.

(c) Amounts in, or contributed to, a health opportunity account must not be counted as income or assets for purposes of determining medical assistance eligibility.

Subd. 6. **Preventive care.** The commissioner shall develop and provide incentives for individuals enrolled in the demonstration project to obtain appropriate preventive care. In developing these incentives, the commissioner shall consider additional account contributions for individuals demonstrating healthy prevention practices and the provision of preventive services or incentives for accessing preventive services that are in addition to those available to medical assistance enrollees not participating in the demonstration project.

Subd. 7. **Allowed uses of account funds.** (a) Except as provided in subdivision 10, money in a health opportunity account may be used only for payment for medical care, as defined in section 213(d) of the Internal Revenue Code of 1986.

(b) Money in a health opportunity account must not be used to pay providers for items and services unless:

(1) the providers are licensed or otherwise authorized under state law to provide the item or service; and

(2) the provider meets medical assistance program quality standards and complies with medical assistance prohibitions related to fraud and abuse.

(c) Money in a health opportunity account must not be used to pay a provider for an item or service if the commissioner determines that the item or service is not medically appropriate or necessary.

(d) The commissioner shall establish procedures to:

(1) penalize or disenroll from the demonstration project individuals who make nonqualified withdrawals from a health opportunity account; and

(2) recoup costs that derive from nonqualified withdrawals.

Subd. 8. **Electronic debit card.** The commissioner shall require all withdrawals and payments from health opportunity accounts to be made using electronic debit cards.

Subd. 9. **Access to negotiated provider payment rates.** The commissioner shall require managed care plans and county-based purchasing plans to:

(1) allow demonstration program participants, when subject to a deductible, to obtain services from providers under contract with the plan at the same payment rate that the provider would otherwise receive from the plan, had the individual not been participating in the demonstration project; and

(2) allow demonstration program participants, when subject to a deductible, to obtain services from providers who are not under contract with the plan, at payment rates that do not exceed 125 percent of the medical assistance fee-for-service payment rate.

Subd. 10. **Use of health opportunity account funds for persons who become ineligible.** (a) If a participant becomes ineligible for medical assistance because of an increase in income or assets:

(1) the state shall make no further contributions to the participant's health opportunity account; and

(2) the balance in the account that is not attributable to private contributions shall be reduced by 25 percent.

(b) Following application of paragraph (a), money in the account shall remain available to the account holder for three years 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 demonstration project, except that the money may also be used as provided in paragraphs (c) and (d).

(c) Money in the account may be used to purchase health coverage from a health plan company. An account holder is not required to purchase a high-deductible policy as a condition for maintaining or using the account.

(d) Individuals who have participated in the demonstration project for at least one year may also use money in the account for job training, educational expenses, and other uses as specified by the commissioner.

Subd. 11. **Participation of enrollees served by managed care and county-based purchasing.** (a) Participation in the demonstration project by enrollees served by managed care and county-based purchasing plans under sections 256B.69 and 256B.692 is subject to the following conditions:

(1) the number of individuals enrolled in a specific plan who participate in the demonstration project must not exceed five percent of the total statewide medical assistance enrollment in the plan; and

(2) the proportion of medical assistance enrollees in a specific plan who participate in the demonstration project must not be significantly disproportionate to the proportion of medical assistance enrollees in other plans who participate.

(b) The commissioner shall adjust capitation payment rates and application of the risk adjustment system under section 62Q.03 to reflect differences in the likely use of health care services between plan enrollees who participate in the demonstration project and plan enrollees who do not participate in the demonstration project.

(c) The commissioner, in consultation with managed care and county-based purchasing plans, shall develop procedures to encourage demonstration project participants with complex or chronic conditions to receive health care services from providers certified as health care homes under section 256B.0751.

Subd. 12. **Additional duties of the commissioner.** (a) The commissioner shall provide enrollment counselors and ongoing education for demonstration project participants. The counseling and education must be designed to meet the project goals specified in subdivision 2, paragraph (b), clauses (1) to (4), provide participants with assistance in the use of electronic debit cards and in accessing providers and obtaining negotiated provider payment rates, and provide participants with information on the benefits of maintaining continuity of care by receiving services through the same health care provider both prior to and after meeting the required deductible.

(b) The commissioner shall present annual progress reports on the demonstration project to the legislature, beginning October 1, 2010, and each October 1 thereafter through October 1, 2014. The commissioner shall include in the progress reports recommendations for any state law changes necessary to improve operation of the demonstration project

or to comply with federal requirements. The commissioner shall include, in the report due October 1, 2013, recommendations on whether the demonstration project should be continued and expanded to include additional participants.

Subd. 13. **Federal approval.** The commissioner shall seek all federal approvals necessary to establish and implement the health opportunity demonstration project as required under this section.

Sec. 3. **[256B.0756] MEDICAL ASSISTANCE REFORM DEMONSTRATION PROJECT.**

Subdivision 1. **Medical assistance reform demonstration project.** The commissioner of human services shall develop and seek federal approval to establish a medical assistance reform demonstration project that meets the criteria specified in this section. The commissioner shall submit the waiver request to the federal Centers for Medicare and Medicaid Services by January 1, 2010, and shall implement the demonstration project beginning July 1, 2011, or upon federal approval, whichever is later.

Subd. 2. **Participation in the project.** The demonstration project must operate in one county within the seven-county metropolitan area and two counties outside of the seven-county metropolitan area. Within each demonstration county, medical assistance enrollees who are children, parents or relative caretakers, pregnant women, or age 65 or older shall be required to participate in the demonstration project if they are not institutionalized, blind, or disabled.

Subd. 3. **Risk-adjusted premium payments.** The commissioner shall develop risk-adjusted premium payments based on individual risk scores using historical utilization data. Project participants may use the risk-adjusted premium payments to enroll in a managed care plan or county-based purchasing plan providing services under section 256B.69 or 256B.692, or to purchase employer-sponsored coverage or individual coverage.

Subd. 4. **Comprehensive and catastrophic premium components.** In developing risk-adjusted premium payments, the commissioner shall consider paying separate premiums for a comprehensive care component and a catastrophic care component. If the commissioner adopts this option, the comprehensive care component of the premium must represent approximately 90 percent of the expected medical expenditures for reform participants, and the catastrophic care component must take effect once a dollar threshold or inpatient day threshold is reached. These thresholds may vary by target population.

Subd. 5. **Benefit set.** (a) Participating managed care and county-based purchasing plans shall have the flexibility to develop benefit sets for participants paying risk-adjusted

premiums that vary from the standard medical assistance benefit set required under this chapter. Benefit sets offered by a managed care or county-based purchasing plan must be approved by the commissioner, and must meet the criteria specified in this subdivision.

(b) Each benefit set must include all federally required Medicaid benefits, but managed care and county-based purchasing plans have the authority to determine which optional benefits to include. Plans may develop benefit sets for specialized populations. A plan may choose to offer a benefit set that is identical to the standard medical assistance benefit set required under this chapter.

(c) A benefit set may vary the amount, duration, and scope of benefits, relative to the standard medical assistance benefit set. A benefit set may contain service-specific coverage limits that are different from the service-specific coverage limits that apply to the standard medical assistance benefit set.

(d) Each benefit set must be actuarially equivalent to the standard medical assistance benefit set for the average member of the target population, based on historical utilization of services.

(e) Each benefit set must cover key benefits at a level sufficient to meet the needs of the target population. The commissioner shall establish standards of sufficiency based on the target population's historical use of health care services.

(f) Each benefit set must comply with the cost-sharing provisions of section 256B.0631.

Subd. 6. **Maximum annual benefit.** The commissioner shall determine a maximum annual benefit limit for each target population. Pregnant women and children shall be exempt from this limit.

Subd. 7. **Enhanced benefits.** The commissioner shall develop a list of preventive care and healthy practices, and shall provide project participants with enhanced benefit dollar credits of a specified amount for participating in each practice. The dollar credits must be deposited into the participant's enhanced benefit account. Credits may be used to purchase health care services not covered under the participant's benefit plan, and may be used by persons who lose medical assistance eligibility to purchase private sector health coverage. All credits must be paid directly from an individual's account to the provider of the service and in no instance shall a project participant directly receive cash payments from an account. Enhanced benefit credits shall be available to individuals for up to 36 months following the loss of medical assistance eligibility.

Subd. 8. **Option to opt out.** An individual may opt out of medical assistance coverage and use the risk-adjusted premium payment to purchase employer-sponsored or individual health coverage. The employer-sponsored or individual coverage must

meet all state requirements for health coverage, but may be more restrictive than medical assistance coverage and need not meet the benefit set criteria specified in subdivision 5. An individual choosing this option must be financially responsible for:

(1) all premium costs in excess of their risk-adjusted premium payment;

(2) all deductibles, co-payments, and other cost sharing; and

(3) the cost of all health benefits not covered under the employer-sponsored or individual coverage.

If the risk-adjusted premium payment exceeds the employee premium contribution under employer-sponsored coverage or the premium cost of individual coverage, the individual may use the remainder of the risk-adjusted premium payment to purchase family health coverage or supplemental health coverage.

Subd. 9. **Annual reports; expansion to MinnesotaCare.** The commissioner shall present to the legislature annual reports on the implementation and operation of the medical assistance reform demonstration project, beginning December 15, 2011, and each December 15 thereafter for the duration of the project. The commissioner shall include in the reports recommendations for any state law changes necessary to improve the operation of the demonstration project or to comply with federal requirements. The commissioner shall include in the report due December 15, 2012, recommendations on whether the demonstration project should be expanded to include the MinnesotaCare program and, if applicable, an implementation plan and draft legislation to accomplish the expansion.

Sec. 4. **[256B.0757] PROPOSAL FOR STATE HEALTH CARE PROGRAM REFORM.**

Subdivision 1. **Evaluation.** The commissioner shall evaluate the results of the:

(1) repackaging and repricing of medical assistance services under section 256B.0754, subdivision 3;

(2) health opportunity account demonstration project under section 256B.0755;

(3) the medical assistance reform demonstration project under section 256B.0756;

(4) the MinnesotaCare voucher demonstration project under section 256L.29, including the commissioner's recommendations under section 256L.29, subdivision 4; and

(5) the payment reform initiatives under sections 62U.02 to 62U.05.

The commissioner shall identify, evaluate, and compare the effect of these initiatives on health care costs and quality.

Subd. 2. **Report to legislature.** Based upon the evaluation in subdivision 1, the commissioner shall develop and present to the legislature by January 1, 2015, a proposal

to reform and restructure the medical assistance, general assistance medical care, and MinnesotaCare programs. The proposal must:

(1) provide enrollees with greater control of health care spending and allow enrollees to become empowered consumers;

(2) strengthen care relationships between patients and health care providers and reduce the role of third-party administrators in patient health care decisions;

(3) allow health care providers flexibility to redesign their services to provide low-cost, high-quality care;

(4) financially reward providers for providing low-cost, high-quality care;

(5) allow enrollees a greater choice of providers and covered services by allowing enrollees to choose among competing private sector health plan companies and allowing state health care programs to offer a range of benefit sets through the private sector;

(6) allow state health care program enrollees greater access to private sector long-term care coverage; and

(7) provide a ten-year timetable for phasing in the reform and restructuring of state health care programs.

The proposal must include recommendations on whether the reform and demonstration initiatives specified in subdivision 1 should be continued and expanded statewide, and any legislation necessary to implement the proposal.

Sec. 5. **[256L.29] MINNESOTACARE VOUCHER DEMONSTRATION PROJECT.**

Subdivision 1. **Development and federal approval.** The commissioner shall develop and seek federal approval for a three-year demonstration project to provide health coverage vouchers on a monthly basis to MinnesotaCare enrollees. Participation in the demonstration project by MinnesotaCare enrollees is voluntary, and the commissioner may set a limit on the total number of demonstration project participants. The commissioner shall implement the demonstration project on July 1, 2010, or upon federal approval, whichever is later.

Subd. 2. **Sliding scale for voucher payments.** The commissioner shall establish a sliding scale for voucher payments that varies with household income. The sliding scale must provide a voucher payment to each enrollee that is equivalent to the premium subsidy the enrollee would otherwise have received under the MinnesotaCare sliding scale established in section 256L.15. The commissioner shall adjust the voucher payment each January 1 to reflect any increases in the average subsidy provided under the MinnesotaCare program.

Subd. 3. **Use of voucher payments.** Vouchers may be used by participants to purchase health care coverage from a health plan company or may be used as contributions into a health savings account. The commissioner shall deposit voucher payments on a monthly basis directly into the health savings account designated by a voucher recipient.

Subd. 4. **Report to legislature.** The commissioner shall present to the legislature, by December 15, 2012:

(1) an evaluation of the demonstration project, including recommendations on whether the demonstration project should be continued or expanded;

(2) recommendations on whether the use of vouchers for the purchase of private sector health coverage should be expanded to medical assistance and general assistance medical care; and

(3) recommendations on whether the use of vouchers should be expanded to include medical assistance coverage of long-term care services.