**INFORMATION BRIEF**
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# Medical Assistance

Medical Assistance (MA) is a jointly funded, federal-state program that pays for health care services provided to low-income individuals. It is also called Medicaid. This information brief describes eligibility, covered services, and other aspects of the program.

## Contents

# Administration

## Congress

Medicaid was established by the U.S. Congress in 1965 as Title XIX of the Social Security Act. This federal law requires all states to offer basic health care services to certain categories of low-income individuals. States are reimbursed by the federal government for part of the cost of providing the required services. The federal law also gives states the option to cover additional services, and additional categories of low-income individuals, in their Medicaid programs. States that provide optional coverage receive federal reimbursement for part of the cost of this coverage.

## U.S. Department of Health and Human Services (DHHS)

Medicaid is administered at the federal level by the Center for Medicare and Medicaid Services (CMS), an agency within DHHS. CMS issues regulations and guidelines for Medicaid that states are required to follow. These regulations and guidelines are found in Title 42 of the Code of Federal Regulations, in the state Medicaid Manual, and in State Medicaid Director letters from CMS.

States establish operating and administrative standards for their own Medicaid programs. All Medicaid programs must stay within the scope of federal rules and regulations, but state programs can and do vary widely, due to differences in coverage of optional services and eligibility groups.

## Minnesota State Legislature

Medical Assistance (MA), Minnesota's Medicaid program, was established by the legislature and implemented in January 1966. The MA law in Minnesota is found primarily in chapter 256B of Minnesota Statutes, which contains the following:

- eligibility requirements, including specific income and asset limits for MA recipients
- administrative requirements, such as the duties of the state Department of Human Services and the counties, and provisions for the central disbursement of MA payments to providers
- a listing of services provided under MA
- requirements for managed care and county-based purchasing plans providing services to MA recipients
- provisions for establishing payment rates for MA providers (provisions relating to hospital payment rates are found in Minnesota Statutes, chapter 256)

## Minnesota Department of Human Services (DHS)

DHS is responsible for administering the MA program at the state level and for supervising the implementation of the program by the counties. DHS has adopted administrative rules and policies that govern many aspects of the MA program.

### Counties

County human services agencies and tribal governments choosing to participate are responsible for determining if applicants meet state and federal eligibility standards.[1] Individuals apply for MA by contacting their county human services agency. Agencies are required to complete eligibility determinations for most individuals within 45 days of receiving an application. (This time limit is 60 days in the case of disabled individuals and 15 days in the case of pregnant women.)

## Eligibility Requirements

MA pays for the cost of medical services provided to eligible low-income persons who cannot afford the cost of health care. MA can retroactively pay for the cost of health care services provided to an individual up to three months before the month of application, if the individual would have been eligible for MA at the time the services were provided. Generally, MA is available to families, children, pregnant women, the elderly, persons with disabilities, and most recently, adults without children who meet the program's income and asset standards.

Determining eligibility for MA is a complex task. The following discussion provides only an overview of the topic. More detailed information can be obtained from intake staff at county human services agencies or by referring to the DHS *Health Care Programs Manual* (available on the DHS website).

To be eligible for MA, an individual must meet the following criteria:

- be a citizen of the United States or a noncitizen who meets specified criteria
- be a resident of Minnesota
- be a member of a group for which MA coverage is required or permitted under federal or state law
- meet program income and asset limits, or qualify on the basis of a "spenddown"
- not reside in a public institution, or in a public or private Institution for Mental Diseases (IMD), if age 21 through 64[2]

Eligibility for most enrollees must be redetermined every six to 12 months.

### Citizenship

To be eligible for MA, an individual must be a citizen of the United States or a noncitizen who meets specified immigration criteria (see MA Eligibility for Noncitizens table on page 4). The state has chosen to provide MA coverage for all groups of noncitizens for which MA eligibility

[1] The DHS central office determines MA eligibility for some individuals who lose MinnesotaCare coverage due to failure to pay the premium and who want to apply for MA without submitting a new application.

[2] Certain exceptions to this limitation apply (e.g., for individuals placed in an IMD by a managed care plan). Individuals may also qualify for state-only funded MA.

is mandatory or optional under federal welfare law. MA coverage funded solely by state dollars for noncitizens who would have been eligible for MA except for passage of federal welfare reform legislation was eliminated on January 1, 2012.

Nonimmigrants and undocumented persons are eligible only for MA coverage of emergency and pregnancy-related services. Emergency MA (EMA) with federal financial participation (FFP) covers MA services necessary to treat an emergency medical condition, including labor and delivery. The 2011 Legislature limited the settings in which EMA services can be provided and also excluded coverage for specified services. These changes, effective January 1, 2012, had the effect of eliminating EMA coverage for many chronic care and long-term care services. The 2012 Legislature temporarily reinstated, for the period of May 1, 2012, to June 30, 2013, coverage for certain dialysis services and certain services to treat cancer.

For noncitizens eligible for MA with FFP, the emergency MA with FFP category is not applicable because emergency services are included in the regular set of MA services for which FFP is received.

**MA Eligibility for Noncitizens**

| Immigration Status | MA with FFP | Emergency MA with FFP |
|---|---|---|
| Refugees, asylees, persons granted withholding of deportation, veterans/active duty military personnel and families, conditional entrants, Cuban/Haitian entrants, Amerasians, American Indians born in Canada, American Indians born outside of the U.S. who are members of a federally recognized tribe, certain Iraqi and Afghani special immigrants, victims of trafficking | Yes | N/A |
| The following individuals residing in the U.S. prior to 8/22/96: lawful permanent residents,[3] noncitizens paroled into the U.S.[4] for at least one year, battered noncitizens and their children | Yes | N/A |
| The following individuals who entered the U.S. on or after 8/22/96: lawful permanent residents,[5] noncitizens paroled into the U.S. for less than one year, battered noncitizens and their children | Yes, for children and pregnant women[6];<br>No for all others, until five years after entry | Yes |
| Others lawfully residing in the U.S.[7] on 8/22/96 and receiving SSI | Yes | N/A |

[3] A lawful permanent resident is generally a person who has a "green card," which means the person has permission to live and work permanently in the United States and can apply for citizenship after living for five continuous years in the United States.

[4] A person is "paroled into the United States" when the U.S. Justice Department uses its discretion to grant temporary admission for humanitarian, legal, or medical reasons.

[5] Until 40 quarters of work are completed, a noncitizen's income and resources are deemed to include the sponsor's income and resources.

[6] Since July 1, 2010, children and pregnant women who are qualified noncitizens or otherwise lawfully present have been eligible for MA with FFP.

[7] Includes lawful temporary residents, family unity beneficiaries, persons whose enforced departure has been deferred, persons with temporary protected status, persons paroled for less than one year, applicants for asylum, and other groups.

| Immigration Status | MA with FFP | Emergency MA with FFP |
|---|---|---|
| Others lawfully residing in the U.S. | Yes, but only for children and pregnant women[8] | Yes |
| Nonimmigrants[9] and undocumented persons | Yes, but only for MA services provided to uninsured pregnant women through the period of pregnancy, including labor and delivery and 60 days postpartum[10] | Yes |

Source: Department of Human Services

## Residency

To be eligible for MA, an individual must be a resident of Minnesota, as determined under federal law,[11] or a migrant worker as defined in Minnesota Statutes, section 256B.06, subdivision 3.

## Eligible Categories of Individuals

To be eligible for MA, an individual must be a member of a group for which MA eligibility is either required by the federal government or mandated by the state under a federal option. In Minnesota, those groups eligible for MA coverage include the following:

- parents or caretakers of dependent children
- pregnant women
- children under age 21
- persons age 65 or older
- persons with a disability or who are blind, as determined by the Social Security Administration or the State Medical Review Team (This category includes most persons

[8] Since July 1, 2010, children and pregnant women who are qualified noncitizens or otherwise lawfully present have been eligible for MA with FFP for all MA-covered services.

[9] A nonimmigrant is a person who is lawfully present in the United States, but who is not permanently residing in the United States (because the person maintains a residence outside the United States). Nonimmigrants are generally admitted temporarily and for a limited purpose (e.g., tourists, foreign students).

[10] These services are funded through the federal Children's Health Insurance Program (CHIP), rather than MA. CHIP provides an enhanced federal match of 65 percent for these services. As of June 20, 2012, Minnesota was waiting for federal approval to use CHIP to fund services during the postpartum period; these services are currently funded through MA without FFP.

[11] Generally, federal law defines residency in terms of being present in a state with an intent to remain and specifically prohibits durational residency requirements (see 42 C.F.R. § 435.403).

eligible for either the Minnesota Supplemental Aid (MSA) or Supplemental Security Income (SSI) programs.)
- adults without children
- children eligible for or receiving state or federal adoption assistance payments

Adults without children with incomes not exceeding 75 percent of federal poverty guidelines (FPG) are a new eligibility group covered by Minnesota under the Medicaid early expansion option of the Affordable Care Act (ACA). The ACA will require Minnesota and all other states to cover adults without children and other individuals with income not exceeding 133 percent of FPG beginning January 1, 2014. (See box below for more information on early expansion and the required Medicaid eligibility expansion.)

Certain disabled children who would normally not be eligible for MA because of parental income are also covered under Minnesota's MA program. MA also pays for Medicare premiums and cost-sharing for certain groups of Medicare beneficiaries.

Individuals with excess income belonging to a group eligible for MA coverage may be able to qualify by spending down their income (see page 11).

**Medicaid Expansion for Low-Income Adults**

*Note: The following information is based upon what is known of federal requirements and the implications of the U.S. Supreme Court decision at this time and is subject to revision based upon implementation details to be provided in forthcoming federal guidance letters and rules.*

The federal Affordable Care Act (ACA), read in light of the U.S. Supreme Court decision, gives states the option to cover adults without children and certain other individuals with incomes up to 133 percent of FPG under their Medicaid programs, beginning January 1, 2014. (*National Federation of Independent Business v. Sibelius,* 567 U.S.__, 132 S.Ct. 2566 (2012))

The ACA also gives states the option of covering some or all of these newly eligible individuals prior to January 1, 2014. Minnesota has chosen to implement this early expansion option, by providing MA coverage for adults without children with incomes up to 75 percent of FPG, effective March 1, 2011.

**New Eligibility Group and the U.S. Supreme Court Ruling**

The ACA, prior to the U.S. Supreme Court decision, required state Medicaid programs to cover, effective January 1, 2014, individuals with incomes not exceeding 133 percent of FPG who are not: (1) elderly; (2) pregnant; (3) entitled to or enrolled in Medicare Part A or Medicare Part B; or (4) described in an already existing group for which Medicaid coverage is mandatory, such as certain parents, children, or disabled persons receiving Supplemental Security Income (SSI) benefits. States that did not comply with this coverage expansion could have been penalized by the federal government with a loss of all or part of the federal funding they receive for their Medicaid programs.

The U.S. Supreme Court decision noted that while Congress can offer funding to states to expand the availability of health care, and can place conditions on the state use of these funds, the loss of potentially all Medicaid funds was a severe penalty that did not give states a genuine choice as to whether or not to implement the expansion. The decision further noted that while Congress can modify the Medicaid program, the ACA coverage expansion was significantly different in scope from previous Medicaid coverage expansions. The court thereby ruled that the federal government was prohibited from withholding existing Medicaid funding from states that do not expand coverage as provided under the ACA. The court further held that all other provisions of the ACA remained intact.

The effect of this ruling is to make the ACA Medicaid expansion a state option rather than a state mandate. States that choose to expand Medicaid coverage as provided in the ACA will receive new federal funding for the expansion; states that choose not to expand Medicaid coverage will not lose their existing Medicaid funding.

In Minnesota, these newly eligible individuals would include adults without dependent children who do not qualify for coverage under Minnesota's early MA expansion—for example, MinnesotaCare enrollees who are adults without children with incomes greater than 75 percent but not exceeding 133 percent of FPG. The newly eligible group may also include certain parents and persons with disabilities who are not otherwise eligible for services through MA or an MA waiver.

**Income and Asset Methods**

When determining Medicaid eligibility for persons in the newly eligible group and certain existing Medicaid eligibility groups, the ACA requires states to: (1) use a new income methodology based on modified adjusted gross income (MAGI) and household income (this is the income methodology used under the ACA to determine eligibility for premium tax credits for coverage purchased through state health insurance exchanges); (2) apply a standard 5 percent income disregard that would replace any state-specific income disregards; and (3) eliminate the use of asset tests. These income and asset requirements do not apply to individuals who are disabled, over age 65, or meet other criteria for exemption specified in the federal law.

**Benefit Changes**

The ACA also requires states to provide individuals in the newly eligible group who are not otherwise exempt with benchmark or benchmark-equivalent benefits—an alternative benefit set authorized by federal law in 2005 as a state benefit option that can be different than a state's regular Medicaid benefit set. Under this alternative benefit set, coverage provided to Medicaid enrollees must be equal to one of three specified benchmark plans, be actuarially equivalent as specified in federal law to one of the benchmark plans, or be coverage that is approved by the Secretary of Health and Human Services. One of the options for secretary-approved coverage is a state's regular Medicaid benefit set. The ACA also requires benchmark

or benchmark-equivalent coverage to cover the essential health benefits that will be required for coverage offered through state health insurance exchanges and to meet other specified requirements.

Certain eligibility groups are exempt from the alternative benefit set requirement, including but not limited to pregnant women, blind or disabled individuals, dual eligibles (persons eligible for both MA and Medicare), and persons who are institutionalized or who qualify for long-term care services.

**Enhanced Federal Match**

If Minnesota implements the optional Medicaid expansion, the federal government will provide the state with an enhanced federal match for the cost of covering nonpregnant adults without children and other newly eligible individuals. The federal match for this group is 100 percent of the cost for calendar years 2014 through 2016. The matching rate phases down over the next four years, such that the federal match will be 90 percent for 2020 and future years.

**Minnesota's Implementation of Early Medicaid Expansion**

The ACA allows states to expand Medicaid coverage to include newly eligible persons prior to January 1, 2014. Minnesota implemented early expansion on March 1, 2011.

The 2010 Legislature authorized the then current or succeeding governor to implement early expansion for eligible adults without dependent children, with incomes not exceeding 75 percent of FPG, by issuing an executive order by January 15, 2011. Gov. Tim Pawlenty did not issue an executive order to implement early expansion. Gov. Mark Dayton issued an executive order on January 5, 2011, to implement early expansion effective March 1, 2011. Under the terms of the 2010 authorizing legislation, the implementation of early expansion was accompanied by the repeal of the General Assistance Medical Care (GAMC) program, since GAMC enrollees would be eligible for coverage as part of the MA expansion group.

States that implement early expansion must comply with the prohibition on asset tests and the benchmark or benchmark-equivalent benefit requirements. Minnesota therefore has not applied an asset test to the early expansion group of adults without children and has provided this group with the regular MA benefit set as secretary-approved benchmark-equivalent coverage. States are not required to initially use MAGI and household income for an early expansion group, but must use these methods beginning with the January 1, 2014, optional Medicaid expansion date. Minnesota and other early expansion states will at first receive their regular federal Medicaid match for individuals covered through early expansion, but will receive the enhanced federal match for these individuals as part of implementation of the optional Medicaid expansion.

## Income Limits

To be eligible for MA, an applicant's net income must not exceed program income limits. Different income limits apply to different categories of individuals. For example, the MA income limit for most children is higher than the MA income limit for parents. This means that not all members of a family may be covered under MA.

MA income limits are based on the federal poverty guidelines (FPG). The guidelines vary with family size and are adjusted annually for inflation.

In determining whether an applicant meets the program income limits, specified types of income such as federal and state tax refunds and Food Stamp benefits are excluded from gross income. Work and dependent care expenses, a specified amount of earned income, a monthly personal needs allowance for persons residing in certain health care facilities, and other specified items may be deducted or disregarded from gross income.

The table on page 12 lists the income standard, asset standard, and covered benefits for each of the principal eligibility groups. (Eligibility criteria for other eligibility groups, such as disabled adult children, disabled widows, and widowers, can be found in Minnesota Statutes, sections 256B.055 and 256B.057.) Tables showing allowable income by household size for the various eligibility groups are included at the end of this information brief.

## Transitional MA[12]

Individuals who lose MA eligibility (under the 100 percent of FPG income limit) due to increased earned income or the loss of an earned income disregard, or due to increased child or spousal support, may be able to retain MA coverage for a transitional period, if: (1) the individual's income did not exceed 100 percent of FPG for at least three of the past six months; and (2) the household contains a dependent child and a caretaker. Individuals who lose eligibility due to earned income or loss of an earned income disregard remain eligible for an initial period of six months and can continue to receive MA coverage for up to six additional months if their income does not exceed 185 percent of FPG. Individuals who lose eligibility due to increased child or spousal support remain eligible for four months.

## Asset Limits

MA has two main asset limits. One applies to persons who are aged, blind, or disabled and the other to parents in MA-eligible families.[13] Children under age 21, pregnant women, and adults without children are exempt from any asset limit. In addition, different asset limits apply to some of the smaller MA eligibility groups (see table on page 12).

[12] Transitional MA is contingent on federal funding. Federal funding is scheduled to expire on December 31, 2012, unless reauthorized by the U.S. Congress.

[13] The Minnesota Long-term Care Partnership (LTCP) program allows individuals with qualified long-term care insurance policies to qualify for MA payment of long-term care services, while retaining assets above the regular MA asset limit equal in value to the amount paid for care by the policy.

**Aged, blind, or disabled.** Persons who are aged, blind, or disabled need to meet the asset limit specified in Minnesota Statutes, section 256B.056, subdivision 3. This asset limit is $3,000 for an individual and $6,000 for two persons in a household, with $200 added for each additional dependent. Certain assets are excluded when determining MA eligibility for persons who are aged, blind, or disabled, including the following:

- the homestead
- household goods and personal effects
- personal property used as a regular abode
- a burial plot for each family member
- life insurance policies and assets for burial expenses, up to the limits established for the SSI program[14]
- capital and operating assets of a business necessary for the person to earn an income
- funds for damaged, destroyed, or stolen property, which are excluded for nine months, and may be excluded for up to nine additional months under certain conditions
- motor vehicles to the same extent allowed under the SSI program[15]

**Parents in MA-eligible families.** A uniform asset limit, identical to that used for the MinnesotaCare program, applies to parents and caretakers in MA-eligible families (see Minnesota Statutes, section 256B.056, subdivision 3c). This asset limit is $10,000 in total net assets for a household of one person, and $20,000 in total net assets for a household of two or more persons. Certain items are excluded when determining MA eligibility for parents in MA-eligible families, including the following:

- the homestead
- household goods and personal effects
- a burial plot for each family member
- life insurance policies and assets for burial expenses, up to the limits established for the SSI program
- capital and operating assets of a business up to $200,000
- funds received for damaged, destroyed, or stolen property are excluded for three months if held in escrow
- a motor vehicle for each person who is employed or seeking employment
- court-ordered settlements of up to $10,000
- individual retirement accounts and funds
- assets owned by children

Minnesota law also has provisions governing the treatment of assets and income for persons residing in nursing homes whose spouses reside in the community. These provisions are found in Minnesota Statutes, sections 256B.0575 to 256B.0595.

[14] The SSI program allows recipients to set aside, or designate, up to $1,500 in assets to cover certain burial expenses.

[15] The SSI program excludes as an asset one vehicle per household, regardless of value, if it is used for transportation by the recipient or a member of the recipient's household.

## Eligibility on the Basis of a Spenddown

Individuals who, except for excess income, would qualify for coverage under MA can qualify for MA through a "spenddown." However, no spenddown option is available for persons eligible as adults without children. Under a spenddown, an individual reduces his or her income by incurring medical bills in amounts that are equal to or greater than the amount by which his or her income exceeds the relevant spenddown standard for the spenddown period (see table below for the spenddown standards). Unpaid medical bills incurred before the time of application for MA can be used to meet the spenddown requirement.

There are two types of spenddowns. Under a six-month spenddown, an individual can become eligible for MA for up to six months, beginning on the date his or her total six-month spenddown obligation is met. Under a one-month spenddown, individuals spend down their income during a month in order to become eligible for MA for the remainder of that month.

**MA Spenddown**

| Eligibility Group | Spenddown Standard |
|---|---|
| Families and children | 100% of FPG |
| Aged, blind, or disabled | 75% of FPG |

## MA Eligibility – Income and Asset Limits – Benefits

| Eligibility Category | Income Limit | Asset Limit | Benefits |
|---|---|---|---|
| Children under age two[16] | ≤ 280% of FPG | None | All MA services |
| Children two through 18 years of age | ≤ 150% of FPG | None | All MA services |
| Children 19 through 20 years of age | ≤ 100% of FPG | None | All MA services |
| Pregnant women | ≤ 275% of FPG | None | All MA services |
| Parents or relative caretakers of dependent children on MA | ≤ 100% of FPG | Uniform MA/ MinnesotaCare asset standard ($10,000 for households of one and $20,000 for households of two or more) | All MA services |
| Aged, blind, disabled | ≤ 100% of FPG | MA asset standard ($3,000 for households of one and $6,000 for households of two, with $200 for each additional dependent) | All MA services |
| Adults without children | ≤ 75% of FPG | None | All MA services |
| Qualified Medicare Beneficiaries (QMBs) | ≤ 100% of FPG | $10,000 for households of one and $18,000 for households of two or more | Premiums, coinsurance, and deductibles for Medicare Parts A and B |
| Service Limited Medicare Beneficiaries (SLMBs) | > 100% but < 120% of FPG | $10,000 for households of one and $18,000 for households of two or more | Medicare Part B premium only |
| Qualifying Individuals (QI)–Group 1[17] | ≥ 120% but < 135% of FPG | $10,000 for households of one and $18,000 for households of two or more | Medicare Part B premium only |
| Qualified Working Disabled Adults | ≤ 200% of FPG | Must not exceed twice the SSI asset limit | Medicare Part A premium only |
| Disabled children eligible for services under the TEFRA children's home care option[18] | ≤ 100% of FPG[19] | None | All MA services |
| Employed persons with disabilities | No income limit | $20,000 | All MA services |

House Research Department

[16] Children with incomes greater than 275 percent and less than or equal to 280 percent of FPG are funded through the federal Children's Health Insurance Program (CHIP) with an enhanced federal match.

[17] Eligibility for persons in this group is contingent on federal funding. Federal funding is scheduled to expire on December 31, 2012, unless reauthorized by the U.S. Congress.

[18] Authorized by section 134 of the federal Tax Equity Fiscal Responsibility Act (TEFRA) of 1982.

[19] Only the income of the child is counted in determining eligibility. Child support and Social Security disability payments paid on behalf of the child are excluded.

### Institutional Residence

Individuals living in public institutions, such as secure correctional facilities, are not eligible for MA. Individuals living in Institutions for Mental Diseases (IMDs) are also not eligible, unless they are under age 21 and reside in an inpatient psychiatric hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or they are age 65 or older, or otherwise qualify for an exception. An IMD is a hospital, nursing facility, or other institution of 17 or more beds that primarily provides diagnosis, treatment, and care to persons with mental illness.

## Benefits

MA reimburses health care providers for health care services furnished to eligible recipients. The federal government requires every state to provide certain services. States may choose whether to provide other optional services.

### Federally Mandated Services for All MA Recipients

The following services are federally mandated and therefore available to all MA recipients in Minnesota:

- Early periodic screening, diagnosis, and treatment (EPSDT) services for children under 21
- Family planning services and supplies
- Federally qualified health center services
- Home health services and medical equipment and supplies
- Inpatient hospital services
- Laboratory and X-ray services
- Nurse midwife services
- Certified family and certified pediatric nurse practitioner services
- Outpatient hospital services
- Physician services
- Rural health clinic services
- Nursing facility services
- Medical and surgical services of a dentist
- Pregnancy-related services (through 60 days postpartum)

### Optional Services for Minnesota's MA Recipients

The following services have been designated "optional" by the federal government but are available by state law to all MA recipients in Minnesota:

- Audiologist services
- Care coordination and patient education services provided by a community health worker

- Case management for seriously and persistently mentally ill persons and for children with serious emotional disturbances
- Case management and directly observed therapy for people with tuberculosis
- Chiropractor services
- Clinic services
- Community paramedic services[20]
- Dental services[21]
- Other diagnostic, screening, and preventive services
- Emergency hospital services
- Extended services to women
- Hearing aids
- Home and community-based waiver services
- Hospice care
- Some Individual Education Plan (IEP) services provided by a school district to disabled students
- Some services for residents of Institutions for Mental Diseases (IMDs)
- Inpatient psychiatric facility services for persons under age 22
- Intermediate care facility services, including services provided in an intermediate care facility for persons with developmental disabilities (ICF/DD)
- Medical equipment and supplies
- Medical transportation services
- Mental health services
- Nurse anesthetist services
- Certified geriatric, adult, OB/GYN, and neonatal nurse practitioner services
- Occupational therapy services
- Personal care assistant services
- Pharmacy services[22]
- Physical therapy services
- Podiatry services
- Private duty nursing services
- Prosthetics and orthotics
- Public health nursing services
- Rehabilitation services, including day treatment for mental illness
- Speech therapy services
- Vision care services and eyeglasses

[20] Effective July 1, 2012, or upon federal approval, whichever is later.

[21] Since January 1, 2010, coverage of dental services for adults who are not pregnant has been limited to specified services (see Minn. Stat. 2010 § 256B.0625, subd. 9). Services provided by dental therapists and advanced dental therapists have been covered since September 1, 2011.

[22] Since January 1, 2006, MA has not covered prescription drugs covered under the Medicare Part D prescription drug benefit for individuals enrolled in both MA and Medicare (referred to as "dual eligibles"). These individuals are instead eligible for prescription drug coverage under Medicare Part D. MA continues to cover certain drug types not covered under the Medicare prescription drug benefit, such as over-the-counter drugs for cough and colds and certain vitamin and mineral products.

## Cost-sharing

MA enrollees are subject to the following cost-sharing:

- $3 per nonpreventive visit
- $3.50 for nonemergency visits to a hospital emergency room[23]
- $3 per brand-name prescription and $1 per generic prescription, subject to a $7 per-month limit. Antipsychotic drugs are exempt from copayments when used for the treatment of mental illness.
- A monthly family deductible for each period of eligibility, effective January 1, 2012

Children and pregnant women are exempt from copayments and deductibles; other exemptions also apply. Total monthly cost-sharing for persons with incomes not exceeding 100 percent of FPG is limited to 5 percent of family income.

Health care providers are responsible for collecting the copayment or deductible from enrollees; MA reimbursement to a provider is reduced by the amount of the copayment or deductible. Providers cannot deny services to enrollees who are unable to pay the copayment or deductible.[24]

The commissioner may allow managed care and county-based purchasing plans to waive the family deductible, and may also waive the family deductible for individuals and allow long-term care and waiver services providers to assume responsibility for payment.

## Some Services Provided in Minnesota Under a Federal Waiver

States can seek approval from the federal government to provide services that are not normally covered and reimbursed under the Medicaid program. These services are referred to as "waivered services." Minnesota has federal approval for the following community-based waivered service programs.

The **Elderly Waiver (EW)** provides community-based care for elderly individuals who are MA eligible and require the level of care provided in a nursing home.

Minnesota also has a solely state-funded program, the **Alternative Care (AC)** program, which provides community-based care for elderly individuals who are at risk of nursing home placement and who are not eligible for MA, but who would become eligible for MA within 135 days of entering a nursing home.

The **Home and Community-Based Waiver for Persons with Developmental Disabilities (DD)** provides community-based care to persons diagnosed with developmental disabilities or related conditions who are at risk of placement in an ICF/DD.

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[23] This copayment is to be increased to $20 upon federal approval.

[24] Minnesota Statutes, section 256B.0631, subdivision 4, allowed providers who routinely refused services to individuals with uncollected debt to include uncollected copayments as bad debt and deny services to enrollees. The Ramsey County District Court in *Dahl et. al. v. Goodno*, court file number C9-04-7537, ruled that this provision was preempted by federal law. The provision was repealed January 1, 2009.

The **Community Alternative Care (CAC)** waiver provides community-based care for chronically ill individuals who are under age 65 and need the level of care provided in a hospital.

The **Community Alternatives for Disabled Individuals (CADI)** waiver provides community-based care to disabled individuals under age 65 who need the level of care provided in a nursing home.

The **Brain Injury (BI)** waiver provides community-based care to persons under age 65 diagnosed with traumatic or acquired brain injury who need the level of care provided in a nursing home that provides specialized services for persons with brain injury or a neurobehavioral hospital.

For each of the federally approved waiver programs, the costs of caring for individuals in the community cannot exceed (in the aggregate) the cost of institutional care.

# Medicaid Managed Care

MA enrollees receive services under a fee-for-service system (described in the next section) or through a managed care system. Some managed care programs require federal waivers from CMS, others may be operated under the Medicaid State Plan, which outlines the MA services states are providing under agreement with CMS.

Under the managed care system, MA enrollees who are families and children receive services under the Prepaid Medical Assistance Program (PMAP) from prepaid health plans or through county-based purchasing initiatives. Enrollees who are elderly (age 65 and over) receive services from prepaid health plans through Minnesota Senior Care Plus or through Minnesota Senior Health Options (MSHO). Enrollees with disabilities have the option of receiving services through the Special Needs BasicCare (SNBC) program, a statewide program for persons with disabilities.

## Programs for Families and Children

Under PMAP, prepaid health plans contract with DHS to provide services to MA enrollees. Plans receive a capitated payment from DHS for each MA enrollee, and in return are required to provide enrollees with all MA covered services, except for some home and community-based waiver services, some nursing facility services, and intermediate care facility services for persons with developmental disabilities. PMAP operates under a federal waiver; one of the terms of the waiver allows the state to require certain MA enrollees to receive services through managed care.

Enrollees in participating counties select a specific prepaid health plan from which to receive services, obtain services from providers in the plan's provider network, and follow that plan's procedures for seeing specialists and accessing health care services. Enrollees are allowed to switch health plans once per year during an open enrollment period. PMAP has contracts with prepaid health plans or county-based purchasing initiatives to provide services in all 87 counties.

County-based purchasing provides an alternative method of health care service delivery under PMAP. County boards that elect to implement county-based purchasing are responsible for providing all PMAP services to enrollees, either through their own provider networks or by contracting with prepaid health plans. DHS payments to counties cannot exceed PMAP payment rates to prepaid health plans. As of May 2012, three county-based purchasing initiatives involving 27 counties were operational.

The 2011 Legislature authorized a two-year competitive bidding pilot project to serve nonelderly, nondisabled adults and children in the seven-county metropolitan area beginning January 1, 2012. The 2012 Legislature authorized the commissioner to continue the use of competitive bidding for managed care contracts effective on or after January 1, 2014.

## Programs for the Elderly

The Minnesota Senior Care waiver replaced PMAP for elderly enrollees on June 1, 2005. This federal waiver provides continued authority for mandatory enrollment of people age 65 or older into managed care. Minnesota Senior Care covered all the same services as PMAP, except that prescription drugs for MA enrollees also eligible for Medicare were covered by Medicare Part D (see footnote 22 on page 14).

The Minnesota Senior Care benefit package was replaced by a broader Minnesota Senior Care Plus benefit package, on January 1, 2009. Minnesota Senior Care Plus first began providing services on June 1, 2005, to elderly enrollees enrolled in county-based purchasing initiatives. It was expanded to 80 nonmetro counties in January 2008 and was further expanded to include the seven metro-area counties in January 2009. In addition to covering all basic Minnesota Senior Care services, Minnesota Senior Care Plus also covers elderly waiver services and 180 days of nursing home services for enrollees not residing in a nursing facility at the time of enrollment.

Elderly enrollees in Minnesota Senior Care Plus must enroll in a separate Medicare plan to obtain their prescription drug coverage under Medicare Part D. However, elderly enrollees also have the option of receiving managed care services through the Minnesota Senior Health Options (MSHO), rather than Minnesota Senior Care Plus. MSHO includes all Medicare and MA prescription drug coverage under one plan. MSHO provides a combined Medicare and MA benefit and is available statewide. MSHO was first implemented in 1997 as part of a federal demonstration project; the program has operated since 2006 under federal Medicare Advantage Special Needs Plan (SNP) authority.[25] DHS also contracts with SNPs to provide MA services. Enrollment in MSHO is voluntary. As is the case with Minnesota Senior Care Plus, MSHO also covers elderly waiver services and 180 days of nursing home services. Most elderly MA enrollees are enrolled in MSHO rather than Minnesota Senior Care Plus because of the integrated Medicare and MA prescription drug coverage. As of May 2012, MSHO enrollment was 35,923, compared to enrollment in Minnesota Senior Care Plus of 12,049.

[25] A Medicare SNP is a Medicare-managed care plan that is allowed to serve only certain Medicare populations, such as institutionalized enrollees, dually eligible enrollees, and enrollees who are severely chronically ill and disabled. SNPs must provide all Medicare services, including prescription drug coverage.

## Programs for Persons with Disabilities

Special Needs Basic Care (SNBC) is an integrated Medicare and Medicaid plan for persons with disabilities that was implemented statewide beginning January 2008. The program also works through contracts with Medicare SNPs and provides all Medicare and Medicaid prescription drugs under one plan. SNBC provides some long-term care services. The program served 27,504 individuals as of May 2012.

## Managed Care Enrollment

Generally, MA recipients in participating counties who are in families with children are required to enroll in PMAP or county-based purchasing. As noted above, recipients who are elderly are required to enroll in Minnesota Senior Care Plus, but a majority have chosen to participate instead in the voluntary MSHO program.

Since January 1, 2012, persons with disabilities have been enrolled in special needs plans, unless they choose to opt out of managed care enrollment and remain in fee-for-service.

As of May 2012, 488,072 MA enrollees received services through PMAP, county-based purchasing, Minnesota Senior Care Plus, MSHO, or SNBC.

## Managed Care Payment Rates

Prepaid health plans and county-based purchasing initiatives receive a capitation rate for each enrollee. Fifty percent of the PMAP capitation rate is based upon the enrollee's age, sex, Medicare status, institutional status, basis of eligibility, and county of residence. The remaining 50 percent of the rate is risk-adjusted to reflect the overall health status of a plan's enrollees. Five percent of each plan's capitation rate is withheld annually and returned pending the plan's completion of performance targets related to various process and quality measures.

SNBC rates are based on historical fee-for-service costs and are paid through a separate risk adjustment system designed for people with disabilities. MSHO and Minnesota Senior Care Plus rates are adjusted for age, sex, institutional status, and geographical area and are identical across programs.[26] Rates for elderly waiver services are based on historical fee-for-service costs.

DHS does not regulate prepaid health plan and county-based purchasing payment rates to health care providers under contract to serve MA enrollees. These payment rates are a matter of negotiation between the health care provider and the prepaid health plan or county boards.

The 2011 Legislature made a number of changes related to managed care payment rates. These include:

[26] Rates for elderly recipients enrolled in Minnesota Senior Care Plus and MSHO are determined using historical data and are not risk-adjusted, since most of the services used to determine risk-adjustment values are covered by Medicare.

- adding as performance targets, measures related to reducing a plan's hospital admission rate and rate of hospital readmission within 30 days of a previous hospitalization; and

- reducing capitation rates by between 2 percent and 10.1 percent, depending upon the enrollee group, beginning September 1, 2011, and for the calendar years 2013 through 2015, setting limits on trend (inflation) increases to capitation rates of between 2 percent and 7.5 percent, depending upon the enrollee group.

The 2012 Legislature modified criteria for implementing performance targets and also required the Office of the Legislative Auditor to contract for biennial independent financial audits of managed care and county-based purchasing plans.

# Fee-for-Service Provider Reimbursement

Under fee-for-service MA, health care providers and institutions (sometimes called "vendors") bill the state and are reimbursed by the state at a level determined by state law for the services they provide to MA recipients.

Under the fee-for-service system, MA recipients, with some exceptions, are free to receive services from any medical provider participating in the MA program. As a condition of participating in the MA program, providers agree to accept MA payment (including any applicable copayments) as payment in full. Providers in Minnesota are prohibited from requesting additional payments from MA recipients, except when the recipient is incurring medical bills in order to meet the MA spenddown (discussed earlier in the eligibility section). DHS has established a central system for the disbursement of MA payments to providers. DHS uses different methods to reimburse different types of providers; the reimbursement methods for major provider groups are described below.

## Physicians and Other Medical Services

Physician services and many other medical services are paid for at the lower of (1) the submitted charge or (2) the prevailing charge. The prevailing charge is defined as a specified percentile of all customary charges statewide for a procedure during a base year. The prevailing charge for physicians is the 50th percentile of 1989 submitted charges, minus either 20 percent or 25 percent depending upon the type of service. The legislature has at times changed the specified percentile and base for different provider types and different procedures. All geographic regions within the state are subject to the same maximum reimbursement rate.

MA services reimbursed in this manner include services from a mental health clinic, rehabilitation agency, physician, physician clinic, optometrist, podiatrist, chiropractor, nurse midwife, physical therapist, occupational therapist, speech therapist, audiologist, community/public health clinic, optician, dentist, and services for children with handicaps.

Other MA services are reimbursed at the lesser of the submitted charge or the Medicare maximum allowable rate. Services reimbursed using the Medicare rate include those for costs relating to a laboratory, a hospice, medical supplies and equipment, prosthetics, and orthotics.

(DHS uses other payment rates for certain laboratory services and medical supplies and equipment if a Medicare rate does not exist.)

The legislature changed payment rates for different services in 2010 and 2011. Changes made during the 2010 legislative session include the following:

- Payment rates for basic care services were reduced by a 1.5 percent for fiscal years 2010 and 2011; this was in addition to a previous reduction of 3.0 percent for a total reduction of 4.5 percent for the time period. This reduction applied to the following services: medical supplies and durable medical equipment, ambulatory surgery, eyeglasses/contact lenses, prosthetics and orthotics, laboratory, end-state renal dialysis, and public health nursing. Managed care and county-based purchasing plans were subject to corresponding reductions. The reduction also applied to physical therapy, occupational therapy, and speech therapy services beginning July 1, 2010 (these services were moved from the physician and professional services to the basic care category effective on that date).

- Physician and professional service payment rates for specialty services were reduced by 6.5 percent beginning in fiscal year 2010 and 5.0 percent beginning in fiscal year 2011, relative to the rates in effect on June 30, 2009. Payment rates for these services, with exceptions for mental health services, were also reduced by an additional 7 percent effective July 1, 2010, over and above the previous 5 percent reduction. Managed care and county-based purchasing plans were subject to corresponding reductions.

Changes made during the 2011 legislative session include the following:

- Payment rates for physician and professional services for the period September 1, 2011, through June 30, 2013, were reduced by 3.0 percent from the rates in effect on August 31, 2011.

- Payment rates for dental services for the period September 1, 2011, through June 30, 2013, were reduced by 3.0 percent from the rates in effect on August 31, 2011. State-operated dental clinics are exempt from this reduction.

- Payment rates for outpatient hospital facility fees for the period September 1, 2011, through June 30, 2013, were reduced by 5.0 percent from the rates in effect on August 31, 2011.

- Payment rates for certain basic care services for the period September 1, 2011, through June 30, 2013, were reduced by 3.0 percent from the rates in effect on August 31, 2011. This reduction applies to ambulatory surgery center facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, anesthesia services, and hospice services.

- Payment rates, grant amounts, and rate limits were reduced by 1.5 percent for the period July 1, 2011, through June 30, 2013, for a range of services and grant programs, including but not limited to home and community-based waivers, nursing services, home health, personal care, day training and habilitation (the reduction was 1.0 percent for this service), alternative care, consumer support grants, family support grants, and aging grants. Managed care and county-based purchasing plans are subject to corresponding rate reductions.

- A contingent reduction of 1.67 percent was authorized for a range of services, including but not limited to home and community-based waivers, nursing services, home health, personal care, day training and habilitation, and alternative care. Managed care and county-based purchasing plans will be subject to corresponding reductions. The reductions would have taken effect July 1, 2012, if the federal government did not approve changes in the criteria used to determine nursing facility level of care under MA, and will expire December 31, 2013.

The 2012 Legislature delayed the effective date of the 1.67 percent reductions until July 1, 2013, and made the reductions contingent on DHS not receiving federal approval of the long-term care realignment waiver, or receiving only partial approval.

## Prescription Drug Reimbursement

Under the MA fee-for-service program, pharmacies are reimbursed for most drugs at the lowest of:

(1) the actual acquisition cost of the drug plus a fixed dispensing fee;

(2) the maximum allowable cost, plus a fixed dispensing fee; or

(3) the usual and customary price charged to the public.

The **actual acquisition cost** is the wholesale acquisition cost (WAC) plus 2 percent (or plus 4 percent for certain rural pharmacies). WAC is the manufacturer's list price to wholesalers or direct purchasers for the prescription drug, not including certain discounts, rebates, or reductions in price. The fixed dispensing fee in most cases is $3.65 per prescription; higher dispensing fees are allowed for intravenous solutions compounded by a pharmacist, cancer chemotherapy products, and total parenteral nutritional products.

The **maximum allowable cost (MAC)** is the payment rate set by the federal government or state for certain multiple-source drugs (drugs for which at least one generic exists). The purpose of a MAC price is to set the reimbursement rate closer to the actual acquisition cost of the generic drug. Federal law requires the CMS to set a MAC (referred to as the federal upper limit or FUL) for certain multiple-source drugs. States can also set state MACs for multiple-source drugs that are lower than any FUL and for drugs for which CMS has not set a FUL. Minnesota has chosen to set state MACs for a large number of multiple-source drugs.

MA reimburses pharmacies at the **usual and customary price** charged to the public, if this is lower than the payment rate under the AWP/WAC formula or the MAC price. This provision allows MA to reimburse large chain pharmacies for generic drugs provided to MA recipients at their discounted price for the general public (e.g., $4.00 per prescription).

In addition, the MA program has negotiated payment rates lower than those described above for specialty pharmacy products, defined as those used by a small number of recipients or by recipients with complex and chronic diseases requiring expensive and challenging drug regimens (see Minn. Stat. § 256B.0625, subd. 13e, para. (e)).

## Hospitals

MA uses a prospective payment system to reimburse hospitals for inpatient hospital services. Hospitals are paid per admission, but the amount of payment varies depending on the medical diagnosis of the patient.

The MA payment to a hospital for an admission is based on the reimbursement amount for the diagnosis-related group (DRG) into which the patient has been classified. The reimbursement for each DRG is hospital-specific and is intended to represent the average cost to a hospital of caring for a patient in that particular DRG classification. Hospitals benefit financially from patient stays that cost less than the DRG reimbursement amount. (The DRG reimbursement level is increased for hospital stays that exceed the average length of stay by a certain margin; these stays are referred to as day outliers.)

Hospital payment rates are not automatically adjusted for inflation, but under Minnesota law were required to be rebased (recalculated using more current cost data) at least every two years. In response to budget shortfalls, the legislature at times delayed rebasing or set the rebasing formula at less than full value. The 2010 Legislature eliminated a provision in current law that would have instituted rebasing at less than full value beginning January 1, 2011, and full rebasing beginning April 1, 2012. The legislature instead prohibited rebasing until January 1, 2013, at which time rebasing would be at full value. Most recently, the 2011 Legislature eliminated any implementation of rebasing.

The legislature has also at times reduced inpatient hospital payment rates and made related changes. The 2010 Legislature delayed June 2011 payments to hospitals until fiscal year 2012. The 2010 Legislature also reduced inpatient hospital rates by an additional 1.96 percent, effective July 1, 2011.

The 2011 Legislature reduced payments for fee-for-service admissions occurring between September 1, 2011, through June 30, 2015, by 10 percent. Payments to IHS facilities, long-term care hospitals, children's hospitals, and payments under managed care are exempt from this reduction. The amount of the required reduction can be reduced if there are reductions in the overall hospital readmissions rate.

The hospital prospective payment system is described in Minnesota Statutes, sections 256.9685 to 256.9695; it is also described in Minnesota Rules, parts 9500.1090 to 9500.1140.

## Intermediate Care Facilities for Persons with Developmental Disabilities (ICFs/DD)

ICFs/DD are reimbursed by MA under a contract system that was implemented on October 1, 2000. Under this system, reimbursement to a facility is based on the facility's current rate, plus any inflation adjustments authorized by the legislature in law. When first implemented, the system provided a floor for property reimbursement that was the greater of $8.13 per person per day or the facility's existing property reimbursement rate. Property reimbursement rates can be adjusted annually for inflation if an appropriation is made specifically for that purpose. Facilities can request variable rate adjustments if the care needs of a resident change and can also request temporary occupancy rate adjustments for vacant crisis beds.

The reimbursement system for ICFs/DD is described in Minnesota Statutes, sections 256B.5011 to 256B.5015.

The 2011 Legislature reduced ICF/DD operating payment rates by 1.5 percent effective July 1, 2011; the reduced payment rates will then be increased by 0.5 percent effective July 1, 2013. The 2011 Legislature also increased payment rates for a specific facility (paid for in a budget-neutral manner by reducing rates for all other facilities).

The 2011 Legislature authorized a contingent reduction in operating payment rates of 1.67 percent that would have taken effect July 1, 2012, if the federal government did not approve changes in the criteria used to determine nursing facility level of care under MA. The 2012 Legislature delayed the effective date of the 1.67 percent contingent reduction until July 1, 2013, and made the reductions contingent on DHS not receiving federal approval of the long-term care realignment waiver, or receiving only partial approval.

## Nursing Facilities

Nursing facilities are reimbursed by MA on a resident-per-day basis. The nursing home reimbursement levels are adjusted under the Resource Utilization Groups (RUGS) case-mix system to reflect the varying care needs of residents. RUGS classifies nursing facility residents into 48 groups based on information collected using the federally required minimum data set. The RUGS case-mix reimbursement system for nursing homes is described in Minnesota Statutes, sections 144.0724 and 256B.438.

MA rates and private pay rates do not vary within a facility. This is due to Minnesota's equalization law, which prohibits nursing facilities from charging private pay residents more than residents whose care is paid for by MA.

Since October 1, 2006, all nursing facilities participating in MA have been reimbursed under the alternative payment system (APS), sometimes referred to as the contract system. APS was developed as an alternative to an existing cost-based system (sometimes referred to as Rule 50). Under the cost-based system, reimbursement to facilities was based upon their reported costs, and at times, certain limits applied to the rate of increase in operating costs. Under APS, facilities are exempt from certain requirements of the cost-based system and are reimbursed at the level of their payment rate in effect just prior to entering into an APS contract with the commissioner.

These payment rates are adjusted annually for inflation, subject to limitations specified in law. Effective July 1, 1999, through September 30, 2013, the automatic inflation adjustment has been or will be applied only to the property-related rate; inflation adjustments for operating costs must be authorized by the legislature. The 2011 Legislature suspended the automatic inflation adjustment to the property-related rate for the rate years beginning October 1, 2011, and October 1, 2012.

The 2007 Legislature required DHS to rebase nursing facility rates, using an eight-year phase-in period. Rebasing is intended to allow nursing facilities to have new or currently unreimbursed expenditures recognized in the facility payment rate, subject to certain limits. Subsequent legislatures modified the phase-in methodology and also temporarily suspended implementation of the phase-in of rebasing. Most recently, the 2011 Legislature prohibited any further phase-in of rebasing. The 2011 Legislature reduced payments to nursing facilities for resident leave days, suspended property rate inflation adjustments for the rate years beginning October 1, 2011, and October 1, 2012, and prohibited the commissioner from accepting applications from facilities for planned closure rate adjustments, effective July 16, 2011. The 2011 Legislature also increased payment rates for certain low-rate facilities by up to 2.45 percent, effective October 1, 2011.

The 2012 Legislature authorized DHS to designate certain nursing facilities as critical access nursing facilities and to provide these facilities with enhanced payments and other benefits.

# Funding and Expenditures

The federal and state governments jointly finance MA.

## Federal Share

The federal share of MA costs for each state, referred to as the federal medical assistance percentage (FMAP), is usually determined by a formula included in Title XIX of the Social Security Act. The formula is based on the state's per capita income and is recalculated annually. Minnesota's FMAP in recent years has been 50 percent.

The American Recovery and Reinvestment Act and the Education, Jobs, and Medicaid Assistance Act provided Minnesota (and other states) with an enhanced FMAP for the period October 1, 2008, through June 30, 2011. Since July 1, 2011, Minnesota's FMAP has returned to its regular level of 50 percent.

## Nonfederal Share

The state, with some exceptions, has been responsible for the nonfederal share of MA costs since January 1991.[27]

[27] Through December 1990, the state paid 90 percent of the nonfederal share and the counties the remaining 10 percent. Counties are currently responsible for the nonfederal share of MA costs for selected services, as follows: 50 percent of the nonfederal share for the cost of placement of severely emotionally disturbed children in regional treatment centers, 20 percent for the cost of nursing facility placements of persons with disabilities under age 65 that exceed 90 days, 10 percent of the cost of placements in ICFs/DD with seven or more beds that exceed 90 days, and

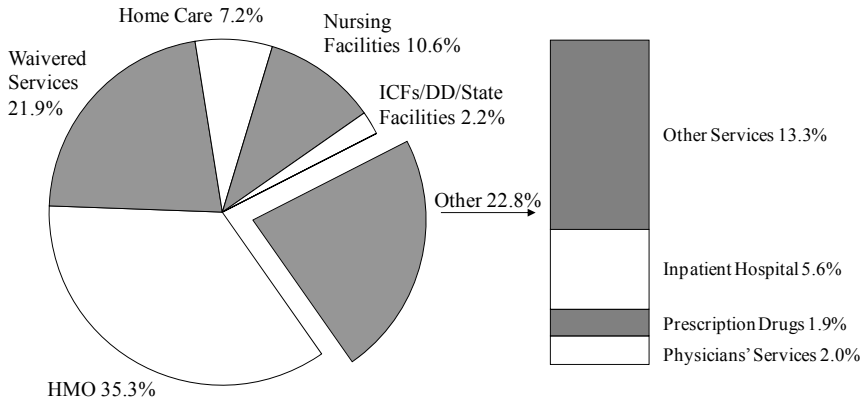
## MA Expenditures – State Fiscal Year 2011

In fiscal year 2011, total MA expenditures for services were $7.525 billion. This total was distributed between the levels of government as follows:

| Actual Expenditures — SFY 2011 | |
|---|---|
| Federal | $4.516 billion |
| Nonfederal | $3.009 billion |

The following chart shows the percentage of MA spending in fiscal year 2011 on the major service categories.

- HMO services was the largest single expenditure category (representing over one-third of MA spending).
- Community-based long-term care (waivered services and home care services) accounted for about 30 percent of MA spending.
- Long-term institutional care (care provided in nursing homes, ICFs/DD, and state facilities) accounted for about 13 percent of MA spending.




Note: The waivered services category includes waiver payments to HMOs.

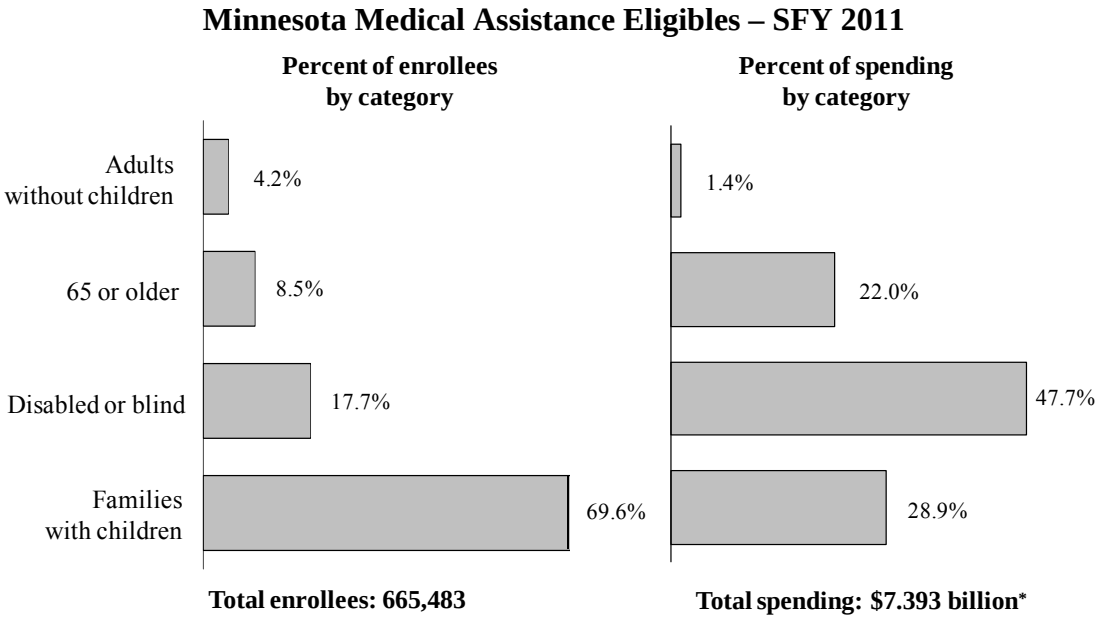
Source: Department of Human Services, November 2011 Forecast, Background Tables

20 percent of the costs of placements in nursing facilities that are institutions for mental diseases (IMDs) that exceed 90 days.

# Recipient Profile

During fiscal year 2011, an average of 665,483 persons were eligible for MA services each month. The graph below shows the percentage of MA eligibles in each of the major eligibility groups. The graph also shows the percentage of MA spending accounted for by individuals from each eligibility group.

- Families with children make up the largest eligibility group, constituting 69.6 percent of eligibles. However, this group accounted for only 28.9 percent of MA spending.
- The elderly, and the disabled or blind, accounted for 69.7 percent of MA spending, although only 26.2 percent of eligibles are in these two groups.




*Does not include consumer support grant expenditures, pharmacy rebates, and adjustments

Source: Department of Human Services

## MA Income Limit – Federal Poverty Guidelines[28] for 7/1/12 through 6/30/13 – 12-month Standard

| Household Size | **75%** | **100%** | **135%** | **150%** | **200%** | **275%** | **280%** |
|---|---|---|---|---|---|---|---|
| 1 | $8,388 | $11,412 | $15,324 | $16,764 | $22,584 | $30,720 | $31,284 |
| 2 | 11,364 | 15,372 | 20,676 | 22,704 | 30,504 | 41,616 | 42,372 |
| 3 | 14,340 | 19,332 | 26,028 | 28,644 | 38,424 | 52,512 | 53,460 |
| 4 | 17,316 | 23,292 | 31,380 | 34,584 | 46,344 | 63,408 | 64,548 |
| 5 | 20,292 | 27,252 | 36,732 | 40,524 | 54,264 | 74,304 | 75,636 |
| 6 | 23,268 | 31,212 | 42,084 | 46,464 | 62,184 | 85,200 | 86,724 |
| 7 | 26,244 | 35,172 | 47,436 | 52,404 | 70,104 | 96,096 | 97,812 |
| 8 | 29,220 | 39,132 | 52,788 | 58,344 | 78,024 | 106,992 | 108,900 |
| 9 | 32,196 | 43,092 | 58,140 | 64,284 | 85,944 | 117,888 | 119,988 |
| 10 | 35,172 | 47,052 | 63,492 | 70,224 | 93,864 | 128,784 | 131,076 |
| Each Additional Person | 2,976 | 3,960 | 5,352 | 5,940 | 7,920 | 10,896 | 11,088 |

House Research Department

[28] Federal poverty guidelines are updated every year, usually in February. New DHS income standards based on updated guidelines are effective later in the calendar year.

# Glossary of Acronyms

**AC:** Alternative care (program)
**ACA:** Affordable Care Act
**APS:** Alternative payment system
**AWP:** Average wholesale price
**BI:** Brain injury (waiver)
**CAC:** Community alternative care (waiver)
**CADI:** Community alternatives for disabled individuals (waiver)
**CHIP:** Children's Health Insurance Program
**CMS:** Center for Medicare and Medicaid Services
**DD:** Developmental disabilities (waiver)
**DHS:** Department of Human Services (Minnesota)
**DHHS:** Department of Health and Human Services (U.S.)
**DRG:** Diagnosis-related group
**EMA:** Emergency Medical Assistance
**EW:** Elderly waiver
**FFP:** Federal financial participation
**FMAP:** Federal medical assistance percentage
**FPG:** Federal poverty guidelines
**ICF/DD:** Intermediate care facility for persons with developmental disabilities
**IMD:** Institution for mental diseases
**JCAHO:** Joint Commission on Accreditation of Healthcare Organizations
**LTCP:** Long-term care partnership
**MAC:** Maximum allowable cost
**MAGI:** Modified adjusted gross income
**MSA:** Minnesota Supplemental Aid
**MSHO:** Minnesota Senior Health Options
**PMAP:** Prepaid Medical Assistance Program
**RUGS:** Resource utilization groups
**SNBC:** Special Needs Basic Care (program)
**SNP:** Special needs plan
**SSI:** Supplemental Security Income
**WAC:** Wholesale acquisition cost

*For more information about health care programs, visit the health and human services area of our website, www.house.mn/hrd/hrd.htm.*