Emergency Medical Assistance

Health Care Administration

April 19, 2013

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Minnesota Department of Human Services
April 2013

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I. Executive Summary

The 2012 Legislature required the Department of Human Services (DHS), in consultation with relevant stakeholders, to develop a plan to provide coordinated and cost-effective care to people eligible for the Emergency Medical Assistance (EMA) program and who are ineligible for other state programs.

Established in 1987, EMA is Minnesota's federally mandated Emergency Medicaid program for non-citizens who are otherwise eligible for Medical Assistance (MA) but for their immigration status. EMA is funded by both state and federal dollars in the same manner as MA. The EMA program is limited to providing treatment for an "'emergency medical condition'…manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

- (A) placing the patient's health in serious jeopardy,
- (B) serious impairment to bodily functions, or
- (C) serious dysfunction of a bodily organ or part."

Since its establishment, the federal government has allowed states discretion in defining what set of health care services might be associated with an "emergency medical condition" in the EMA program. For many years, the EMA program in Minnesota operated without an explicit list of services that would meet, or be excluded from, the definition of "emergency medical condition."

In State Fiscal Year (SFY) 2010, Minnesota's EMA program expenditures totaled to approximately $47 million and annual enrollment was 3,622 individuals. Following the 2011 Minnesota Legislative Session, the scope of the program was limited and program funds were reduced by $30 million. Nonetheless, annual EMA enrollment increased to 4,463 individuals. The 2012 State Legislative Session restored $4.7 million to the program for dialysis and cancer treatments effective May 1, 2012, to June 30, 2013. Despite these additions, annual enrollment in 2012 dropped slightly to 4,379 individuals.

Per the legislative report requirements, DHS discusses options in this report to establish programs that may reduce or mitigate the high cost of care provided to the EMA population by including additional services, programs, and funding mechanisms that would allow individuals

who are eligible for EMA (or more generally uninsured) to access services that are less costly than emergency services. The models DHS examined were:

1. **Uncompensated Care Pool -** a set amount of funding would be dedicated to a pool distributed to providers based on the amount of uncompensated care each provider delivered to uninsured populations. This model could require that the treated patients meet specific eligibility requirements related to income or immigration status but would not require them to enroll in a program. The treating provider would document and attest that the patient met the criteria.

2. **State Funded Grant Program for Providers** – this model would establish a set of eligibility criteria for grant applicants and funds would be distributed based on those criteria. Providers or a group of providers could receive grant funding from the state to provide a broader set of health care services, including preventive and primary care, to individuals eligible for EMA or who are otherwise uninsured.

3. **State Funded Program for EMA Enrollees** – this model would establish a health care program for the EMA target populations that provides broader coverage to individuals who meet the eligibility criteria. This model would be similar to the program under which Minnesota provides a MinnesotaCare benefit set to lawfully present non-citizens that are not eligible for Medical Assistance.

4. **Partnership with a Local Access to Care Program** – under this model, a not-for-profit entity would administer the health care delivery program (establish eligibility, collect enrollee contributions, and establish provider networks) and the state would contribute funding.

DHS developed each of the program options considering the following factors:

- Incentives to provide a broader set of services that might reduce the prevalence of expensive hospital-based services, such as preventive and primary care;
- Targeting funds to the providers that incurred the highest levels of uncompensated care to the relevant populations;
- Flexibility of options and option components for broader participation (patient and provider) and ability to meet local needs and conditions;
- Oversight activities that would ensure that funds were appropriately spent and how effective the funds were at reducing the overall costs for care; and
- Administrative burden each model placed on the enrollee, providers, and the state.

In addition to informal discussions with a variety of stakeholders, DHS convened meetings with relevant advocate and health care provider stakeholders to gather input on each of the options,

the EMA target populations, and the uninsured in general. There was broad agreement among stakeholders that education and outreach to the EMA population were key components for reducing costs and improving health status, particularly as it relates to resolving immigration status issues that would allow an individual to become eligible for an existing state program with a more comprehensive benefit set, such as MinnesotaCare for lawfully present non-citizens. There was also broad agreement that providing comprehensive and primary care coverage was in the best interest of the target populations and an effective means of reducing costs overall.

Another common theme from the stakeholder meetings was that the examined options should not be considered to be mutually exclusive. Some of the options such as an uncompensated care pool might be best suited for higher cost institutional services such as hospital and nursing facility care or in areas of the state where patients and providers are dispersed across a broad geographic area. Other options such as state-funded grants or local access to care programs might work better as an effective means to provide more primary care services and to serve a specific geographic area where the program could meet local conditions.

The feasibility of each option also varied in terms of scalability and how effectively each could operate in outstate versus metro-area locations. For example, local access to care program currently operates in the metro area but might be challenged to create provider networks in non-metro areas without additional funding and infrastructure. One approach to expanding a local access to care model might be to leverage an existing organization's, such as Portico's, current efforts with additional state funding.

Providers and advocates agreed that more effort should be directed at ensuring that a legal immigration status is established whenever possible when an individual with an undetermined immigration status needs higher cost health care services. Some stakeholders suggested that a connection to help with immigration status be developed when the patient first presents for treatment. There was also recognition that more immigration law expertise capacity is needed across the board.

Many of the provisions of the Affordable Care Act will take effect in January 2014. These health care reform provisions include a requirement that all individuals have comprehensive health care, reforms to the private insurance market, the establishment of new health care exchanges

that facilitate the purchase of coverage via a standardized marketplace and federal subsidies that make coverage more affordable as well as an expansion of public health care programs to individuals with incomes up to 200 percent of poverty. These changes will transform the health care coverage landscape and reduce the number of uninsured Minnesotans from 500,000 now to less than 200,000 by 2016 when the programs are fully implemented (Gruber & Gorman, 2013).

Meeting the needs of the populations that remain uninsured will present many challenges. Programs targeted to these populations will have to address their specific needs and ensure that whatever program or programs are implemented can be integrated into the overall health care coverage landscape.

II. Legislation

The 2012 Legislature required the commissioner of Human Services, in consultation with relevant stakeholders, to develop a plan to provide coordinated and cost-effective care to people eligible for EMA. The plan must be submitted to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and financing.

> Minnesota Session Laws 2012, Chapter 247, article 1, section 28: a) The Commissioner of Human Services shall develop a plan to provide coordinated and cost-effective health care and coverage for individuals who meet eligibility standards for emergency medical assistance and who are ineligible for other state public programs. The commissioner shall consult with relevant stakeholders in the development of the plan. The commissioner shall consider the following elements: (1) strategies to provide individuals with the most appropriate care in the appropriate setting, utilizing higher quality and lower cost providers; (2) payment mechanisms to encourage providers to manage the care of these populations, and to produce lower cost of care and better patient outcomes; (3) ensure coverage and payment options that address the unique needs of those needing episodic care, chronic care, and long-term care services; (4) strategies for coordinating health care and nonhealth care services, and integrating with existing coverage; and (5) other issues and strategies to ensure cost-effective and coordinated delivery of coverage and services. (b) The commissioner shall submit the plan to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and financing.

III. Purpose

The purpose of the Emergency Medical Assistance (EMA) study is to examine state options for providing coordinated and cost-effective health care coverage to individuals who are ineligible for other state and federal programs but who meet eligibility standards for EMA. This report is submitted to the Minnesota Legislature pursuant to Minnesota Session Laws 2012, Chapter 247, Article 1, Section 28.

This report begins with an introduction to the EMA program, a summary of how the program has changed over time and a profile of the populations served, and a profile of health care providers affected by the program's policy changes. The report also presents other coverage programs that serve undocumented non-citizens and other uninsured populations in other states as well as a summary of stakeholder input concerning the future direction of the EMA program in Minnesota. Finally, several alternative coverage options are examined in light of the need to ensure cost-effective and coordinated health coverage that meets the unique needs and challenges of populations eligible for the EMA program.

IV. Introduction

Established in 1987, EMA is Minnesota's federally mandated Emergency Medicaid program for non-citizens who are otherwise eligible for Medical Assistance (MA) but for their immigration status. EMA is funded by both state and federal dollars. In SFY 2010, Minnesota's EMA program expenditures totaled to approximately $47 million. Following the 2011 Minnesota Legislative Session, program funds were reduced to $30 million. The 2012 State Legislative Session restored $4.7 million to the program to cover costs of dialysis and cancer treatments effective May 1, 2012, to June 30, 2013.

V. The EMA Population in Minnesota

For the entire 2011 calendar year there were 4,463 total individuals that used EMA at some point during the year and for the entire 2012 calendar year, 4,379 individuals used EMA services at some point. DHS analyzed eight months of data starting each quarter (January, April, July, October), in 2011 and in 2012, to create a monthly profile of the EMA population. The EMA

profiles provide a “snapshot” of the program, indicating the expected number of cases created and individuals enrolled each month. In 2011, the EMA program had an average monthly enrollment of 2,469 individuals and in 2012 there was an average monthly enrollment of 2,084 individuals. Individual enrollees may have multiple cases throughout the year. A case is generated when a qualifying individual is admitted to an emergency room or inpatient hospital for treatment of an emergency medical condition. The monthly average number of cases in 2011 was 2,515 and in 2012, approximately 2,128 cases.

As shown in Table 1, the projected average enrollment for any month in both 2011 and 2012 was between 2,000 and 2,500 individuals and the majority of enrollees were undocumented. Other individuals are eligible for Medical Assistance (MA) including: refugees, asylees, deportees, parolees, individuals with conditional entry, individuals with temporary visas, lawfully permanent residents, and others who are lawfully residing. The typical EMA enrollee lived in Hennepin or Ramsey counties accounting for approximately 64 percent and 10 percent respectively. The remaining 26 percent of enrollees reside outside of Hennepin and Ramsey counties. However, the EMA population accounts for less than 1 percent of the population in 39 counties outside of the metro area.

Adults over age 65 were the most represented age group followed by the 36-to-45 age group. Nearly 38 percent of enrollees were eligible because they were a parent of a dependent child, and women accounted for the majority of all EMA enrollees. Hispanics were the predominant race/ethnicity represented followed by African-Americans and Asian-Americans. Approximately 69 percent of all EMA enrollees were approved for the program because their medical condition, of any eligible type, placed their health in serious jeopardy. The tables in Appendix A provide comparison summary data for each year as well as averages over the two-year period.

While this information provides greater insight into the EMA population, there are data limitations to acknowledge. First, there are several race and/or ethnicity categories that are blank or categorized as “unable to determine,” which leads to under reporting races and/or ethnicities represented. Also, there is no standard used to account for individuals who identify as “mixed race” because the enrollee cannot specify any mixed race combination. In addition, many

enrollees have multiple cases that were never closed or that have an indefinite status. To account for this, DHS made a strong effort to avoid double counting cases and individuals when necessary.

Table 1: Highlights from EMA Monthly Profile Averages

	2011	**2012**
Average Monthly Enrollment	2,469 Individuals	2,084 Individuals
Average Monthly Cases*	2,515 Cases	2,128 Cases
	%	%
Counties Highest EMA		N/A
Hennepin	64.3	
Ramsey	10.4	
All Other Counties	26.0	
Undocumented Non-citizens	63.5	59.21
Race/Ethnicity		
Hispanic	36.2	59.4
African-American	15.3	18.3
Asian-American	10.2	11.1
Gender		
Female	63.8	64.4
Male	36.2	35.6
Age		
65+	31.6	33.1
36-44	19.4	17.8
26-35	18.0	16.7
Eligibility Type		
Parent of Dependent Child	37.5	32.2
Over Age 65	31.4	33.0
Reason for Enrolling		
Chronic Condition	57.0	54.3
Sudden Condition	34.3	36.2

VI. Federal Legislation History

Under Title XIX, Section 1903(v)(3) of the Social Security Act of 1986, states are required to provide emergency medical services to unlawfully present non-citizens for an "'emergency medical condition'…manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

- (A) placing the patient's health in serious jeopardy,
- (B) serious impairment to bodily functions, or

- (C) serious dysfunction of a bodily organ or part."

This provision includes emergency labor and delivery but specifically excludes care and services related to organ transplants (SSA Section 1903(v) (2) (C)). Similar language concerning emergency Medicaid was included in the Consolidated Omnibus Reconciliation Act of 1986 and the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). PRWORA also resulted in the elimination of federally-funded Medicaid eligibility for certain categories of non-citizens. The Balanced Budget Act of 1997 and the Medicare Prescription Drug Improvement and Modernization Act of 2003 allocated federal funds to states for emergency services granted to undocumented non-citizens. For Federal Fiscal Year (FFY) 1998 to FFY 2001, the Balanced Budget Act of 1997 appropriated $25 million for payments to each of 12 states with the highest number of undocumented non-citizens. These funds went directly to each state's Emergency Medicaid programs. Minnesota was not among these initial 112 states and did not receive funding. The Medicare Prescription Drug Improvement and Modernization Act of 2003 appropriated $167 million annually for FFY 2005 to FFY 2008 to fund states based on the percentage of undocumented non-citizen residents. As a result of this change in the funding formula, Minnesota was allocated $1.4 million annually to be paid directly to eligible hospitals, physicians, and ambulance providers.

The Centers for Medicare & Medicaid Services (CMS) have provided limited guidance around defining "emergency medical condition" beyond the legislative language cited above. In commentary to federal regulations addressing emergency medical condition coverage for non-citizens, CMS stated:

> "[W]e believe the broad definition [of emergency medical condition] allows States to interpret and further define the services available to aliens covered by section 1903(v)(2) which are any services necessary to treat an emergency medical condition in a consistent and proper manner supported by professional medical judgment. Further, the significant variety of potential emergencies and the unique combination of physical conditions and the patient's response to treatment are so varied that it is neither practical nor possible to define with more precision all those conditions which will be considered emergency medical conditions" (55 Federal Register 36,813, 36,816 (1990)).

Therefore, expanding coverage for services that are not provided at the time of treatment an "emergency" may no longer be eligible for Federal Financial Participation (FFP) under EMA.

VII. Federal Review of Emergency Medical Services Across States

Although CMS has given states broad discretion to define "emergency medical condition" within the confines of federal legislation, in recent years, the federal Office of the Inspector General (OIG) has audited a number of states regarding effective internal controls to ensure that federal reimbursement was claimed only for services provided to undocumented non-citizens that it defined as emergencies. Between 2004 and 2007, OIG audited New York, Texas, Florida, Washington state, and New Jersey. Of these, only New Jersey was found to have adequate controls to ensure that the services provided in the EMA program were emergency services.

VIII. State EMA Operation and Administration

Following the enactment of EMA in 1987, the next state amendment to the EMA program did not occur until July 1, 1995, when Minnesota explicitly prohibited coverage of organ transplants and related services under EMA (1995 Minnesota Session Laws, Chapter 207, article 6, section 38).

Over a decade later, during the 2011 First Special Legislative Session, Minnesota Statutes 2010, section 256B.06 was amended to limit EMA to services provided in an emergency room, an ambulance, or in an inpatient hospital setting following admission from an emergency room or clinic, and "follow-up services that are directly related to the treatment of the emergency medical condition and are covered by the global payment made to the provider" (2011 First Special Session, Chapter 9, article 6, section 27). Preventive care, prenatal care, and home and community-based waivers were specifically excluded. These changes were accompanied by a $15 million budget reduction to the EMA program. The changes were effective Jan. 1, 2012, for individuals enrolled before this date. Beginning July 2011, the Minnesota Department of Human Services (DHS) mailed notices to EMA recipients about the coverage change on five separate occasions. EMA enrollees were notified of their right to appeal the changes in the Nov. 28, 2011, notice. Due to the large number of appeals received, DHS extended the EMA coverage deadline to Jan. 8, 2012, and later extended the deadline again to June 30, 2012.

An amendment in the 2012 regular session restored $4.7 million to the EMA program to cover dialysis. Cancer treatment, including surgery, chemotherapy, radiation, and related services are also covered in EMA if approved through a Care Plan Certification (CPC) request and if the cancer is not in remission (2012 Regular Session, Chapter 247, article 1, section 29). This amendment was effective May 1, 2012, and ends June 30, 2013. Treatment with dates of service after this date will only be covered if provided in an emergency room, an ambulance, or an inpatient hospital setting and if follow-up services are directly related to the original service provided to treat the emergency medical condition. Treatments after June 30, 2012, will also be covered if approved through a CPC. DHS mailed notices to EMA recipients about the service amendment on April 13, 2012. From 2011 to 2012, average enrollment in the EMA program decreased by nearly 16 percent including the 530 appeals filed. Excluding these appeals, which allow the appellant to continue receiving full benefits while the appeal is pending, average EMA enrollment decreased by approximately 37 percent between 2011 and 2012.

Below is a current list of services **not** covered by EMA (MN Statutes 256B.06):

- Services delivered in an emergency room or inpatient setting to treat a nonemergency condition
- Organ transplants, stem cell transplants, and related care
- Services for routine prenatal care
- Continuing care
- Elective surgery
- Outpatient prescription drugs, unless the drugs are administered or dispensed as part of an emergency room visit
- Preventative health care and family planning services
- Rehabilitation services
- Physical, occupational, or speech therapy
- Transportation services
- Case management
- Prosthetics, orthotics, durable medical equipment, or medical supplies
- Dental services
- Hospice care
- Audiology services and hearing aids
- Podiatry services
- Chiropractic services
- Immunizations
- Vision services and eyeglasses
- Waiver services
- Individualized education programs
- Chemical dependency treatment

Following enactment of the 2011 legislative amendment to EMA, individuals were able to continue receiving services in settings other than emergency room, ambulatory, or inpatient

hospital settings under certain circumstances. DHS added a limited exception group for enrollees who were receiving medical care in a nursing facility (NF) or home or community setting who could request a limited exception to the statutory changes. Nursing facility residents and recipients who received home care services were granted an exception only when the individual's cardiovascular or respiratory condition would reasonably be expected to result in placing his or her health in serious jeopardy, serious impairment to bodily functions, serious dysfunction of any bodily organ or function, or death within 48 hours of the end of services delivered in these settings.

In March 2012, DHS implemented the CPC process in which providers must request prior authorization for treatment of medical services that are not rendered in an emergency department or inpatient hospital setting. The CPC process also allows for approval of prescription drug payment. The CPC process has since replaced the limited exception process for any new requests for health services that do not meet the baseline EMA criteria. However, if a recipient was previously authorized through the limited exception process, they remain eligible through the limited exception authorization period. For both the limited exception and CPC processes, a recipient remains authorized until the end of the treatment plan up to one year. The recipient must submit and be approved for a new CPC request to continue receiving services following the end of the initial authorization period.

Appendix B, Table B-1 details the full list of services, total service days, and total reimbursements claimed during the 2012 calendar year as of Feb. 21, 2013. The categories of service with the highest reimbursement amounts overall are shown in Table 2 below.

Table 2: Five Services with the Highest Reimbursement Amount for all EMA Recipients CY 2012

Category of Service	Total Reimbursement
Inpatient Hospital	$12,926,691
Physician Services	$2,388,142
Personal Care Services	$2,382,061
Nursing Facility	$2,321,986
Outpatient Hospital	$1,232,084

*Data retrieved Feb. 21, 2013

In March 2011, Minnesota implemented an early expansion of Medicaid to cover childless adults with incomes up to 75 percent of poverty under the Affordable Care Act of 2010. Legislation authorizing the state to proceed with the full expansion to include adults with incomes up to 133 percent of poverty (with 5 percent disregard) effective January 1, 2014, was recently signed into law (2013 Minnesota Session Laws, Chapter 1—H.F. No. 9, section (5)(b)). This state Medicaid expansion will also expand the number of individuals eligible to receive Emergency Medicaid. There are approximately 97,140 non-elderly (19-64) undocumented non-citizens in Minnesota. Of these 97,140 people, 46,130 are below 138 percent of federal poverty guidelines (FPG) and will account for 10 percent of Minnesota's total number of low-income uninsured nonelderly adults (SHADAC, 2013). When Minnesota proceeds with MA expansion, the expanded group of undocumented non-citizens eligible for EMA will be funded by both federal and state dollars and will be subject to the same services covered for the current EMA population following amendments made to the program.

IX. Providers Serving the EMA Population

There are several types of providers that render health care treatment and services to undocumented non-citizens. For all EMA enrollees, physicians, pharmacies, and hospitals accounted for the most fee-for-service claims submitted in Calendar Year (CY) 2012 as shown in Table 3. Hospitals accounted for 9 percent of the 1,174 total claims submitted but captured over 59 percent of the reimbursement dollar amount. By number of claims submitted, physicians accounted for nearly 31 percent and pharmacies nearly 24 percent of claims, but comprised of only 4.6 percent and 5.3 percent of the reimbursement dollar amounts respectively.

Table 3: EMA Claim Reimbursements for all Eligible EMA Enrollees in CY 2012

Provider Type	Number of Providers Submitting Claims	Reimbursement Amount	Percent of Total Dollars
Physicians*	362	$1,110,725	4.63%
Pharmacy	277	$1,262,454	5.26%
Hospitals	106	$14,200,563	59.18%
Personal Care Provider	72	$2,121,426	8.84%
Renal Dialysis Free Standing	42	$781,707	3.26%
Medical Supplier	42	$226,514	0.94%
Medical Transportation Provider	41	$249,060	1.04%
Chemical/Mental Health#	30	$90,711	0.38%
Nursing Facilities	26	$2,147,074	8.95%
FQHC/CHC	17	$77,099	0.32%
Independent Laboratory	16	$23,899	0.10%
Home Health Agency	15	$125,458	0.52%

*Includes claims submitted by a separate billing entity for Physician Services
Includes billing entity for Mental Health, County Mental Services, and Community Mental Health Clinics

Also among the top 10 provider types with the highest number of EMA claims submitted are nursing facilities and Federally Qualified Health Centers (FQHCs). There are 399 MA-certified and/or state licensed NFs in Minnesota, with a total of 33,878 active beds. Nearly 67 percent of all resident stays are paid for by state and federal funds while residual costs are paid for privately or by other payment sources. In CY 2012 nursing facilities accounted for over 2 percent of the number of EMA claims submitted and nearly 9 percent of the total dollar amount for EMA reimbursements.

FQHCs are safety net health care providers that provide comprehensive clinic services for low-income and uninsured populations. FQHCs also provide other social support services to their patient population. Currently, there are 66 FQHCs actively enrolled in Minnesota Health Care Programs. Fifty-nine of the active FQHCs are located in Minnesota, five are in North Dakota, one is in Iowa and one is in Wisconsin. On average, federal grants account for 26 percent of FQHC funding while remaining costs are covered by third party sources such as public and private insurance reimbursement and support from local government, individual donors, and state and local foundations. FQHCs accounted for nearly 2 percent of the number of EMA claims submitted and less than 1 percent of the total dollar amount for EMA reimbursements. There

were also 18 registered FQHC "look-alike" clinics in Minnesota that meet the same requirements as actual FQHCs but do not receive federal operating grants.

Appendix C, Table C-1 contains a full list of provider types that submitted claims for EMA during CY 2012.

X. Other Sources of Coverage and Funding for Non-Citizens and Uninsured

In addition to EMA, there are several other programs in Minnesota that cover non-citizens that meet certain eligibility criteria.

The Children's Health Insurance Program Reauthorization Act of 2009

Under the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009, states have the option of covering uninsured undocumented non-citizen pregnant women that would have qualified for Medicaid or CHIP coverage but for their immigration status. These women receive full MA benefits for the duration of pregnancy and the 60-day postpartum period. The state receives a 65 percent federal match rate for the cost of these services. Under CHIP standards, federal funds may be used to cover undocumented non-citizen pregnant women so that health care is provided to the unborn citizen child. In Minnesota, undocumented non-citizen pregnant women with income at or below 275 percent FPG without a spend-down are eligible for CHIP-funded MA unless they have other insurance. If an undocumented non-citizen pregnant woman is ineligible for CHIP-funded MA, she may be eligible for payment of labor and delivery costs through EMA.

Tax Equity and Fiscal Responsibility Act of 1982

All non-citizen children with a disability who are not eligible for EMA due to their parents' excess income may receive EMA under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) if they have an emergency condition regardless of immigration status. TEFRA coverage is limited to treatments and services covered by EMA.

Disproportionate Share Hospital Program

Congress developed the Medicaid Disproportionate Share Hospital (DSH) program in 1981 to help states provide additional assistance to hospitals that serve a high number of low-income and uninsured patients, which often include undocumented non-citizens. DSH programs have become a large source of funding for hospitals.In FFY 2011 Minnesota received nearly $75 million in DSH funds. The Affordable Care Act of 2010 (ACA) enacts quarterly reductions to state Medicaid DSH allotments starting in 2014.

All hospitals meeting one of the following statutory minimum criteria are eligible to receive DSH payments:

i. A Medicaid inpatient utilization rate in excess of one standard deviation or more above the mean for all hospitals in the state OR

ii. A low-income utilization rate exceeding 25 percent.

States may also choose to include hospitals that have a Medicaid utilization rate of at least 1 percent. Each state's federal DSH allotment is capped at 12 percent of the state's total Medicaid benefits payments for a past allotment year. Table 4 lists Minnesota hospitals with the highest uncompensated care costs along with their DSH payments for the 2009 calendar year for comparison. None of the listed hospitals exceeded DSH funding limits.

Table 4: DSH Payments to Minnesota Hospitals with Highest Uncompensated Care Costs 2009

Hospital	**Uncompensated Care Costs**	**DSH Payment**
Hennepin County Med. Ctr.	$44,364,494	$13,526,788
Mayo Clinic St. Mary's Hosp.	$35,331,134	Zero
Regions Hospital	$33,121,387	$4,020,288
Abbott Northwestern Hosp.	$26,492,199	$183,277
Fairview-University Med Ctr.	$23,539,856	$7,624,250
St. Cloud Hospital	$20,892,501	$485,035
United Hospital-St. Paul	$20,188,752	$229,934
Owatonna Hospital	$19,002,426	$67,613
North Memorial Healthcare	$17,499,586	$430,002
Healtheast St. Joseph's Hosp.	$14,258,403	$223,609

Federally Qualified Health Centers

Section 330 of the Public Health Services Act provides federal grant funding for FQHCs. Included in this category are the Community Health Center (CHC) program, the Migrant Health program, the Health Care for the Homeless program, and the Public Housing Primary Care program. FQHCs are designed to serve adults and children in rural and urban areas who experience financial, geographic, or cultural barriers to care. FQHCs are mandated to see all patients however, proof of residence, proof of income, and co-payments are often required. FQHCs provide preventive care, mental health services, dental services, primary care, and translation services on a sliding fee scale. The Minnesota Association of Community Health Centers estimates that one out of six uninsured individuals in Minnesota receives care at a FQHC.

Local Access to Care Programs

Local Access to Care Programs (LACPs) are locally financed and organized by nonprofit agencies or providers to provide a structured set of health benefits and services to uninsured working-age adults. LACPs typically enroll members that meet income eligibility requirements for free care or care on a sliding fee scale. Members receive a defined set of benefits by a limited local provider network as contractually agreed by the LACP and local care provider. LACPs may also contract with FQHCs and FQHC look-alike programs to provide care to their members.

Portico Healthnet is a nonprofit LACP in Minnesota that started as a pilot project for the federal Department of Health and Human Services in 1995. A local hospital system further developed the program to better utilize funds being spent to cover uncompensated emergency care. The Portico network now includes 12 local hospitals and participation from the majority of health plans to serve the low-income and non-legal residents of Dakota, Hennepin, Ramsey, and Washington counties. Portico strives to reduce the number of people lacking health insurance in two ways. First, the program employs community health workers to screen uninsured individuals for potential eligibility for Minnesota Health Care Programs (MHCP) and, if eligible, community health workers provide personalized assistance with the application and renewal process.

Second, if individuals are ineligible for MHCP, then Portico offers prevention-based coverage that includes primary and preventive medical care, specialty and urgent care clinics, outpatient mental health services, prescription medications, and interpreter services for medical appointments.

Portico assesses a monthly participation fee, typically between $25 and $50 per household per month based on a sliding scale according to income and household size for its prevention-based coverage. Portico does not cover emergency room utilization or inpatient hospitalization. To be eligible for the Portico program, individuals must have a household income at or below 275 percent FPG and must be ineligible for any other public or private source of affordable coverage. Portico has approximately 1,300 individuals currently reenrolled and 1,100 qualifying individuals waitlisted for the program.

Uncompensated Care Pool

An uncompensated care pool (UCP) is a financing mechanism designed to mitigate financial disincentives to providers serving low-income and uninsured individuals. A UCP is a mechanism that strives to spread the burden of financing uncompensated care more equitably across various providers and helps reduce the costs of uncompensated care that providers might otherwise pass along to other payers. For providers with a large volume of uncompensated care, a UCP subsidizes costs to partially offset their higher levels of uncompensated care.

An example of an uncompensated care pool is the **New Jersey Hospital Care Payment Assistance Program**, a state operated UCP financed by the state's Health Care Subsidy Fund which is matched dollar-for-dollar with federal funds. In addition, taxes on tobacco products, health care providers, and Health Maintenance Organizations and Intergovernmental Transfers contribute to the fund. Acute care hospitals seeking state assistance for uncompensated care must submit patient-level claims to the state health and human services agency that certify that the patient is eligible for the state charity care subsidy program. To be eligible, the individual must be a New Jersey state resident. There is no citizenship requirement. The individual must not have health insurance or have coverage that pays for only part of the hospital bill. The individual also cannot be eligible for any other public insurance program. Finally, the individual's income cannot exceed $7,500 and family assets cannot exceed $15,000 per year. Individuals may spend-

down to these limits for eligibility. Applications for the program are accepted at the point of service and are in effect for up to one year after the initial date of treatment. The percentage of costs that a patient pays is dependent on their income as a percentage of FPG. Patients with incomes above 300 percent FPG are not eligible for the program.

Multi-Share Programs

Multi-share programs at the state level often operate under federal approval via Medicaid Health Insurance Flexibility and Accountability waivers to expand coverage to the working uninsured. Such programs blend sources of funding from employers, the employee, and the public. Because of the use of federal funds, multi-share programs at the state level are not an option for providing health coverage to undocumented non-citizens. States have greater flexibility at the community level where only state and county general funds are used for the public share of financing.

In Minnesota, **Values Health of PrimeWest Health** is a community-based program offered to small businesses in rural Minnesota to provide affordable coverage to employees that cannot get health insurance from their employer. The employee, the employer, and the local community contribute to the health coverage premium for members. In 2009, PrimeWest Health also received funds from the State Health Access Program grant which has since expired. Preventive services and the first $300 of paid services per contract year are fully covered by Values Health. There is a 50 percent split for the next $300 to $2,300 of paid services. For any amount above $2,300, Values Health pays 80 percent while the employee is responsible for 20 percent of costs. Values Health is not insurance and both employers and employees must meet requirements.

Employers can have between one and 50 employees and the corporate office must be in a county where Values Health is offered. The average wage of eligible employees must be at or below 350 percent FPG and the employer cannot offer health coverage at the time of employment or in the 12 months preceding the application date. For an employee to be eligible, they must work at least 32 hours per week and cannot be eligible for any other private or public insurance sources. Values Health operates in Douglas and Meeker counties and may be available in Beltrami, Big Stone, Clearwater, Grant, Hubbard, McLeod, Pipestone, Pope, Renville, Stevens, and Traverse

counties as well. A similarly structured program, **HealthShare**, operates in Carlton, Cook, Lake, and St. Louis counties in Minnesota. Neither program mentions a U.S. citizenship requirement.

National Provider Networks

National Provider Networks are a referral system to enlist volunteer specialists who agree to treat uninsured patients for minimal to no cost. Often, patients are referred by local FQHCs and primary health clinics. Network coordinators schedule patient visits, process paperwork, and arrange transportation and translation services if required. Services provided are depended on the community served, but typically include primary care, health education for adults, prescription drugs, and even some dental and mental health services. National Provider Networks have begun to serve a large immigrant population in recent years, including many who are undocumented.

The **Project Access Model of the Physicians' Innovation Network** began with the Buncombe County Medical Society in North Carolina as a physician volunteer initiative to provide charity care to low-income, uninsured community members. Physicians and community partners donate their services without reimbursement or compensation. Although the Project Access model is not health insurance, physicians donate services ranging from routine annual physicals, open heart surgery, transportation, and translational services. The Project Access Model has been adopted by nearly 50 communities nationwide, with populations ranging in size from 22,000 to over 1 million.

County Indigent Care Models

Financed and administered by local health and human services agencies, low-income and uninsured residents of eligible counties receive basic health care services, coordinated care, and case management through a county indigent care model. The administrative structure of each county health plan varies, but the goal of each program is to provide health coverage for individuals who are not eligible for conventional public programs.

Healthy San Francisco is a program in California designed to serve uninsured residents of the city and county of San Francisco regardless of immigration status. Administered by the San Francisco Department of Health, the program provides a medical home and primary physician to each enrollee to focus on preventive care, specialty care, urgent and emergency care, laboratory,

inpatient hospitalization, radiology, and pharmaceuticals. Healthy San Francisco is not insurance and to qualify residents must be between the ages of 18 and 64, below 500 percent FPG, have been uninsured for at least 90 days, and be ineligible for all other public and private insurance. The program assesses quarterly enrollment fees based on a sliding fee scale where individuals below poverty pay nothing. Currently there are 36 participating medical homes. The plan is subsidized by city and county contributions as well as by employers that do not provide employer-sponsored health insurance.

Provider Sponsored Healthcare Initiatives

Clinics, hospitals, local health care systems, or other providers may recognize a need to increase health care access in the local community and establish a program where low-income and uninsured individuals can be treated at small network clinics for free or at a reduced rate based on a sliding fee scale. The sponsoring organization is responsible for fully operating and funding the initiative. Common funding sources include property tax revenues, DSH funds, and grants.

Hennepin Care in Minnesota is a program created and operated by the Hennepin County Medical Center to offer free and discounted care to uninsured residents of Hennepin County. There are a few out-of-county exceptions and a financial assistance program is available to out-of-county patients. To qualify, individuals cannot have assets greater than $5,000 and families cannot have assets in excess of $10,000. Maximum income levels are based on family size and may be adjusted based on current medical debt. Uninsured patients that do not qualify for financial assistance can use the self-pay discount option. These patients make an estimated payment at the time of service and are billed at a discounted amount for any additional charges. Whereas a financial counselor is required for the financial assistance program for all out-of-county residents, self-pay discount members are not required to visit a financial counselor.

Population Specific Programs

Some states design programs to cover all children, all non-citizen pregnant women, or all seniors regardless of immigration status. The **All Kids** program for the state of Illinois provides comprehensive and affordable health insurance for children 18 and younger who are state residents, and whose family meets qualifying income guidelines regardless of immigration or health status. All Kids insurance will not affect a child's immigration status as long as the child

does not receive long-term care in a nursing or mental health facility. Undocumented children who apply for the program will not be reported to USCIS. All Kids covers doctor visits including check-ups and immunizations, hospital stays, prescription drugs, vision care, dental care, and eyeglasses. The program also covers special services such as medical equipment, speech therapy, and physical therapy for children who need them.

State-Operated High Risk Pool

Individual states implement high risk pool programs to offer health insurance to residents who, because of pre-existing medical conditions, are unable to purchase affordable coverage in the private market. Thirty-four states nationwide had a state-operated high risk pool that provided health insurance to nearly 200,000 U.S. residents in 2010. State high risk pools are not to be confused with the federal high risk pool implemented by the ACA, which only covers U.S. citizens and legal immigrants. State high risk pools generally allow individuals to enroll if they are medically eligible, HIPAA eligible, Health Coverage Tax Credit eligible, or if they have a specified medical condition such as HIV/AIDS, cancer, or diabetes.

Minnesota was the first state to establish a high-risk pool in 1976. Today, the **Minnesota Comprehensive Health Association (MCHA)** has five different methods by which an individual may qualify for coverage including loss of group coverage, the Health Coverage Tax Credit program, health-related rejection, presumptive condition(s), and ineligibility for Medicare. With the exception of Medicare eligibility, MCHA only has a state residency requirement. To qualify on the basis of Medicare eligibility an individual must also submit a letter from the Social Security Administration. Forty-seven percent of funding from MCHA is from premiums, 52 percent from fees assessed to providers, and 1 percent from miscellaneous grants.

XI. Stakeholder Input

To better understand the health programming opportunities and challenges unique to EMA and other uninsured populations in Minnesota, two 90-minute public meetings were facilitated at DHS to gather input from key stakeholder groups. Separate meetings were held for community advocates of the EMA population and health care providers including hospitals and safety net providers. In total, DHS received input from 13 stakeholder organizations. DHS presented

background on EMA and the options initially considered by DHS for the purposes of this report and stakeholders were invited to provide feedback and suggestions. The following is a summary of the stakeholder meetings classified into common themes that resulted from the meetings.

Population Coverage

Education and Outreach

Both stakeholder groups agreed that key components for any EMA policy option should be education and outreach. The community advocates especially made a case for empowering EMA enrollees and the treating providers to establish potential eligibility for other Minnesota Health Care Programs. One meeting attendee stated, "We want to keep this group…as small as possible…. We want to figure out every possible way to get them into [more comprehensive coverage options]". Because EMA is open to other populations besides undocumented non-citizens, some enrollees may be eligible for other state programs that would provide comprehensive preventive and routine care as well as emergency coverage. The goal is to get individuals into the most comprehensive program for which they qualify so that individuals with no other coverage options are using EMA. One attendee referenced workshops in rural areas that have proven successful in targeting individuals who are eligible for certain health care programs to sign up. Such a strategy could also be successful in other areas. Providers also recommended better use of community clinics that have experience in providing outreach and serving these populations such as La Clinica, CLUES, and Centro for outreach to the EMA population before they become very sick.

Positive Messaging

Although hundreds of EMA enrollees could be eligible to receive more comprehensive coverage, many enrollees are unaware of their immigration status or fearful of working with state institutions. Both stakeholder groups recommended positive and safe messaging to reduce fear and provide assurance that an undocumented status will not be shared with other government authorities. Both stakeholder groups also recommended partnerships between community organizations and providers as well as training on how to send a positive message about seeking healthcare before crises. In addition, community advocates highlighted the larger immigration

issue by suggesting that it should be their role as well as the provider role to help unlawfully present individuals gain a lawfully present status whenever possible and appropriate. One meeting attendee mentioned, “Sometimes [health care] providers are their only point of contact and they’re probably already very sick,” recommending that providers be incentivized to assist with the immigration process. “If you fix someone’s immigration status, sometimes that’s half the battle right there.”

Patient Discharge and Transition

A solution for discharging hospital patients into other care facilities was strongly encouraged by both stakeholder groups. Community advocates emphasized that hospitals in Minnesota have experienced significant losses because they are unable to discharge a very sick patient without coverage and who needs continued care, but no other facility will accept the individual without some guarantee of reimbursement. There should be a set discharge plan according the varying needs of the EMA population.

Similarly, providers wanted to eliminate the cycle of not having discharge facilities available. There should be a mechanism designed to reward providers for improving an individual’shealth status instead of penalizing them. One attendee noted, “If the hospital does a good job and discharges the patient to us and we do a good job there is no place to send them in a community setting.” In addition to providing incentives to long-term care facilities for transitioning patients, providers felt that such facilities also needed to be dispersed throughout the state to accommodate the EMA population. No one provider should have to bare a disproportionate amount of costs, “Discharge planning is critical.” This concern will be acknowledged moving forward. However, DHS’ data indicates that there is no specific provider subset baring a disproportionate uncompensated care burden. There is currently an even distribution across providers.

Financial Feasibility

Adequate and Appropriate Incentives

Community advocates recognized the need for providers to be adequately reimbursed and incentivized to treat the EMA population. Yet, they also warned that providers may not be

focused on finding the best care plan for this population. One meeting attendee noted that an uncompensated care pool may not provide the best incentive for providers to ensure that an individual gets into the best coverage program for their specific needs. Community advocates recommended system controls to ensure the primary focus is the best client solution and not reimbursement in the absence of the best care.

Reimbursement Structure

Members of both stakeholder groups asked if there are certain providers that are disproportionately affected. They agreed that if data demonstrates that there are certain providers with an exceptionally large amount of uncompensated care, then a small state-funded grant for providers would be a good consideration. Furthermore, providers introduced the idea of other options that may reduce cost in the EMA program by wrapping around a more comprehensive set of services including care coordination to partially finance these benefits provided to EMA enrollees. Under this structure, the state would need to apply for a federal demonstration project waiver so that the EMA population could receive limited coordinated care and services beyond emergency episodes. A participant stated, "By keeping people out of the hospital and by avoiding crisis, we can make those dollars go a lot further." The provider group felt very strongly about not replicating the reporting structure of the General Assistance Medical Care (GAMC) Coordinated Care Delivery System. They emphasized that it did not provide administrative and operational efficiency and that it was also costly and burdensome.

Targeting Dollars

Each stakeholder group had ideas about criteria to distribute funds among providers. Community advocates, for instance, mentioned that smaller hospitals could have greater difficulty accessing funds, while larger hospital already had the necessary systems in place to obtain funding. Providers recommended that funds should be targeted to providers that have expertise in working with the EMA population. One attendee stated, "This is a population that requires specialized types of services…patients choose to go where services are right for them…in thinking about the best place to get care, think about what's the right place for them to get care too."

<u>Administrative Feasibility</u>

Not Mutually Exclusive Options

The provider group encouraged the notion of tailoring different options to specific sub-groups within the EMA population for a variety of reasons. One attendee noted, "For some people, enrolling in a program would be the best way for them to get their care, but for other[s]…they are not going to see this as a very friendly mechanism." Another attendee recognized that total cost of care could change over time and noted that only one of these options may not be the answer; "You might have several back to back choices depending on if we improve their care and they [providers] meet certain criteria." Moreover, it was acknowledged that a medically-based and a community-based combined solution may serve this population best. Multiple options may also allow for greater patient choice, to accommodate the diverse needs of the EMA population and allow local solutions and participation of more provider types. For example, one stakeholder suggested that chronic care management services be included in EMA to serve enrollees over age 65 and that acute care services be targeted to other populations within the program.

Other Considerations

Lessening Risk

Community advocates held different opinions about developing a solution for all uninsured individuals versus only undocumented non-citizens as a way of limiting the amount of risk to providers. Some noted that for programs in other states, including other uninsured populations has been beneficial. One meeting attendee cited the example of one county where they don't typically distinguish between legal and illegal uninsured and used that as a way to communicate services are not only for the undocumented, but for everybody who is uninsured. This strategy has helped to reduce fear of deportation among undocumented non-citizens and mixed immigration families. With a larger risk pool there is also opportunity to insure a larger uninsured population that includes healthier people to offset the impact of EMA enrollees who do not reach out until they are severely ill.

A similar suggestion was raised at the provider meeting during a discussion of the option where the state would partner with a non-profit organization, like Portico Healthnet, to gain access to younger people in EMA so that they would sign up before getting sick and make a reduced payment that could help fund the program. This would also allow for care management so that illnesses are addressed before they become crises. They also recommended that the risk "be spread among all uninsured populations" especially within the context of the policy changes and coverage options available in 2014 under the ACA which is projected to have a remaining, though much smaller, smaller population of uninsured. Additionally, by not making a distinction between other insured populations and undocumented populations there may be a greater likelihood of continuous funding.

XII. Options to Supplement EMA

Based on the preceding federal and state legislative history, an examination of programs that serve individuals who are eligible for emergency medical services in other states, and stakeholder input from providers and advocates of the EMA population, the following describes several state options for providing coordinated and cost-effective health care to such individuals. The options are grouped by two categories, Fixed Funding Options and Flexible Program Options.

Fixed Funding Options

Option 1: Uncompensated Care Pool

Background

In 2010, Minnesota's General Assistance Medical Care (GAMC) program, designed to cover medical costs for low-income, non-disabled adults ages 21-64 without dependent children, was modified such that coverage under the program was restricted to hospitals contracting as a Coordinated Care Delivery System (CCDS), or an Uncompensated Care Pool (UCP) for hospital providers not participating as a CCDS, in addition to a Prescription Drug Benefit Pool available to all GAMC enrollees. To qualify for GAMC, individuals were to be below 75 percent FPG or receiving payments under General Assistance or Group Residential Housing and unable to obtain any other public or private health care coverage. Meeting GAMC eligibility requirements allowed enrollees to receive medically necessary care at CCDS member hospitals or at providers

seeking funding through the UCP. For SFYs 2010-2011, a $71 million capped block grant from the state's General Fund was used to fund CCDS hospitals that provided care to GAMC enrollees. In addition, a $56 million prescription drug pool was established for SFYs 2010-2011 to cover prescription medications for GAMC enrollees, and CCDS hospitals were required to match 20 percent of costs of prescription drugs for their specific enrollees. The UCP was a temporary nine-month funding pool established to reimburse non-CCDS member hospitals that provided medically necessary care to GAMC enrollees. In SFYs 2010-2011, the temporary UCP was funded with $30 million from the Health Care Access Fund.

Minnesota has the option to create an UCP where the state allocates a fixed amount of money for the purpose of reimbursing providers for all medically necessary uncompensated care services provided to low-income and uninsured state residents. It is an option to determine whether the UCP is intended for all uninsured Minnesota residents and legal residents who experience a coverage gap during the year or only for undocumented non-citizens. The state would need to identify sources of funding for a UCP, such as the state general fund, health care access fund or a dedicated source of revenue, such as a tax or fee. In addition, a fair and equitable standard metric for dividing funds among providers would need to be established. Similarly, the distribution of providers funded must be easily accessible and geographically relevant to the target population. DHS would have to ensure that, through accurate reporting, providers are held accountable for treatment rendered.

The GAMC and CCDS structure did not have a mechanism to directly contract with community pharmacies. To ensure access to prescription drug therapy through community pharmacies, a separate prescription drug funding stream may be required for any UCP or similar solution. To help offset prescription costs in the separate funding stream, the Legislature could consider establishing a drug rebate program exclusively for the EMA population. While DHS already administers a drug rebate, the CMS federal Medicaid rebate program only applies to prescriptions for individuals eligible for federally-funded Medicaid. The EMA population, by definition, is ineligible for federally-funded Medicaid and the federal rebate program. It would be important to consider if drug manufacturers would be hesitant to participate in a rebate program for such a small population. There are also implementation challenges. Approximately

six months to one year of implementation time is required to establish rebate contracts with each manufacturer. The state could instead choose to fund a prescription drug benefit without rebates; however, without rebates medications for the EMA population would be significantly more expensive than medications for Medicaid enrollees. Drug rebate programs usually cover nearly 50 percent of prescription drug costs for state public health care programs.

Because the UCP would likely include enrollee eligibility requirements and submission of fee-for-service claims, an advantage to this approach is having a uniform funding mechanism across the state for both hospital and non-hospital providers without having to guarantee certain payments or benefits that fall outside the definition of an emergent medical condition. The UCP would give providers more time to create customized and local solutions to mitigate uncompensated care while affording the state oversight to monitor the use of these funds. Potential disadvantages include a lack of financial incentives for providers to coordinate care and reduce costs, having to adhere to federal reporting requirements if the state received any federal funding for the pool, as well as for patients, upfront disclosure of citizenship status to ensure an individualis not eligible for a program that provides more comprehensive benefits and may receive federal funding.

Alternative Fixed Funding Models

To establish a fixed funding model, the state of Minnesota could appropriate funds to cover the costs of uncompensated care provided to undocumented non-citizens and other indigent and uninsured populations.

Option 2: State Funded Grant Program for Providers

One way by which the state could provide funding to providers for the cost of unreimbursed care provided to individuals eligible for EMA is by implementing a block grant. The block grant would be distributed among a representative subset of safety net providers to provide health care services to enrollees. The capped amount of funds allocated to each provider or system would allow for greater flexibility in services provided. This would encourage a more cost-effective and coordinated care model. This option differs from a UCP because it is not based on the amount of uncompensated care provided nor does it require that providers submit claims for payment.

Instead, DHS would have the flexibility to design a metric to determine how funds are allocated between providers as well as establish any reporting standards providers must follow. However, such flexibility may be disadvantageous because money allocated to each provider is not directly based on services provided, and potentially not specifically to the undocumented population. Rather, providers could use funds for any uninsured individual treated at their facilities. If there are fewer funding and reporting parameters in place, there is less data available for program measurement and evaluation.

This option may be best suited for funding providers that have a disproportionately large amount of uncompensated care. Appendix D, Table D-1 shows providers that submitted the largest dollar amount claims in CY 2012 according to each provider type. As referenced earlier, based on DHS data there is currently no subset of providers that carry a disproportionately large amount of uncompensated care compared to their counterparts.

Option 3: State Funded Program for Individual EMA Enrollees

An additional way by which the state could provide coverage is by allowing individuals who qualify for EMA to enroll in a separate program in which funds are allocated for additional medically necessary health care services. For services that are approved, the agency would directly reimburse the treating provider for services delivered to the individual. Using this option, DHS would recommend controls similar to the CPC process used to authorize services under the EMA program now.

It may prove to be administratively difficult to manage the disbursement of state and federal funds for services that are delivered to the same patient and for services that may be listed on the same claims. DHS would need to ensure that providers are paid only from state funds or federal funds based on the service type rendered. Extensive system changes may be required to support ongoing updates to each enrollee's care plan and medical review as well as to accommodate the requirements of managing both EMA and a separate state program for enrollees. While this is more difficult to administer, it provides the state better oversight capability to ensure that reimbursements are solely for providers treating the targeted population.

Flexible Program Options

Option 4: Local Access to Care Partnership

Portico Healthnet is a Local Access to Care Program (LACP) in Minnesota that provides a structured set of health benefits administered by a limited provider network as contracted with a local care provider. The largest portion of revenues, 44 percent, was attributed to federal and state government grants followed closely by hospital contributions at 34 percent. Government funds cover health coverage and care management as well as outreach and enrollment efforts. The Portico program is limited to Dakota, Hennepin, Ramsey, and Washington counties and is at-capacity with a wait list of 1,100. Portico's membership is currently 1,300 and is expected to rise. The program serves a largely immigrant population and estimates that over 50 percent of program participants are undocumented non-citizens.

One option would be to use state funds to subsidize the expansion of the Portico program and other similar programs or models with additional local partners in other areas. The expansion would provide coverage to undocumented non-citizens and other uninsured individuals throughout the state and address funding shortfalls due to increased needs in areas already served. Portico's strong outreach and enrollment efforts already help DHS enroll individuals who are eligible for MA and MinnesotaCare. Many remaining uninsured individuals are enrolled at Portico and, through partnerships with FQHCs and community clinics, are provided prevention-based care and care in clinical settings.

Subsidizing the costs of services to an organization in a Portico-like model to provide subsidized care could be an effective means of reaching the state's undocumented and uninsured population. Portico is well established and has demonstrated success over its 20 years of operation. Leveraging existing infrastructures and replicating the model in other areas could avoid substantial costs associated with building a brand new program. Moreover, the profile of Portico's members is similar to that of current EMA enrollees, as avast majority of members are of Hispanic/Latino descent, most are female, most are Spanish-speaking, and most live in Ramsey or Hennepin County. Finally, a Portico-like model requires that an area hospital become a partner in the care delivery model. Additional state-funded support could encourage more hospitals and health care systems to financially support the program. Hospitals and systems

would have the incentive to contribute to a program that provides greater coverage of preventive and primary care because it would reduce more costly uncompensated care in the form of emergency room use and inpatient admissions.

However, by funding a Portico-like model expansion, it is essential to consider how the program will be supported by staff and how DHS will contribute to its capacity-building efforts. A potential expansion strategy might begin with building capacity in the Twin Cities metro area while working to secure the funding necessary for administrative activities and care management before beginning operations in new counties.

No Changes to EMA

The state may choose not to implement any changes to the current EMA program. Avoiding additional changes also eliminates the need to continue shifting people and case files between different programs and processing entities, which may confuse EMA enrollees and add greater complexity for providers. The state, too, would avoid costs associated with restructuring or restoring EMA to broader categories of coverage or eligible providers, which would require additional systems, administrative, and contracting work and potentially enhanced program management to ensure compliance with federal requirements for internal controls if the state pursues federal funding for any additional services. However, former EMA enrollees who left the program because benefits were limited may be reluctant to re-enroll when the need arises. Instead of restoring benefits to EMA, DHS could instead provide a guide to other programs throughout the state to help meet the healthcare needs of the EMA population. As illustrated previously, FQHCs, LACPs, and other resources are already operative throughout Minnesota and may sufficiently provide cost-effective and coordinated care to the EMA population without additional state involvement.

XIII. Conclusion

To provide cost-effective and coordinated care to individuals who meet eligibility standards for EMA and who are ineligible for federally-funded programs, the state policy solution must adequately address the needs of the EMA population and potentially other uninsured populations, be geographically relevant, and balance the goal of providing coverage for more services with ensuring accountability for the cost of services. The policy solution should also help minimize the negative financial impact to providers delivering care to undocumented non-citizens and establish a mechanism for proper patient discharge and transition. In addition, the policy should be administratively feasible and designed to minimize overall operating costs. The state should consider providing the EMA population with access to primary and specialty care, including chronic care management and coordination, that could reduce costs for inpatient hospital stays and emergency rooms visits. The needs of individuals in long-term care as well as home and community-based services must also be considered. Overall, there should be a focus on lessening fear associated with seeking preventive health care and reducing inappropriate use of the emergency room, and maximizing community partnerships for education and outreach, as well as helping undocumented non-citizens to obtain a lawfully present status that allows them to enroll in more comprehensive health care coverage programs.

XIV. Appendices

Appendix A:

Table A-1: 2011 Population Profile

Average Total EMA Enrollees: 2,469
Average Number of Cases: 2,515

Category	Estimated Averages	Estimated Percentages
Citizenship		
Yes	8	0.29%
No	2430	98.42%
Immigration Status		
Refugee	1	0.01%
Asylee	1	0.04%
Deport/Remove Withheld	1	0.06%
LPR	673	27.25%
Paroled ≥1 Year	1	0.03%
Non-Immigrant	138	5.56%
Undocumented	1569	63.53%
Other Lawfully Residing	46	1.83%
Gender		
Male	895	36.22%
Female	1575	63.78%
Age		
0-18	269	10.90%
19-20	37	1.47%
21-25	99	4.01%
26-35	444	17.97%
36-44	478	19.35%
46-55	183	7.39%
56-64	184	7.45%
65+	780	31.58%
Ethnicity		
Non-Hispanic	895	63.76%
Hispanic	1575	36.24%
Race		
White	1024	41.44%
Asian	253	10.22%
Black	378	15.30%
Native American/Alaskan Native	6	0.22%
Pacific Islander/Native Hawaiian	6	0.21%
Mixed Race	52	2.11%

Category	Estimated Averages	Estimated Percentages
Medical Condition		
Sudden Onset of a Condition	847	34.29%
Chronic Medical Condition	1406	56.92%
Labor & Delivery (Pregnant)	10	0.21%
Accident	203	0.38%
Health Consequence		
Places the Person's Health in Serious Jeopardy	1690	68.45%
Causes Serious Impairment to Bodily Function	310	12.53%
Causes Serious Bodily Organ Dysfunction	265	10.70%
Eligibility Type		
Parent of a Dependent Child	926	37.49%
MA Adult without Children	201	8.12%
Blind	1	0.02%
Infant to Age 2	2	0.07%
Children Ages 2-18	250	10.12%
Children Ages 19 & 20	24	0.94%
Disabled Child Ages 18-20	6	0.21%
MA for Employed w/Perm. Disability	2	0.08%
Disabled TERFRA	9	0.33%
Disabled	268	10.82%
Over Age 65	775	31.38%
Pregnant Woman	9	0.34%

*Variances in averages Values and Percentages originate from the categories "Unknown," "Unable to Identify," and "Blanks" as well as by rounding the nearest whole number.

Table A-2: 2012 EMA Population Profile

Average Total EMA Enrollees: 2,084
Average Number of Cases: 2,128

Category	Estimated Averages	Estimated Percentages
Citizenship		
Yes	6	0.26%
No	2070	99.32%
Immigration Status		
Refugee	None	None
Asylee	1	0.04%
Deport/Remove Withheld	1	0.04%
LPR	655	31.41%
Paroled ≥1 Year	3	0.13%
Non-Immigrant	138	6.62%
Undocumented	1234	59.21%
Other Lawfully Residing	38	1.80%
Gender		
Male	742	35.57%
Female	1343	64.43%
Age		
0-18	178	8.53%
19-20	30	1.43%
21-25	77	3.70%
26-35	347	16.68%
36-45	372	17.83%
46-55	185	8.85%
56-64	204	9.77%
65+	691	33.14%
Ethnicity		
Non-Hispanic	852	40.85%
Hispanic	1238	59.41%
Race		
White	794	38.07%
Asian	231	11.07%
Black	381	18.28%
Native American/Alaskan Native	6	0.29%
Pacific Islander/Native Hawaiian	5	0.24%
Mixed Race	37	1.78%
Medical Condition		
Sudden Onset of a Condition	755	36.20%
Chronic Medical Condition	1132	54.30%

Category	Estimated Averages	Estimated Percentages
Medical Condition		
Labor & Delivery (Pregnant)	7	0.32%
Accident	8	0.35%
Health Consequence		
Places the Person's Health in Serious Jeopardy	1439	69.06%
Causes Serious Impairment to Bodily Function	242	11.61%
Causes Serious Bodily Organ Dysfunction	235	11.24%
Eligibility Type		
Parent of a Dependent Child	672	32.21%
MA Adult without Children	346	16.59%
Blind	1	0.02%
Infant to Age 2	2	0.07%
Children Ages 2-18	168	8.06%
Children Ages 19 & 20	22	1.04%
Disabled Child Ages 18-20	5	0.20%
MA for Employed w/Perm. Disability	2	0.10%
Disabled TERFRA	6	0.28%
Disabled	175	8.40%
Over Age 65	682	32.72%
Pregnant Woman	6	0.28%

*Variances in averages Values and Percentages originate from the categories "Unknown," "Unable to Identify," and "Blanks" as well as by rounding the nearest whole number.

Table A-3: 2011-2012 Combined EMA Population Profile

Average Total EMA Enrollees: 2,277
Average Number of Cases: 2,321

Category	Estimated Averages	Estimated Percentages
Citizenship		
Yes	7	0.28%
No	2250	98.83%
Immigration Status		
Refugee	1	0.01%
Asylee	1	0.04%
Deport/Remove Withheld	2	0.05%
LPR	664	29.15%
Paroled ≥1 Year	2	0.08%
Non-Immigrant	138	6.05%
Undocumented	1402	61.55%
Other Lawfully Residing	42	1.82%
Gender		
Male	818	35.92%
Female	1459	64.08%
Age		
0-18	224	9.81%
19-20	33	1.45%
21-25	88	3.87%
26-35	396	17.38%
36-44	425	18.65%
46-55	184	8.06%
56-64	194	8.51%
65+	736	32.29%
Ethnicity		
Non-Hispanic	873	38.35%
Hispanic	1407	61.77%
Race		
White	909	39.09%
Asian	242	10.61%
Black	380	16.67%
Native American/Alaskan Native	6	0.25%
Pacific Islander/Native Hawaiian	6	0.23%
Mixed Race	45	1.95%
Medical Condition		
Sudden Onset of a Condition	801	35.16%
Chronic Medical Condition	1269	55.72%

Category	Estimated Averages	Estimated Percentages
Medical Condition		
Labor & Delivery (Pregnant)	6	0.26%
Accident	9	0.37%
Health Consequence		
Places the Person's Health in Serious Jeopardy	1565	68.73%
Causes Serious Impairment to Bodily Function	276	12.11%
Causes Serious Bodily Organ Dysfunction	250	10.95%
Eligibility Type		
Parent of a Dependent Child	799	35.08%
MA Adult without Children	273	12%
Blind	1	0.02%
Infant to Age 2	2	0.07%
Children Ages 2-18	209	9.18%
Children Ages 19 & 20	23	0.99%
Disabled Child Ages 18-20	5	0.21%
MA for Employed w/Perm. Disability	2	0.09%
Disabled TERFRA	7	0.31%
Disabled	222	9.71%
Over Age 65	729	31.99%
Pregnant Women	8	0.31%

*Variances in averages Values and Percentages originate from the categories "Unknown", "Unable to Identify", & "Blanks" as well as by rounding the nearest whole number.

Appendix B:

Table B-1: CY 2012 Service Date Based Payments for all EMA Eligibles

Provider Type	Total Reimbursements
All Provider Type Total:	**$26,933,112**
Inpatient hospital general	$12,926,691
Physician services	$2,388,142
Personal care services	$2,382,061
Nursing facility	$2,321,986
Outpatient hospital services	$1,232,084
Pharmacy services	$1,062,514
Private duty nursing	$981,290
End-stage renal dialysis	$791,312
Radiology, technical component	$659,854
Laboratory	$327,320
Medical supply and DME	$265,914
Transport, ambulance	$264,978
Mental health	$228,416
ICF-DD	$210,351
Hospice	$182,920
Anesthesia	$136,929
Access services	$112,688
Inpatient Hospital No DRG	$95,284
Nurse practitioner services	$91,262
IEP nursing	$52,728
Case management - mental health	$35,365
Chemical Dependency	$35,340
Physical therapy	$23,050
Day training and habilitation	$16,372
Dental	$13,662
Occupational therapy	$13,082
Ambulatory surgery	$12,947
Home health services	$9,812
CD extended care and halfway house	$8,925
Vision care	$8,510
Prosthetics and orthotics	$8,424
Supported living services (SLS)	$8,360

Provider Type	Total Reimbursements
Podiatry	$6,499
Speech therapy	$5,492
Chiropractic	$4,238
Developmental disabilities (DD) screening	$2,848
Case management - other	$2,400
LTC consultation - pas	$1,001
Nurse midwife services	$50

Appendix C:

Table C-1: Number of Claims Submitted for All EMA Eligibles by Provider Type (CY 2012)

Provider Type	**Number of Claims Submitted**
Physician	347
Pharmacy	277
Hospital	106
Personal Care Provider	72
Renal Dialysis Free Standing	42
Medical Supplier	42
Medical Transportation Provider	41
Nursing Facility	26
Independent Laboratory	16
FQHC	15
Home Health Agency	15
Bill Entity for Physician Services	15
Certified Registered Nurse –Anesthesia	13
Bill Entity for Mental Health	12
County Reservations Services	12
School District	11
Dentistry	10
Target Case Management	10
Public Health Nursing Organization	9
Ambulatory Surgery Center	8
Community Mental Health Center	7
County Contract for Mental Health Rehabilitation	6
Family Planning Agency	5
Hospice	5
Podiatrist	5
Rehabilitation Agency	5
Chemical Health	5
Bill Entity for Rehabilitation	4
Private Duty Nurse	4
Rural Health Clinic	4
Day Training and Habilitation Center	3
Independent X-Ray	3
ICF-DD Facility	3
Public Health Clinic	3
Community Health Clinic	2
Intensive Residential Treatment Service	2
Individually Licensed Social Worker	2
Psychologist	2
Chiropractor	1
Independent Diagnostic Testing Facility	1
Registered Physical Therapist	1

Appendix D:

Table D-1: Specific Minnesota Providers with Highest EMA Claims Dollar Amounts in Each Category of Provider CY 2012

Provider Type	Providers	City	Reimbursements
Ambulatory Surgery Center	Minnesota Vascular Surgery Center	New Brighton	$7,330
Chemical/Mental Health*	Micah Halfway House	Minneapolis	$24,537
	South Metro Human Services	St. Paul	$21,997
	Lifespan of Minnesota Inc.	Burnsville	$11,134
County Reservations	Hennepin County Human Services	Minneapolis	$18,957
Dentist	HCMC Dental Clinic	Minneapolis	$3,029
	Advanced Dentistry Inc.	St. Louis Park	$1,422
Family Planning Agency	PPMNS Centro	Minneapolis	$2,383
FQHC/CHC	West Side Community Health	St. Paul	$27,972
	Community University Health	Minneapolis	$18,845
	Northpoint Health and Wellness Center/downtown	Minneapolis	$14,709
Home Health Agency	Home Health Care Inc.	Golden Valley	$49,142
	International Health Care Services	Golden Valley	$29,872
	Carefocus Corporation	St. Paul	$23,732
Hospice	Hospice of the Twin Cities Inc.	Plymouth	$86,902
	HealthPartners Hospice & Palliative	Minneapolis	$60,619
	Hennepin County Medical Center	Minneapolis	$6,836,271
	Regions Hospital	St. Paul	$1,963,575
ICF/DD - facility	Hammer Ridgeview	Wayzata	$106,215
	Renville County Comm Res	Bird Island	$81,964
Intensive Residential	IRTS - Wadena	Wadena	$107,627
Laboratory, Independent	Davita Labs	Deland	$17,018
Medical Supplier	Midwest Medical Services Inc.	Mounds View	$63,343
	Reliable Medical Supply Inc.	Brooklyn Park	$42,654

Provider Type	Providers	City	Reimbursements
Medical Supplier	Allina Home Oxygen & Medical Equip	St. Paul	$33,873
Medical Transportation	North Memorial Ambulance Service	Brooklyn Center	$51,635
	Medical Transportation Management	St. Paul	$55,473
	Benedictine Health Center of Minneapolis	Minneapolis	$562,035
Nursing Facility	YMG Home Care Services Inc.	Minnetonka	$405,761
Personal Care Provider	Hennepin County Medical Center	Minneapolis	$416,429
Pharmacy	Mayo Clinic	Rochester	$116,555
Physician	Regions Specialty Clinic	St. Paul	$122,846
	University of Minnesota Physicians	Minneapolis	$67,971
	Midwest Podiatry Center Richfield	Richfield	$1,045
Podiatrist	Chez Vous Home Care LLC	Richfield	$320,954
Private Duty Nurse	Provident Home Healthcare LLC	St. Anthony	$263,387
	Accurate Home Care LLC	Elk River	$236,217
	MN Visiting Nurse Agency	Minneapolis	$3,653
Public Health Nursing Org	St David's Center Child and Family	Minnetonka	$14,410
Rehabilitation Agency	New Hope Dialysis Center	New Hope	$71,902
Renal Dialysis Free Standing	Home Dialysis Unit of TRC Inc.	Minneapolis	$70,485
	Minneapolis Dialysis Unit	Minneapolis	$60,674
	Centracare Health System - Melrose	Melrose	$821
Rural Health Clinic	Centracare Health System-Long Prairie	Long Prairie	$690
	Minneapolis #0001	Minneapolis	$17,320
School District	Dilworth-Glyndon-Felton #2164	Dilworth	$9,329

* Limited to paid FFS claims with non-zero reimbursement amounts. Due to overlapping services, dollar amounts in this table will not add up to dollar amounts in other tables in this report.

Appendix E

Acronyms

ACA: Affordable Care Act of 2010

CCDS: Coordinated Care Delivery System

CHC: Community Health Center Program

CHIP: Children's Health Insurance Program Reauthorization Act of 2009

CMS: Centers for Medicare and Medicaid Services

CPC: Care Plan Certification

CY: Calendar Year

DHS: Minnesota Department of Human Services

DSH: Disproportionate Share Hospital Program

EMA: Emergency Medical Assistance

FFP: Federal Financial Participation

FPG: Federal Poverty Guidelines

FQHC: Federally Qualified Health Center

FY: Fiscal Year

GAMC: General Assistance Medical Care

HHC: Health and Hospital Corporation

HSN: Health Safety Net

IUMG/PC: Indiana University Medical Group/Primary Care

LACP: Local Access to Care Program

MA: Medical Assistance

MCHA: Minnesota Comprehensive Health Association

MHCP: Minnesota Health Care Programs

NF: Nursing Facility

NMED: Noncitizen Medical Assistance

OIG: Office of the Inspector General

PRWORA: Personal Responsibility and Work Opportunity Reconciliation Act

SAVE: Systematic Alien Verification for Entitlements

TANF: Temporary Assistance for Needy Families

TEFRA: Tax Equity and Fiscal Responsibility Act of 1982

UCP: Uncompensated Care Pool

USCIS: U.S. Citizenship and Immigration Services

WSCHS: West Side Community Health Services

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