INFORMATION BRIEF
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Minnesota House of Representatives
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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, including changes made to comply or conform with the federal Affordable Care Act.

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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 and MNsure

County human services agencies, MNsure—the state's health insurance exchange established under the Affordable Care Act (ACA)—and tribal governments choosing to participate, share the responsibility for determining if applicants meet state and federal eligibility standards for MA. Depending on their basis of eligibility, individuals apply for MA by:

- submitting an application online through the MNsure eligibility determination system;
- contacting MNsure by other means; or
- contacting their county human services agency or tribal government.

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.)

MNsure, in cooperation with county human services agencies and tribal governments, determines MA eligibility for applicants who are children, infants, parents and caretakers, pregnant women, and adults without children (groups for whom compliance with program income standards is determined using modified adjusted gross income (MAGI), as required under the ACA). (MAGI is described on page 5.) Eligibility determination through MNsure is done online and through submitting paper application forms. MNsure determines eligibility for MA, MinnesotaCare,[1] and for premium tax credits and cost-sharing reductions available under the ACA for coverage purchased through MNsure.

County agencies, and tribal governments choosing to participate, are the primary entities responsible for determining eligibility for MA applicants who are aged, blind, or disabled.

Eligibility Requirements

MA pays for 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 children, parents and caretakers, pregnant women, the elderly, persons with disabilities, and most recently, adults without children, who meet the program's income and asset standards.

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

[1] MinnesotaCare is a jointly funded, federal-state program administered by DHS that provides subsidized health coverage to low- to moderate-income Minnesotans. For more information, see the House Research information brief *MinnesotaCare*.

- meet program income and any applicable asset limits, or qualify on the basis of a "spenddown" (described later in this information brief)
- not reside in a public institution, or in a public or private Institution for Mental Diseases (IMD), if age 21 through 64

Eligibility for most enrollees is redetermined every 12 months. Persons who qualify for MA through a spenddown have their eligibility redetermined every six 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. MA eligibility criteria vary by immigration status. For example, asylees and refugees are generally eligible for MA, while lawful permanent residents who are not pregnant women or children are not eligible for MA until they have resided in the United States for five or more years. Minnesota has generally chosen to provide MA coverage for all groups of noncitizens for which MA eligibility is mandatory or optional under federal welfare law and for which a federal match is provided.

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 and a limited set of chronic care and long-term care services. The 2011 Legislature limited the settings in which EMA services can be provided and also excluded coverage for specified chronic care and long-term care services. These changes, effective January 1, 2012, eliminated EMA coverage for many chronic care and long-term care services. The 2012 Legislature temporarily reinstated coverage for certain dialysis services and certain services to treat cancer from May 1, 2012, to June 30, 2013. The 2013 Legislature made the reinstatement of these services permanent and also provided EMA recipients with coverage of elderly waiver and certain rehabilitative services.[2]

For more information on MA eligibility and immigration status, refer to the table "Immigration Status and Minnesota Insurance Affordability Program Eligibility," from the Department of Human Services Insurance Affordability Programs Manual, available online at: http://hcopub.dhs.state.mn.us/iapmstd/IAPM_documents/Immigration_Status_and_Minnesota_Insurance_Affordability_Program_Eligibility.pdf

Residency

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

[2] These services have been covered under EMA since July 1, 2013, and are subject to a funding limit of $2.2 million for the biennium ending June 30, 2015. Funding for these services is to be provided by claiming additional disproportionate-share hospital payments from the federal government, for inpatient hospital services provided under MinnesotaCare to enrollees who are not eligible for a federal match due to immigration status.

[3] 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 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 eligible for either the Minnesota Supplemental Aid (MSA) or Supplemental Security Income (SSI) programs.)
- adults without children, ages 21 through 64
- children eligible for or receiving state or federal adoption assistance payments
- individuals under age 26 who received foster care services while age 18 or older, and who were enrolled in MA or MinnesotaCare at the time foster care services ended[4]

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 8).

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.

Income determination. An income methodology that specifies countable and excluded income is used to determine net income for different eligibility groups. Since January 1, 2014, as required by the ACA, MAGI[5] has been used as the income methodology for children, infants, parents and caretakers, pregnant women, and adults without children. Prior to this date, the income methodology used for these eligibility groups was that used by the state's Aid to Families with Dependent Children (AFDC) program as of July 16, 1996. The income

[4] Coverage for these former foster care youth was required by the ACA, effective January 1, 2014. No income limit applies to persons covered under this category.

[5] MAGI is defined as adjusted gross income increased by: (1) foreign earned income exclusion; (2) tax-exempt interest; and (3) an amount equal to the value of Social Security benefits not subject to tax (I.R.C. § 36B).

methodology used for enrollees who are aged, blind, or disabled is based on that used by the federal SSI program.

As part of ACA compliance, and since January 1, 2014, the state has used a standard 5 percent of FPG disregard when determining eligibility for groups for whom MAGI is required to be used as the income methodology. This standard disregard replaced state-specific disregards and has the effect of raising the FPG income limit for MAGI groups by 5 percentage points.

Recent changes in income limits. Adults without children with incomes not exceeding 75 percent of FPG have been covered by Minnesota under the Medicaid early expansion option of the ACA, since March 1, 2011. Effective January 1, 2014, the income limit for adults without children, parents and caretakers, and children 19 through 20 was increased to 133 percent of FPG, as part of the state's implementation of the ACA's option to expand eligibility for these groups.

Effective January 1, 2014, the MA income limit for children ages two through 18 was increased from 150 percent to 275 percent of FPG. This change was accompanied by a reduction in the MinnesotaCare income limit from 275 percent to 200 percent of FPG for children and other eligibility groups, and the establishment of an income floor for MinnesotaCare coverage of 133 percent of FPG.

The table on page 9 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[6]

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.

[6] Transitional MA is contingent on federal funding. Federal funding is scheduled to expire on April 1, 2015, unless reauthorized by the U.S. Congress.

Asset Limits

MA has two main asset limits. One applies to persons who are aged, blind, or disabled.[7] The other applies to parents and caretakers who qualify for MA through a spenddown. Children under age 21, pregnant women, parents and caretakers who do not qualify through a spenddown, 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 9).

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[8]
- 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[9]

Parents and caretakers on a spenddown. An asset limit of $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, applies to parents and caretakers who qualify for MA through a spenddown.[10]

Certain items are excluded when determining MA eligibility for these individuals, 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

[7] 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.

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

[9] 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.

[10] This asset limit applied to all parents and caretakers through December 31, 2013, but was eliminated effective January 1, 2014, for parents and caretakers not on a spenddown, as part of ACA compliance.

- 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.

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 – Effective January 1, 2014

Eligibility Group	Spenddown Standard
Families and children	133% of FPG
Aged, blind, or disabled	75% of FPG

The spenddown standard for families and children was increased from 100 percent to 133 percent of FPG, effective January 1, 2014.

MA Eligibility – Income and Asset Limits – Benefits
(Effective January 1, 2014)

Eligibility Category	Income Limit	Asset Limit	Benefits
Children under age two[11]	≤ 283% of FPG	None	All MA services
Children two through 18 years of age	≤ 275% of FPG	None	All MA services
Children 19 through 20 years of age	≤ 133% of FPG	None	All MA services
Pregnant women	≤ 278% of FPG	None	All MA services
Parents or relative caretakers of dependent children on MA	≤ 133% of FPG	None, unless on spenddown	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	≤ 133% 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[12]	≥ 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[13]	≤ 100% of FPG[14]	None	All MA services
Employed persons with disabilities	No income limit	$20,000	All MA services

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[11] Children with incomes greater than 275 percent and less than or equal to 283 percent of FPG are funded through the federal Children's Health Insurance Program (CHIP) with an enhanced federal match. As part of the conversion from the existing net income standard to an equivalent standard based on MAGI income methodology, the income limit for children under age two was increased from 280 to 283 percent of FPG and the income limit for pregnant women was increased from 275 to 278 percent of FPG, effective January 1, 2014.

[12] Eligibility for persons in this group is contingent on federal funding. Federal funding is scheduled to expire on April 1, 2015, unless reauthorized by the U.S. Congress.

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

[14] 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 generally not eligible for MA, except that since January 1, 2014, the MA program has paid for covered services provided to inmates while they are inpatients in a hospital or other medical institution.

Individuals living in Institutions for Mental Diseases (IMDs) are generally 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.[15] 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)

[15] For example, individuals placed in an IMD by a managed care plan are eligible for MA with a federal match. Persons residing in an IMD who do not qualify for an exception may qualify for state-only funded MA services.

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
- Dental services[16]
- Doula services[17]
- 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 for children and adults
- Nurse anesthetist services
- Certified geriatric, adult, OB/GYN, and neonatal nurse practitioner services
- Occupational therapy services
- Personal care assistant services
- Pharmacy services[18]

[16] Coverage of dental services for adults who are not pregnant is 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. Adult dental coverage was expanded, effective July 1, 2013, to include: (1) house calls or extended care facility calls; (2) behavioral management; (3) oral or IV sedation in specified circumstances; and (4) additional prophylaxis.

[17] Federal approval for coverage of doula services was received on September 25, 2014.

[18] MA does not cover 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.

- 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

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[19]
- $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 of $2.75

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.[20]

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

Benchmark Coverage

The ACA requires states to provide persons who are newly eligible under the optional MA expansion, 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 from 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 to one of these 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

[19] Federal approval to increase this copayment to $20 was not granted.

[20] 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.

regular Medicaid benefit set; this is the benefit set Minnesota has adopted for its newly eligible MA enrollees (adults without children) under the ACA expansion option.

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.

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 that 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 provide 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 July 2014, three county-based purchasing initiatives involving 26 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 18 on page 11).

The Minnesota Senior Care benefit package was replaced by a broader Minnesota Senior Care Plus benefit package, on January 1, 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, is available statewide, and operates under federal Medicare Advantage Special Needs Plan (SNP) authority.[21] 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, due in part to the integrated Medicare and MA prescription drug coverage. As of July 2014, MSHO enrollment was 35,294, compared to enrollment in Minnesota Senior Care Plus of 13,057.

Programs for Persons with Disabilities

Special Needs Basic Care (SNBC) is a managed care program for persons with disabilities between the ages of 18 and 64. Some SNBC plans integrate MA with Medicare services, for persons who are dually eligible. The program served 48,358 individuals as of July 2014.

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 July 2014, 714,414 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 plans receive a capitated payment rate for each enrollee (a capitated payment is fixed and does not vary with the actual services provided to the 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. Payment rates are the same for both prepaid health plans and county-based purchasing plans.

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

[21] 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.

rates are adjusted for age, sex, institutional status, and geographical area and are identical across programs.[22] 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.

Providers participating in the Integrated Health Partnership (IHP) demonstration project have their negotiated payment rates adjusted in an annual reconciliation process, to reflect the financial terms of the demonstration project. The IHP demonstration project was authorized by the legislature in 2010 and initially called the health care delivery systems demonstration project (see Minn. Stat. § 256B.0755). The intent of the demonstration project is to provide financial incentives for providers to reduce the total cost of care for participating MA enrollees for a specified set of core services, while maintaining or improving the quality of care. The financial incentives include sharing in any savings relative to a target spending amount, and sharing in any losses resulting from overspending relative to the target spending amount. Shared savings and shared losses are calculated and applied to providers annually in the form of a reconciliation payment. As of May 2014, 145,000 MA enrollees in both fee-for-service and managed care were served by nine integrated health partnerships.

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 selected provider types are described below.

Providers participating in the IHP demonstration project (see description in previous section) have their fee-for-service payments adjusted in an annual reconciliation process, to reflect sharing in any savings and losses relative to the target spending amount established under the demonstration project.

[22] 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.

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 legislature has at times changed the specified percentile and base for different provider types and different procedures. Providers in all geographic regions of 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, physical therapist, occupational therapist, speech therapist, audiologist, community/public health clinic, optician, dentist, and psychologist.

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 has modified payment rates for physician and other services a number of times in recent years.

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.)

Beginning November 1, 2014, MA will use the All Patient Refined DRGs (APR-DRGs) as its DRG system. The APR-DRG system incorporates improvements to the existing DRG system (e.g., it can subdivide individual DRGs into subclasses that distinguish severity of illness and risk of mortality). The APR-DRG system, unlike the existing DRG system, is also able to process claims that use ICD-10 diagnosis and procedure codes (ICD-10 refers to the International Statistical Classification of Diseases and Related Health Problems, 10th Revision). The federal government will require hospitals to adopt the use of ICD-10 codes, in place of the prior ICD-9 coding system, beginning October 1, 2015.

Hospital payment rates are not automatically adjusted for inflation, but under Minnesota law were initially 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 this rebasing or set the rebasing formula at less than full value. Most recently, the 2014 Legislature has required rebasing as part of implementing the APR-DRG system.

The legislature has also at times reduced inpatient hospital payment rates and made related changes.

For example, the 2011 Legislature reduced payments for fee-for-service admissions occurring between September 1, 2011, through June 30, 2015, by 10 percent. Payments to Indian Health Service (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 2014 Legislature eliminated this 10 percent reduction effective November 1, 2014, and also provided a time-

limited exemption from the reduction for children's admissions at a hospital in Hennepin County.

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.

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.

Minnesota receives an enhanced federal payment through the Children's Health Insurance Program (CHIP) for the cost of MA services provided to:

(1) children under age two with household incomes greater than 275 percent but not exceeding 283 percent of FPG;
(2) uninsured pregnant women who are nonimmigrants or undocumented, through the period of pregnancy, including labor and delivery and 60 days postpartum; and
(3) children with household incomes greater than 133 percent but not exceeding 275 percent of FPG.

The enhanced payment is the difference between the state's CHIP federal matching rate of 65 percent and the state's MA federal matching rate of 50 percent.

As part of implementing the optional expansion of eligibility for adults without children and other groups under the ACA, Minnesota receives an enhanced federal match for the cost of services provided to enrollees who are newly eligible.[23] In Minnesota, the newly eligible group comprises adults without children; Minnesota will receive the regular federal Medicaid match for parents and caretakers, persons certified as disabled, and other persons in groups not considered to be newly eligible. The enhanced federal match is 100 percent of MA costs for 2014 through 2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent of costs from 2020 on.

[23] Under the ACA, persons are newly eligible if they would not have been eligible under the MA state plan or a waiver (such as that under which the MinnesotaCare program operates), as of December 1, 2009.

Nonfederal Share

The state, with some exceptions, has been responsible for the nonfederal share of MA costs since January 1991.[24]

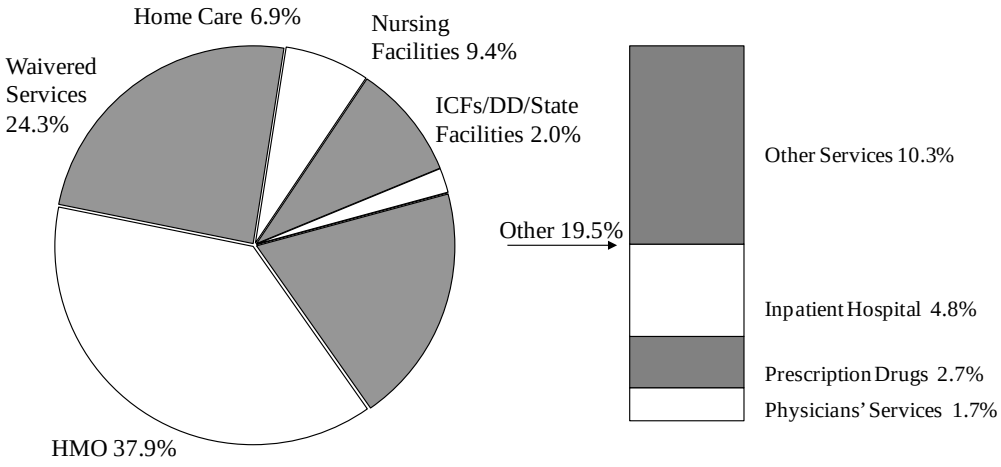
MA Expenditures – State Fiscal Year 2013

In fiscal year 2013, total MA expenditures for services were $8.045 billion. This total was distributed between the levels of government as follows:

Actual Expenditures – SFY 2013	
Federal	$4.032 billion
Nonfederal	$4.013 billion

The following chart shows the percentage of MA spending in fiscal year 2013 on the major service categories.

- HMO services was the largest single expenditure category (representing just under 38 percent of MA spending).
- Community-based long-term care (waivered services not funded under managed care and home care services) accounted for about 31 percent of MA spending.
- Long-term institutional care (care provided in nursing homes and ICFs/DD) accounted for just under 12 percent of MA spending.



Note: The waivered services category includes waiver payments to HMOs. The prescription drug spending percentage is prior to any federal rebates.

Source: Department of Human Services, February 2014 Forecast, Background Tables

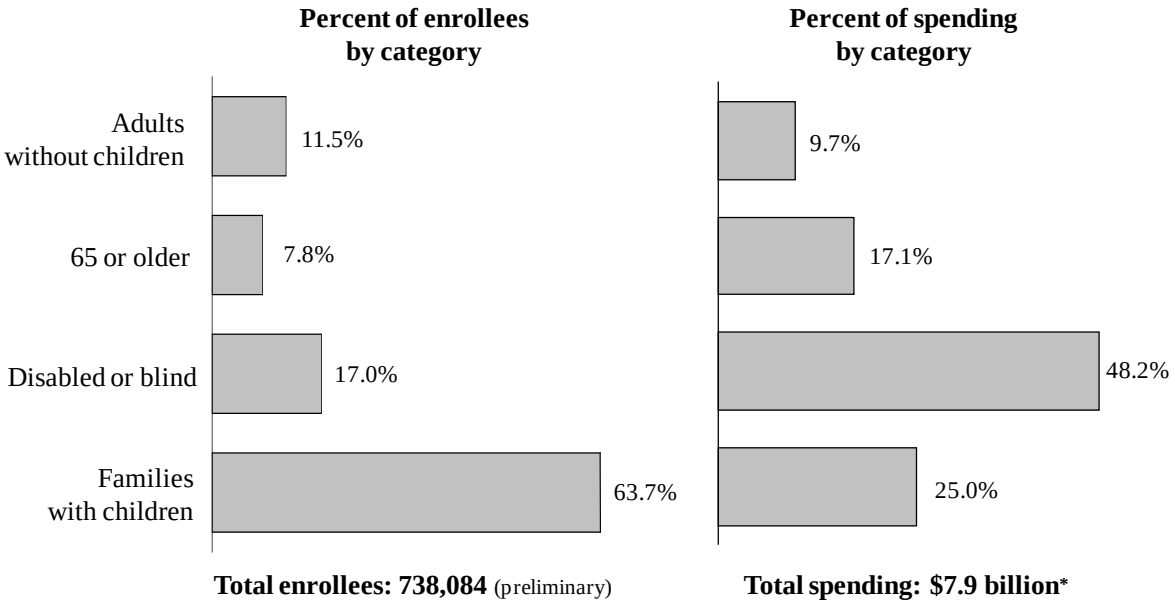
[24] Through December 1990, the state paid 90 percent of the nonfederal share and the counties the remaining 10 percent. Counties are currently responsible for the nonfederal share of MA costs for selected services, as follows: 50 percent of the nonfederal share for the cost of placement of severely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

Recipient Profile

During fiscal year 2013, an average of 738,084 persons (preliminary figure) 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 63.7 percent of eligibles. However, this group accounted for only 25.0 percent of MA spending.
- The elderly, and the disabled or blind, accounted for 65.3 percent of MA spending, although only 24.8 percent of eligibles are in these two groups.

Minnesota Medical Assistance Eligibles – SFY 2013



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

Source: Department of Human Services

MA Income Limit – Federal Poverty Guidelines for 7/1/14 through 6/30/15 – 12-month Standard

Household Size	75%	100%	120%*	133%	135%*	200%*	275%	278%	283%
1	$8,760	$11,676	$14,244	$15,521	$15,996	$23,580	$32,092	$32,422	$33,026
2	11,808	15,744	19,116	20,920	21,480	31,704	43,257	43,729	44,515
3	14,856	19,812	23,988	26,320	26,964	39,828	54,422	55,016	56,005
4	17,904	23,880	28,860	31,720	32,448	47,952	65,587	66,303	67,495
5	20,952	27,948	33,732	37,120	37,932	56,076	76,752	77,589	78,985
6	24,000	32,016	38,604	42,520	43,416	64,200	87,917	88,876	90,475
7	27,048	36,084	43,476	47,919	48,900	72,324	99,082	100,163	101,964
8	30,096	40,152	48,348	53,319	54,384	80,448	110,247	111,450	113,454
Each Additional Person	3,048	4,068	4,872	5,399	5,484	8,124	11,165	11,286	11,489

* Includes a $20 disregard

Source: Department of Human Services, Insurance Affordability Programs (IAPs) – Income and Asset Guidelines

Glossary of Acronyms

AC: Alternative care (program)
ACA: Affordable Care Act
APR-DRG: All Patient Refined diagnosis-related group
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
ICD-10: International Statistical Classification of Diseases and Related Health Problems, 10th Revision
ICF/DD: Intermediate care facility for persons with developmental disabilities
IHP: Integrated Health Partnership
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
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/.