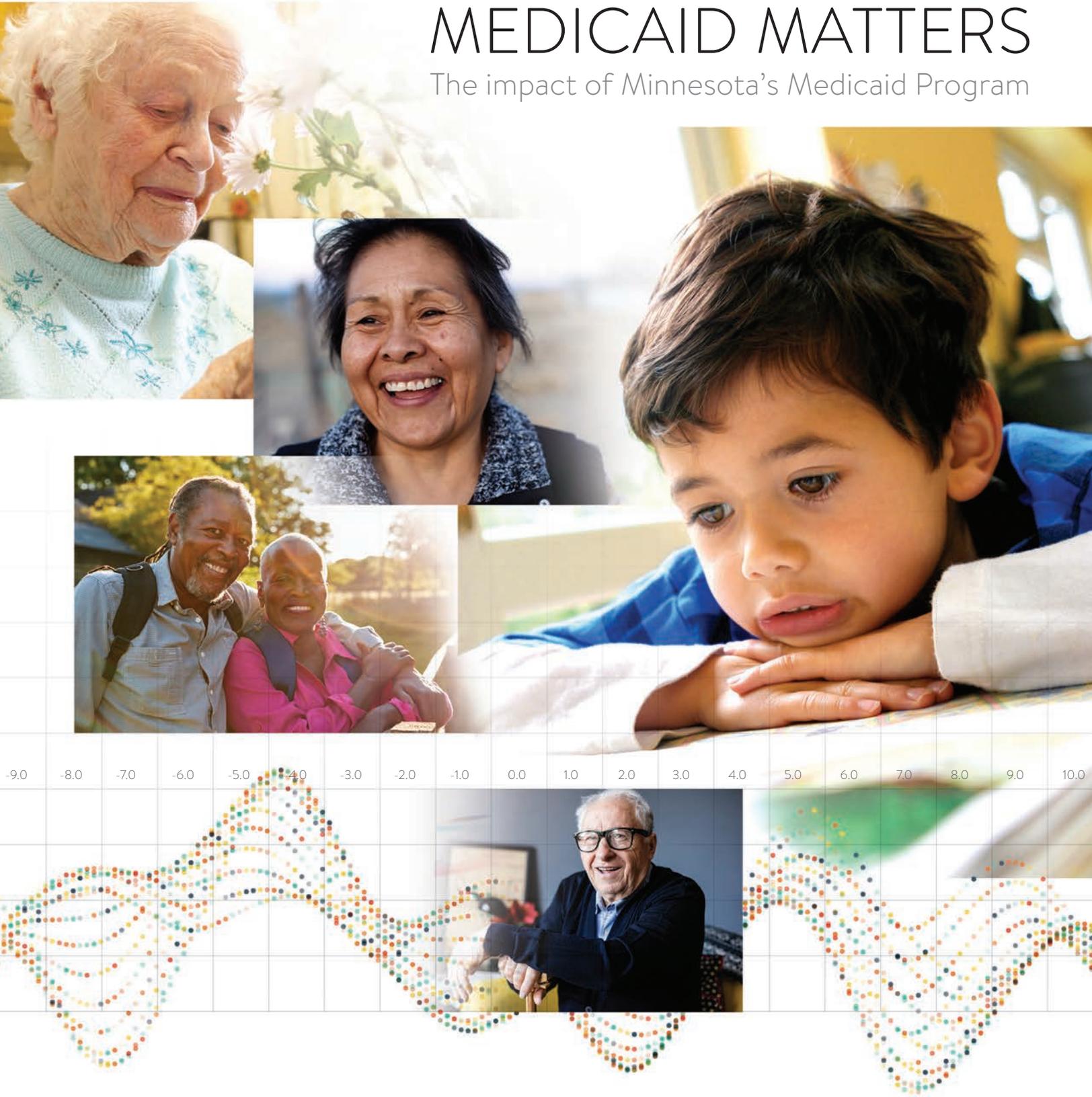


MEDICAID MATTERS

The impact of Minnesota's Medicaid Program



INTRODUCTION

It's been more than 50 years since the Medicaid program was signed into law. Today, Minnesota's Medicaid program is a cornerstone of our state's system of health and long-term care coverage, with more than one million people, including children, parents, people with disabilities and seniors covered in 2017. Over the years, the program has helped Minnesota lead the nation in health care innovations, such as the creation of MinnesotaCare, a health insurance program that provides affordable coverage to approximately 89,000 Minnesotans who are ineligible for Medicaid.

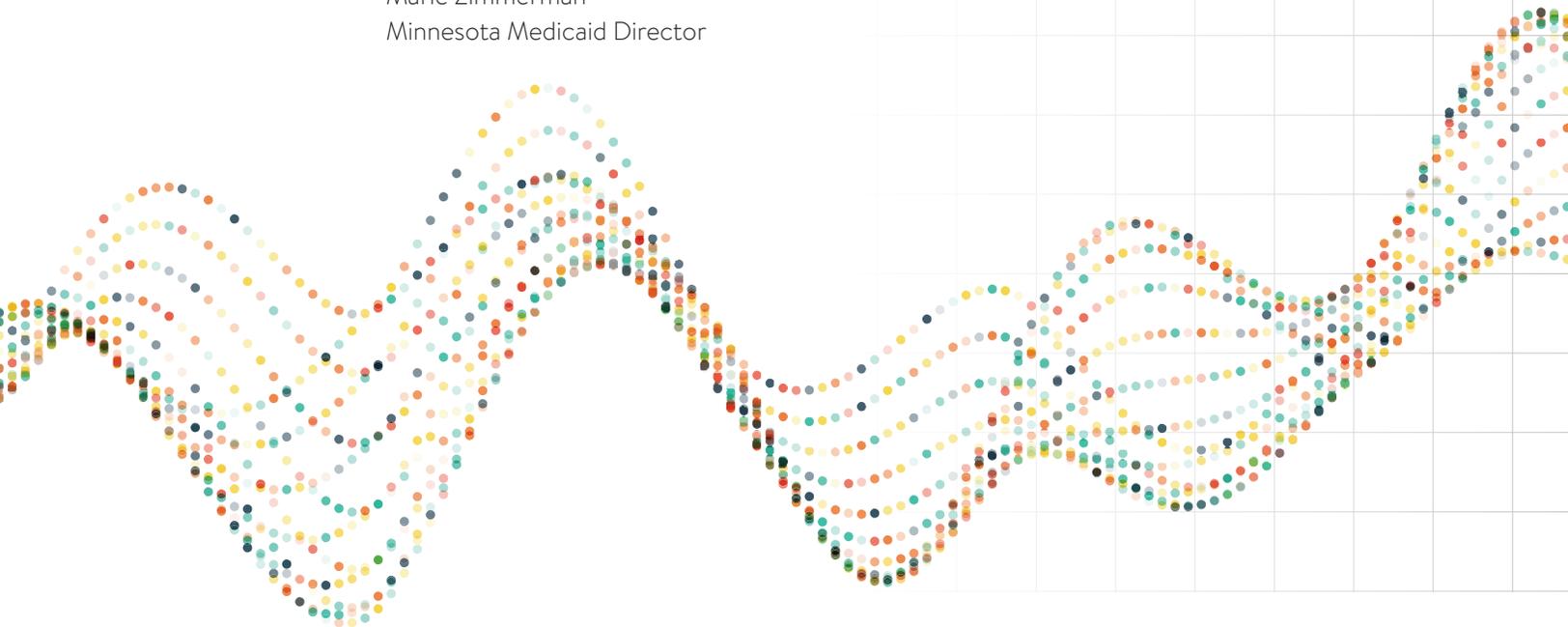
The goal of this report is to highlight why Medicaid matters for every Minnesotan by telling the story of Medicaid's history in the state, offering a detailed snapshot of who is currently eligible and what services they receive and describing Medicaid's impact on our state's individual communities.

We appreciate your support of Minnesota's Medicaid program and look forward to hearing from you about what we can incorporate into next year's report.

Sincerely,

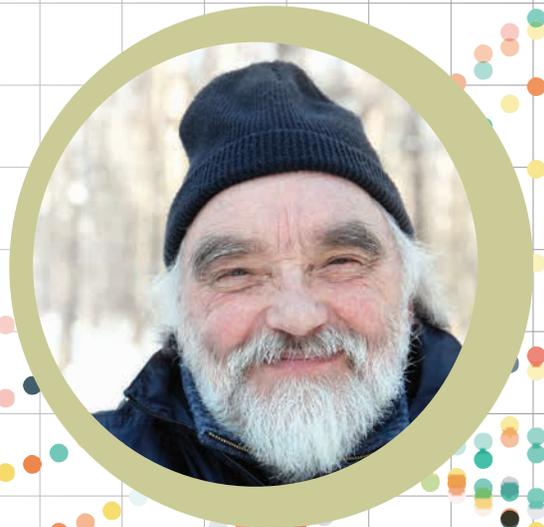


Marie Zimmerman
Minnesota Medicaid Director



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MEDICAID: THE BASICS

On July 30, 1965, President Lyndon B. Johnson signed into law legislation that led to the establishment of Medicare and Medicaid. Together, these programs currently provide health care coverage to about 41 percent of the nation's population, with Medicaid serving 24 percent.¹

Today, Medicaid is the nation's single largest health care insurer, covering approximately 77.7 million people in the United States in 2016 - more than one million of whom live in Minnesota.²

Medicaid contributes significantly to the financing of the U.S. health care system, supporting local public health infrastructure, hospitals, mental health centers, at-home care, community clinics, nursing homes, physicians and many other health professions. Medicaid – not Medicare – is the primary source of coverage for people who need long-term care services, such as nursing home services.

Currently, the federal government shares financial responsibility for the Medicaid program by matching state costs with federal dollars. While certain federal requirements outline who and what must be covered in each program, states generally have flexibility to tailor and expand their Medicaid program to meet the needs of their population and state budgets.

Who's eligible?

All individuals who meet federal Medicaid income eligibility requirements are guaranteed coverage. States can expand upon the minimum federal requirements, add optional or special populations to their Medicaid programs or increase the income eligibility limits. For example, all states have expanded Medicaid coverage to children beyond the minimum required under federal law, but not all states have opted to expand Medicaid to adults without dependent children.³ Adults without dependent children will be referred to as “adults” from this point onward in the report.

What's covered?

Individuals eligible for Medicaid are guaranteed a basic set of benefits covering specific services and settings. States can add to or vary these benefits in terms of the duration, type, amount and scope of services covered. For example, all states have opted to cover prescription drugs, but not every state covers community emergency medical technicians, doulas, comprehensive behavioral health services or chiropractic services.

¹ Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Expenditures: 2016, Table 22. Accessed on Jan. 17, 2017, at www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html.

² *ibid.*

³ Historically, adults without children were excluded from Medicaid. Under the Affordable Care Act, states had the option of expanding Medicaid eligibility to adults with incomes up to 133 percent of the federal poverty guidelines. Minnesota opted to expand Medicaid coverage to this group in 2011.



Medicaid: a state and federal program that provides coverage for both medical and long-term care at no or very low cost to individuals living in poverty.

Medicare: a federal program that provides health insurance for hospital and medical care to seniors age 65 and older and some people with disabilities regardless of their income. People enrolling in Medicare typically have out-of-pocket costs.

How are Medicaid services purchased and delivered?

States, in general, set the standards or policies for how they deliver services to Medicaid enrollees within the federal framework and requirements. They also choose how to purchase services and distribute payments

to providers. The most common methods of payment in Medicaid programs:

- Fee-for-service, where the state directly pays providers a flat fee for each service delivered.
- Managed care, where the state contracts with health plans and pays them a monthly per member capitation payment to provide all covered services.

Other payment arrangements with providers, care systems and partner organizations, referred to as accountable care organizations or models, are also growing in Medicaid as the health care system moves to pay for health outcomes versus procedures. A few states have implemented innovative models of service delivery and provider payment – such as Minnesota’s Integrated Health Partnerships – to reduce overall costs while improving enrollee outcomes.

Regardless of the structure, states must ensure sufficient statewide access of services to enrollees.

How can states shape the program to address priorities?

States can address their priorities by seeking waivers from federal law or choosing certain variations in the Medicaid program.

For example:

- States can use Medicaid to cover services provided in home and community-based settings instead of nursing homes.
- States can choose to require some form of cost sharing for certain populations or services.
- States can choose to use Medicaid dollars during public health emergencies to help pay for unexpected health care costs associated with response efforts, such as paying for insect repellent during the Zika outbreak.

Federal Medical Assistance Percentage (FMAP)

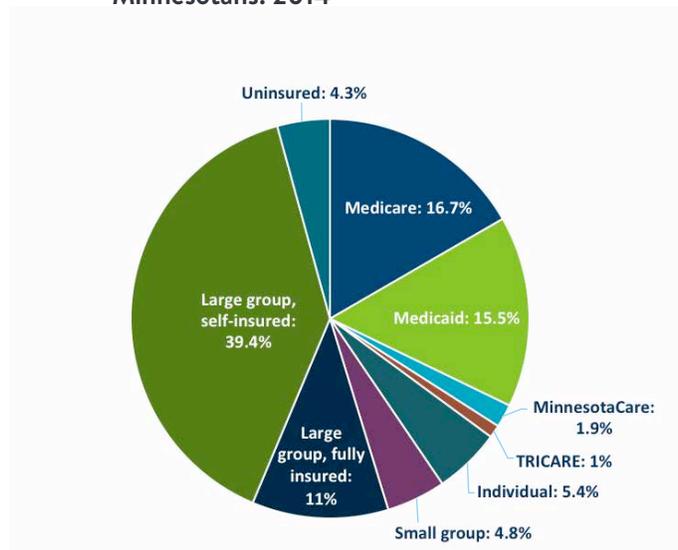
Federal Medicaid funding to states, called the Federal Medical Assistance Percentage (FMAP), is calculated by comparing personal income in each state with the national average. Minnesota's typical federal contribution rate is 50 percent. Minnesota also receives an enhanced federal funding rate of 94 percent for coverage of adults without dependent children. The Children's Health Insurance Program (CHIP) provides additional funding for Minnesota's Medicaid program which supports coverage for children and pregnant women. The state share of Medicaid funding is appropriated by the Minnesota Legislature.

MEDICAID IN MINNESOTA

In 1966, Minnesota implemented the state's Medicaid program, which is called Medical Assistance. Today, it covers one out of every five Minnesotans. As the third largest insurer in the state after self-insured employer-based coverage and Medicare, it makes up nearly 16 percent of the state's health insurance market.

Minnesota is known for its comprehensive approach to providing Medicaid coverage. Minnesota covers a broad group of people and services beyond the minimum standards set in federal law. This includes expanding coverage to higher-income children and adults and covering long-term care in the home and community instead of an institutional setting. Minnesota also covers many special populations in need of services who would otherwise be ineligible for Medicaid because of their income level, including children with disabilities whose parents are given the option to access Medicaid by paying a parental fee, women who have been diagnosed with breast or cervical cancer through the state's cancer screening program, and families in need of family planning services.

Figure 1: Primary source of health care coverage for Minnesotans: 2014



Source: Minnesota Department of Health, 2015

ELIGIBILITY

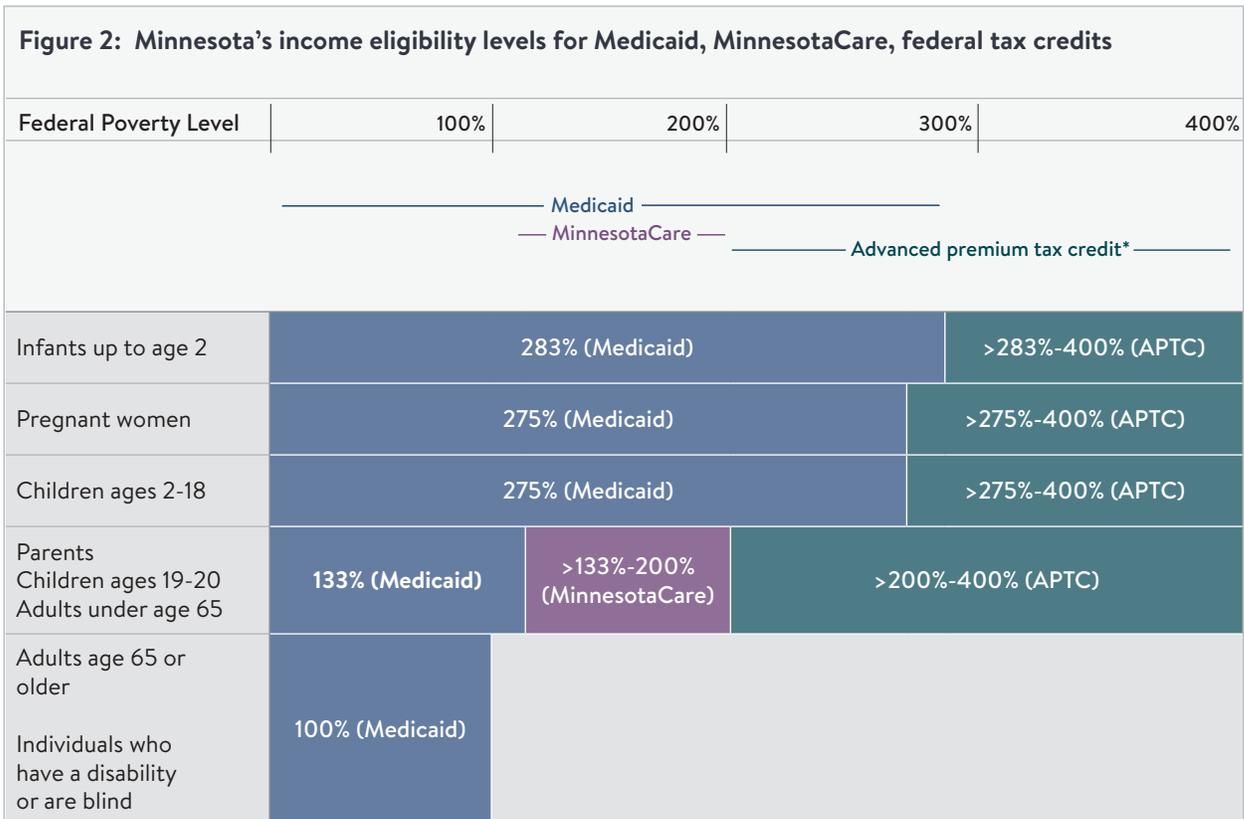
Minnesotans may enroll in Medicaid in Minnesota if they meet certain eligibility requirements under the following categories:

- a) Parents and children
- b) Age 65 or older, blind or have disabilities
- c) Adults.

Medicaid enrollees must demonstrate their program eligibility at least once a year. An individual’s eligibility is determined by factors such as household income, family size, age,

disability status, and citizenship or immigration status. These criteria are set by federal and state law and vary by category. To access more detailed information about income eligibility limits in Minnesota’s Medicaid program, see the income and asset guidelines.⁴

If someone makes more than the income limit, they may still be eligible for coverage using a spenddown, a cost-sharing approach that allows people with incomes greater than the applicable limit to “spend down” their excess



Does not reflect MinnesotaCare coverage from 0 to 200 percent of the federal poverty guidelines for lawfully present noncitizens who are ineligible for Medicaid.

* Advanced premium tax credits reduce the cost of premiums for coverage purchased through MNsure and were made available under the Affordable Care Act.

⁴ Access the income and asset guidelines online at <http://edocs.dhs.state.mn.us/lfserver/Public/DHS-3461A-ENG>.

income to the appropriate income limit by deducting certain health care expenses. Medicaid will pay for covered services once their income is at or below the income limit after deducting these medical expenses.

Applying for coverage

Before the Affordable Care Act, county workers primarily determined Medicaid eligibility. Most people had to apply for Medicaid by filling out a paper application and mailing it to their local county human services agency or submitting it in person.

People can still fill out a paper application,⁵ however today they can also go online through the state's online health insurance marketplace, MNsure, at www.mnsure.org to determine whether they are eligible for the state's Medicaid program, MinnesotaCare or federal tax credits through the individual health insurance marketplace. People may also shop for individual health insurance through MNsure, which means they pay the full cost of their health plan if they do not qualify for federal tax credits.

While some eligibility requirements for Minnesota's Medicaid program have been simplified or streamlined by the Affordable Care Act, many people shopping for health insurance may still have questions or need help navigating the system. People can receive free in-person help with the application and enrollment process by contacting the MNsure assister program at www.mnsure.org/help/find-assister.

Minnesota's health care coverage assistance

Medicaid (Medical Assistance): A state and federal program that fully covers a broad array of health care services for people living in poverty, including seniors and people with disabilities. On average, more than one million Minnesotans receive Medicaid.

MinnesotaCare: A state and federal program that provides a low-cost health insurance option to people who earn too much to qualify for Medicaid yet struggle to afford health insurance. Minnesota is one of two states with this type of coverage assistance, which is known as a Basic Health Program. On average, 89,000 Minnesotans purchase their coverage through MinnesotaCare.

Advanced premium tax credits: A federal tax credit program that reduces the cost of premiums for individual health insurance based on income. It is only available through federal or state marketplaces, such as MNsure. During open enrollment in 2017, 117,000 people enrolled in commercial health plans through MNsure and 64 percent received federal tax credits to help pay for premiums.

⁵ Access the paper application at <https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/resources/paper-applications.jsp>.

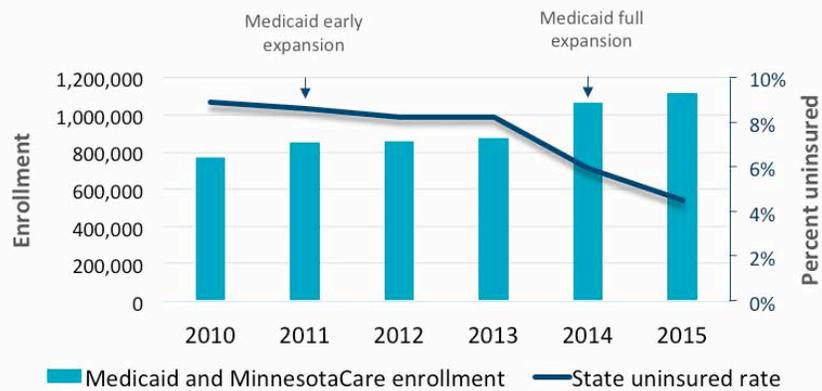
The Affordable Care Act

Simplified income methodology: The Affordable Care Act introduced a simple income method for determining eligibility for Medicaid, MinnesotaCare and tax credits to purchase a commercial health plan. The modified adjusted gross income methodology replaced prior complex formulas for determining income eligibility and eliminated asset tests for certain Medicaid applicants and enrollees. It does not apply to individuals who are 65 or older, blind, and those who are eligible based on a disability.

Integrated application process: The law requires states to simplify enrollment for consumers. This makes it easier for families and individuals to enroll in health care coverage without having to submit separate applications and navigate multiple systems. This is especially important for families where different members of the family qualify for different programs.

Expansion for adults: The Affordable Care Act provided federal funding to expand coverage for lower income adults. Before the law, Minnesota covered about 87,000 adults through MinnesotaCare or the General Assistance Medical Care program. These programs had limited benefit sets, had higher enrollee premiums and received no federal funds. In 2011, Minnesota began expanding coverage to adults in Medicaid (early expansion) and completed this expansion of coverage in 2014 (full expansion). Today, the state's Medicaid and MinnesotaCare programs provide comprehensive coverage to more than 240,000 lower income adults. Figure 3 shows the relationship between the coverage expansions allowed under the Affordable Care Act and the declining rate of uninsurance in Minnesota between 2010 and 2015.

Figure 3: Minnesota's Medicaid and MinnesotaCare enrollment and uninsured rate



Source: State Health Compare, SHADAC, University of Minnesota

COVERED BENEFITS AND SERVICES

Every state must cover a specific set of services in its Medicaid program. The federal list of mandatory and optional benefits has evolved since the program's inception in 1965 because the health needs of Medicaid enrollees have changed significantly due to advances in medical care and technology, the complexities of caring for people with disabilities and chronic diseases, changes in disease patterns, and longer lifespans.

Federal law allows states some flexibility in designing their Medicaid benefit packages, as long as services are available statewide and equal in terms of availability and scope for all enrollees.

All states must cover the following services in Medicaid:

1. Inpatient and outpatient hospital services
 2. Physician services
 3. Nursing facility services
 4. Early periodic screening, diagnostic and treatment services for children, including dental care
 5. Laboratory and x-ray services
 6. Home health services⁶
 7. Rural health clinic services
 8. Federally Qualified Health Center services
 9. Transportation to medical care
 10. Certified pediatric and family nurse practitioner services
 11. State-licensed or state-recognized free standing birth center services
 12. Emergency medical services for certain noncitizens, also known as Emergency Medical Assistance
 13. Family planning services, including nurse midwife services
 14. Tobacco cessation counseling for pregnant women.
- E. Eyeglasses
 - F. Hearing aids
 - G. Home care, including personal care assistant services
 - H. Hospice care
 - I. Interpreter services
 - J. Medical equipment and supplies
 - K. Prescriptions and medication therapy management
 - L. Rehabilitative services, including many mental health services
 - M. Inpatient and outpatient substance use disorder treatment
 - N. Case management
 - O. Care coordination
 - P. Autism spectrum disorder services or treatment.

Minnesota's Medicaid program also covers the following optional services:

- A. Alcohol and drug treatment
- B. Chiropractic care
- C. Limited dental care for non pregnant adults
- D. Emergency hospital services

Federal law requires states to cover all medically necessary services listed under mandatory and optional services for children under age 18 regardless of whether the state's Medicaid program covers the services. These include physician and hospital services; private duty nursing; personal care services; home health; medical equipment and supplies; rehabilitative services; and vision, hearing and dental services. Additionally, states must offer the full range of early periodic screening, diagnostic and treatment services to the family of an enrolled child in order to meet that individual child's needs.

⁶ This includes nursing services, home health aides, and medical supplies and equipment. This does not include home and community-based waiver services or personal care assistants.

See Appendix A for more information about services covered by Minnesota’s Medicaid program.

Payment and service delivery

Most Minnesotans enrolled in Medicaid receive services through the state’s contracted managed care organizations, which include both health maintenance organizations and county-based purchasing plans. The remaining enrollees receive services through the traditional fee-for-service system, where providers receive a payment from the Department of Human Services (DHS) directly for each service provided to an enrollee. Fee-for-service enrollees may choose from any provider enrolled in the Medicaid program.

In any given year, a certain portion of fee-for-service payments come from enrollees temporarily accessing their services through the fee-for-service system until they select their managed care plan. Enrollees who remain in fee-for-service primarily consist of those who are not required to enroll in managed care or who have chosen to opt out of managed care. In general, these individuals include:

- Individuals with disabilities
- Individuals who are eligible through using a spenddown
- People with “cost-effective” health insurance⁷
- Children receiving adoption assistance
- American Indians who live on a federally-recognized reservation.

In 2016, about 280,000 people were enrolled in the state’s fee-for-service system in any given month with just over 807,000 people enrolled in managed care.

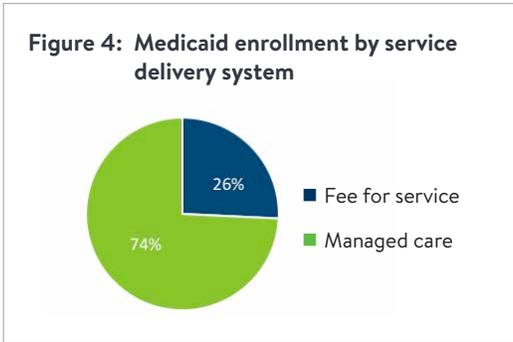
See pages 20-21 for maps of Minnesota Medicaid enrollment by county in managed care, county-based purchasing and other delivery systems.

The payer of last resort

Under federal law, Medicaid serves as the payer of last resort. This means that other insurers or programs such as Medicare or employer insurance that cover an enrollee must pay their share of costs before Medicaid makes any payments. This is known as third party liability.

Federal law requires states to take steps to ensure that medical providers bill third parties first before requesting payments from the Medicaid program. If a state has paid claims and later discovers the existence of a liable third party, the state must attempt to recover the money from that third party.

⁷ An enrollee with access to other health insurance may be eligible for help in paying the premiums if it is cost-effective. Cost-effective means that paying for the other plan would be less costly for the state than the amount for an equivalent set of services paid for by Medicaid. If a plan is cost-effective, Medicaid reimburses the premium for the enrollee’s health plan and provides coverage for all Medicaid benefits not included in the plan.



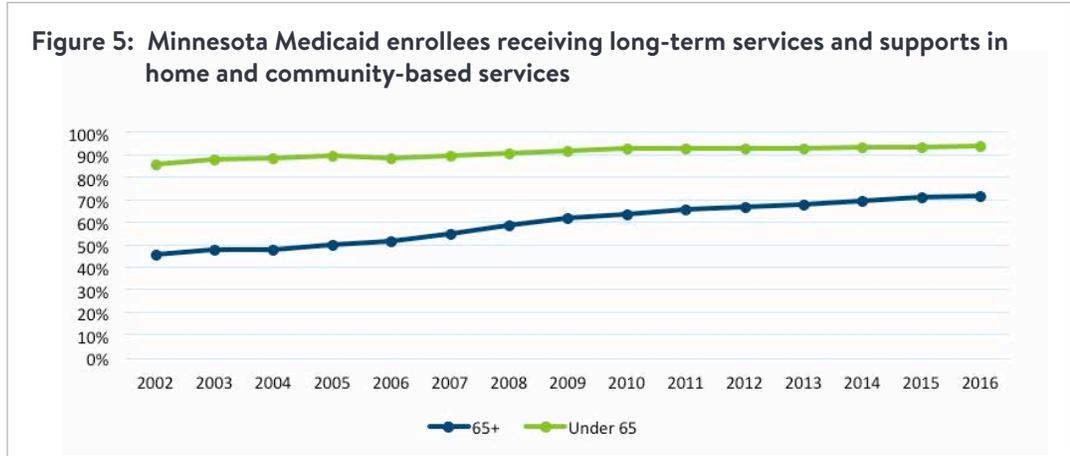
daily living tasks.⁸ In Medicaid, the services generally consist of ongoing care or supports that a person needs to manage a chronic health condition or disability. The services can be provided in institutional settings, such as hospitals and nursing homes, or in people’s homes and other community settings. Federal law requires all state Medicaid programs to cover these services when provided in an institutional setting or nursing facility.

Long-term services and supports

Thirty years ago, people who needed help with daily living tasks, such as bathing, dressing, eating and preparing meals, were faced with the choice of when, not if, they would move from their home into an institution or similar setting. Today, older Minnesotans and people with disabilities have many options and services available. This approach provides a higher quality of life for people as they have access to the right service at the right time, and it leads to more cost-effective services over time.

Long-term services and supports are a spectrum of health and social services that support Minnesotans who need help with

For more than 35 years, Minnesota has expanded this coverage to individuals receiving services in their homes and communities, which is often more effective and desirable than an institutional setting. In order to ensure that people with disabilities and older adults enjoy the same quality of life as other Minnesotans, the services and supports that they depend on must be available in the homes and communities where they choose to live. Home and community-based services are generally more cost-effective and preferred by the people who rely on services. Figure 5 shows that more enrollees receiving long-term care services and supports choose home and community-based services in Minnesota each year.



⁸ Currently, long-term services and supports is the nationally recognized term for this range of services and is used by the federal government.

HOME AND COMMUNITY-BASED SERVICE WAIVERS

Home and community-based services are long-term services and supports delivered in homes or communities and not institutional settings.

Minnesota has a long history of working to help all people live with dignity and independence. By 1995, Minnesota had shifted from predominantly institution-based care to predominantly home and community-based care. Today, 83 percent of Minnesotans receiving long-term services and supports get them through home and community-based services.

Minnesota has received federal approval to use Medicaid dollars to pay for these services through its home and community-based services waiver programs. These programs allow Medicaid to pay for services for people in their homes and communities if the services would otherwise be eligible for coverage in nursing facilities or hospitals.

DHS administers waiver programs in collaboration with county and tribal social services and public health programs. The vast majority of Minnesota's Medicaid spending on long-term care services and supports goes to enrollees in home and community-based waiver programs. For example, more than 90 percent of Medicaid long-term care spending for people with disabilities in Minnesota goes toward services provided in the community.

What is a home and community-based services waiver?

Congress established home and community-based services waivers in 1983 in section 1915(c) of the Social Security Act, giving states the option to seek a waiver of Medicaid rules governing institutional care to allow them to expand Medicaid services to home and community settings. These services became a Medicaid state plan option in Minnesota in 2005. Several states include home and community-based services in their Medicaid state plans, with 47 states and Washington, D.C., operating at least one 1915(c) waiver.

Minnesota's waivers

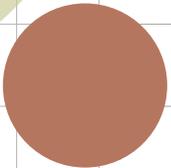
Brain Injury: Allows Medicaid to cover services for people with a traumatic or acquired brain injury who need the level of care provided in a nursing facility or neurobehavioral hospital and choose to receive such care in home and community-based service settings.

Community Alternative Care: Allows Medicaid to cover services for people who are chronically ill or medically fragile and in need of the level of care provided at a hospital and choose to receive such care in home or community-based service settings.

Community Access for Disability Inclusion: Allows Medicaid to cover services for people who need the level of care provided in nursing facilities and choose to receive such care in home and community-based service settings.

Developmental Disabilities: Allows Medicaid to cover services for people with developmental disabilities or related conditions who need the level of care provided at an intermediate care facility for people with developmental disabilities and choose to receive such care in home and community-based service settings.

Elderly Waiver: Allows Medicaid to cover services for those age 65 and older who need the level of care provided in a nursing facility and choose to receive such care in home and community-based service settings.





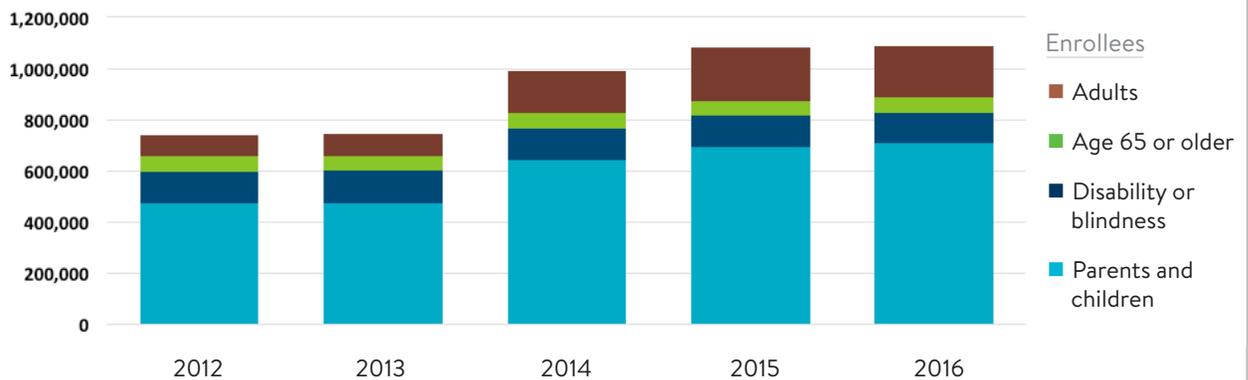
WHOM MEDICAID SERVES

Enrollment

Average monthly enrollment in Minnesota’s Medicaid program in 2016 remained relatively unchanged from 2015 with about 1.1 million people covered. In the five-year period from calendar years 2012 to 2016, the number of Medicaid enrollees grew by 47 percent. Much of this increase can be attributed to changes authorized by the Legislature in 2013, including the expansion of Medicaid coverage for adults, the movement of pregnant women and children from MinnesotaCare to Medicaid, and growth caused by the individual mandate to have health insurance.

Roughly two-thirds of those covered in 2016 qualified for the parents and children eligibility category, which includes pregnant women.

Figure 6: Minnesota Medicaid enrollment by eligibility category: 2012-2016

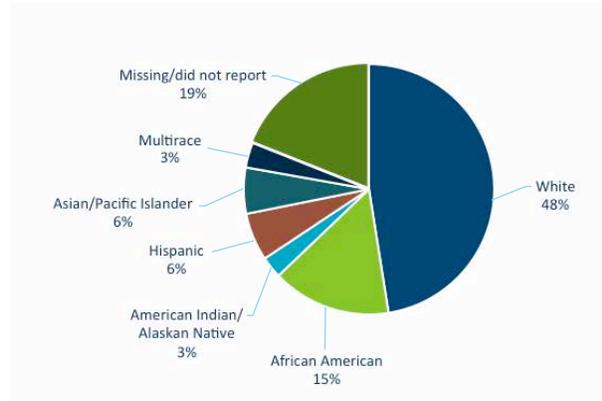


Demographics

Race and ethnicity

Enrollees may report race and ethnicity data at application and renewal; the data is optional in the state’s Medicaid application. Roughly 80 percent of enrollees provided this information in 2016, and about half of the enrollees who responded were white (non-Hispanic).

Figure 7: Race and ethnicity of Minnesota Medicaid enrollees: 2016

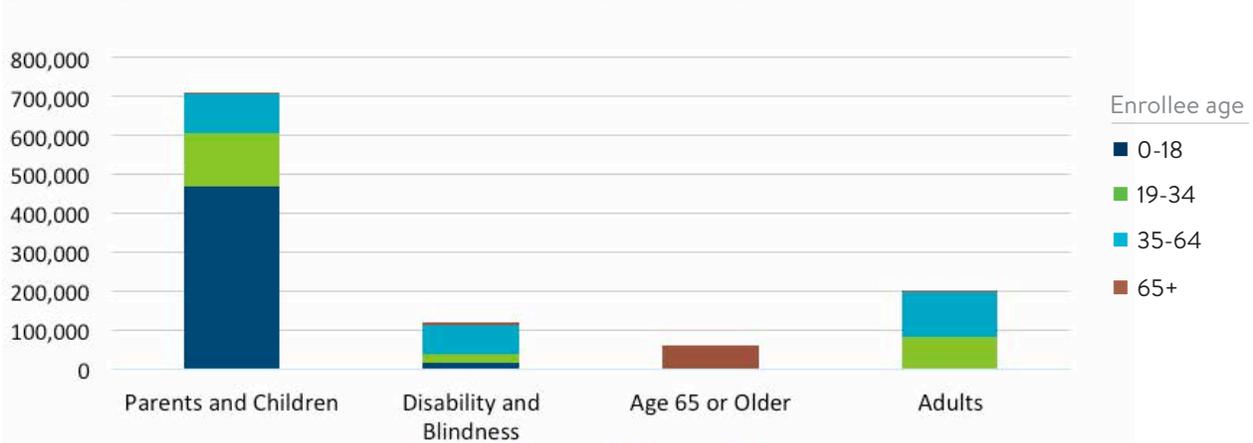


Age

Children ages 0 to 18 are the single largest group in Minnesota’s Medicaid program making up 45 percent of total enrollment. Most of the children enrolled in the program are in the “parents and children” eligibility category with the remaining children eligible on the basis of having a disability. Adults 19-34 years old make up about 22 percent of the population, people ages 35-64 are 27 percent, and people age 65 or older are around 6 percent of the enrollee population. The majority of the Medicaid population with disabilities is between the ages of 35 and 64.



Figure 8: Age of Minnesota Medicaid enrollees by eligibility category: 2016

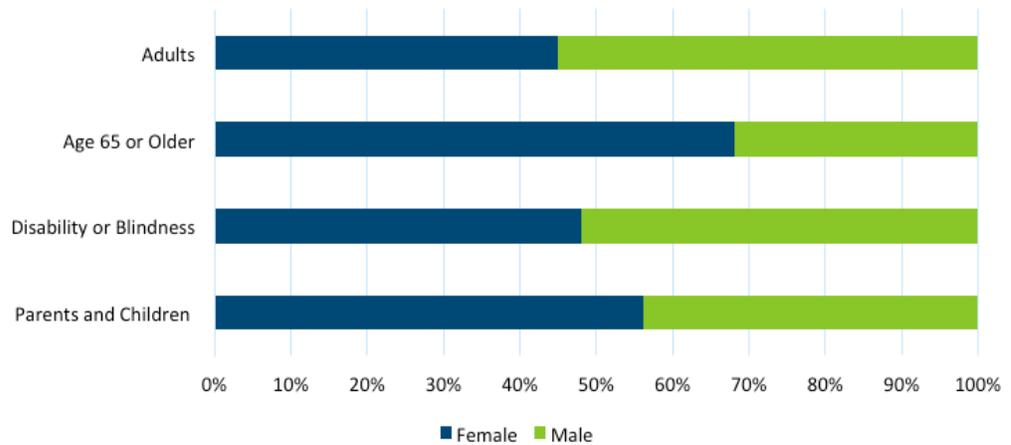




Sex

Data collected at application indicate that more than 585,000, or 54 percent, of Medicaid enrollees are female. Females make up the majority of enrollees in the “parents and children” and “age 65 or older” eligibility categories. Both the “adult” and “disability or blindness” eligibility categories include more men than women.

Figure 9: Minnesota Medicaid population by sex: 2016



Region

Figure 10 shows the distribution of Medicaid enrollees by region. Minnesota Medicaid enrollment is split nearly evenly between the seven-county metro area and Greater Minnesota. However, Medicaid enrollment makes up a higher percentage of the total population in many Greater Minnesota counties compared to the metro area.

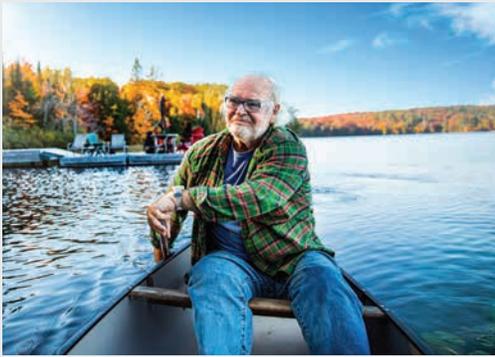


Figure 10: Medicaid enrollment by region: 2016

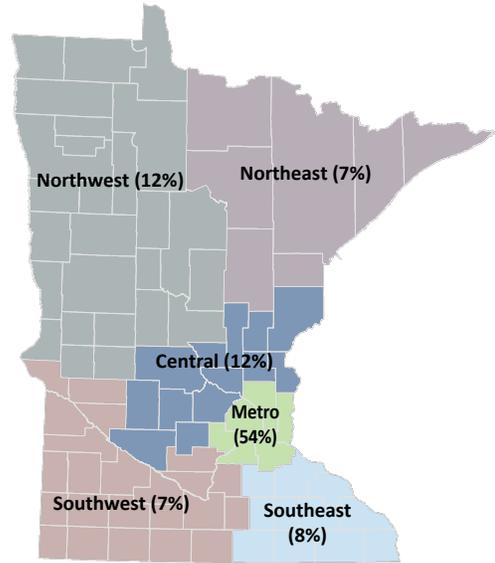
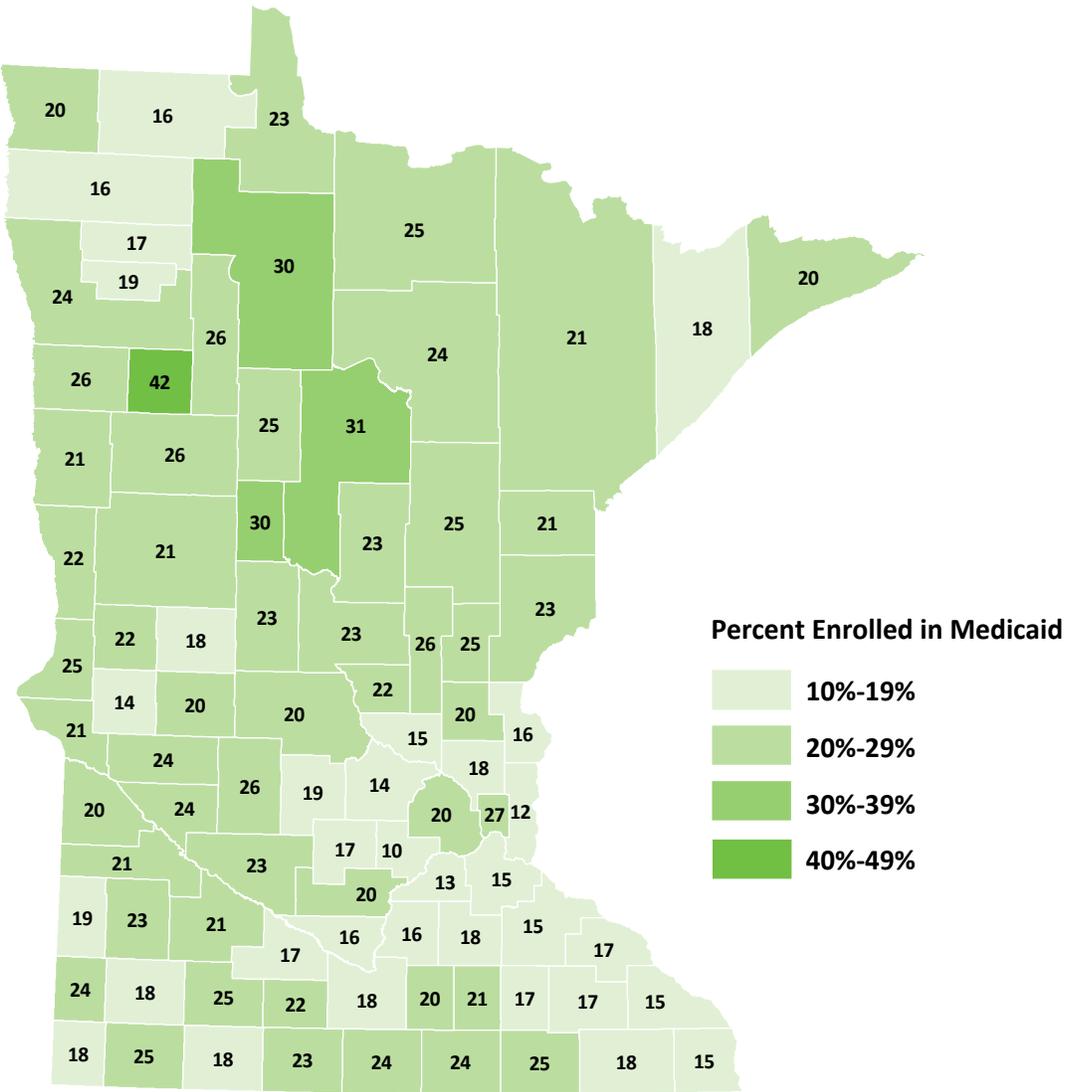


Table 2: Average monthly Medicaid enrollment by Minnesota region: 2016

Eligibility group	Central	Northeast	Northwest	Southeast	Southwest	Metro	Total
Adults	22,099	15,567	21,972	15,299	12,092	114,428	201,457
Age 65 or older	6,138	4,893	8,147	5,585	5,023	30,599	60,384
Disability or blindness	12,643	9,924	13,357	9,275	8,183	64,694	118,076
Parents and children	90,944	41,209	87,670	59,989	53,970	372,947	706,729
• Parents	22,449	10,921	22,159	14,982	12,871	89,013	172,395
• Children	62,494	27,097	59,976	41,596	37,595	259,250	488,008
• Pregnant women	2,843	1,166	2,601	1,946	1,814	11,980	22,350
• Other	3,158	2,025	2,934	1,464	1,692	12,703	23,976
Medicaid total	131,824	71,592	131,146	90,148	79,268	582,668	1,086,646

Figure 11: Percent of Minnesota Population Enrolled in Medicaid by County: 2016



Source: United States Census Bureau

The Medicaid program covered nearly one in five of Minnesota’s 5.5 million residents in 2016, or 19.6 percent of the population. Across Minnesota counties, the rate of Medicaid coverage ranged from a low of 9.9 percent in Waseca County to a high of 42 percent in Mahnomon County.

MEDICAID INVESTS IN HEALTH CARE

Minnesota's optional and mandatory populations

Federal law requires states to cover certain categories of people in their Medicaid programs in order to receive federal matching funds. In the past few decades, federal policy has shifted to expand coverage to additional populations. This is because Medicaid has evolved since 1965 when it was initially focused on the needs of individuals receiving cash welfare payments.

Today, Medicaid provides comprehensive health care coverage to millions of low-income children, parents, adults, elderly individuals and people with disabilities.

States have the option to extend coverage to additional populations or cover mandatory groups at higher income levels. Minnesota, among many other states, has taken these options to cover a broader population in Medicaid. States that cover optional populations do so in order to proactively manage the health of people who would eventually become eligible for Medicaid due to loss of income and assets or due to a greater deterioration of health. This investment gives enrollees access to preventive, primary and specialty care that can help manage acute and chronic conditions. If Minnesota stopped covering some of the optional populations, the state would likely end up covering a sizeable proportion of them later due to loss of income and assets, a greater deterioration of health or a disabling condition.

People who are considered part of the mandatory coverage group under federal law include low-income children, pregnant

women, people age 65 or older and individuals with a disability who receive Supplemental Security Income up to certain income levels. **Currently, approximately 570,000 people, or about 51 percent, of Minnesota Medicaid enrollees are enrolled as mandatory under federal law. In 2016, Medicaid spending on the mandatory population made up about \$3.4 million, or 30 percent, of the \$11.5 billion in total spending.¹⁰**

The remaining Medicaid population consists of about 546,000 Minnesotans who are eligible for one of the various state options or waivers that Minnesota has chosen to include as part of its Medicaid program, some of which are smaller state-only funded programs. **While these optional coverage groups make up 49 percent of the total number of people enrolled in Minnesota's Medicaid program, they accounted for a greater proportion of the spending in 2016, totaling roughly \$8.1 billion, or 70 percent, of the \$11.5 billion in expenditures.**

Minnesota covers several optional coverage groups permitted under the Medicaid state plan, including women receiving treatment for breast or cervical cancer, adults with incomes up to 133 percent of the federal poverty guidelines, and people with disabilities who are employed (also known as Medical Assistance for Employed Persons with Disabilities). The state also includes several waiver programs for home and community-based services for people who would otherwise be ineligible for Medicaid.

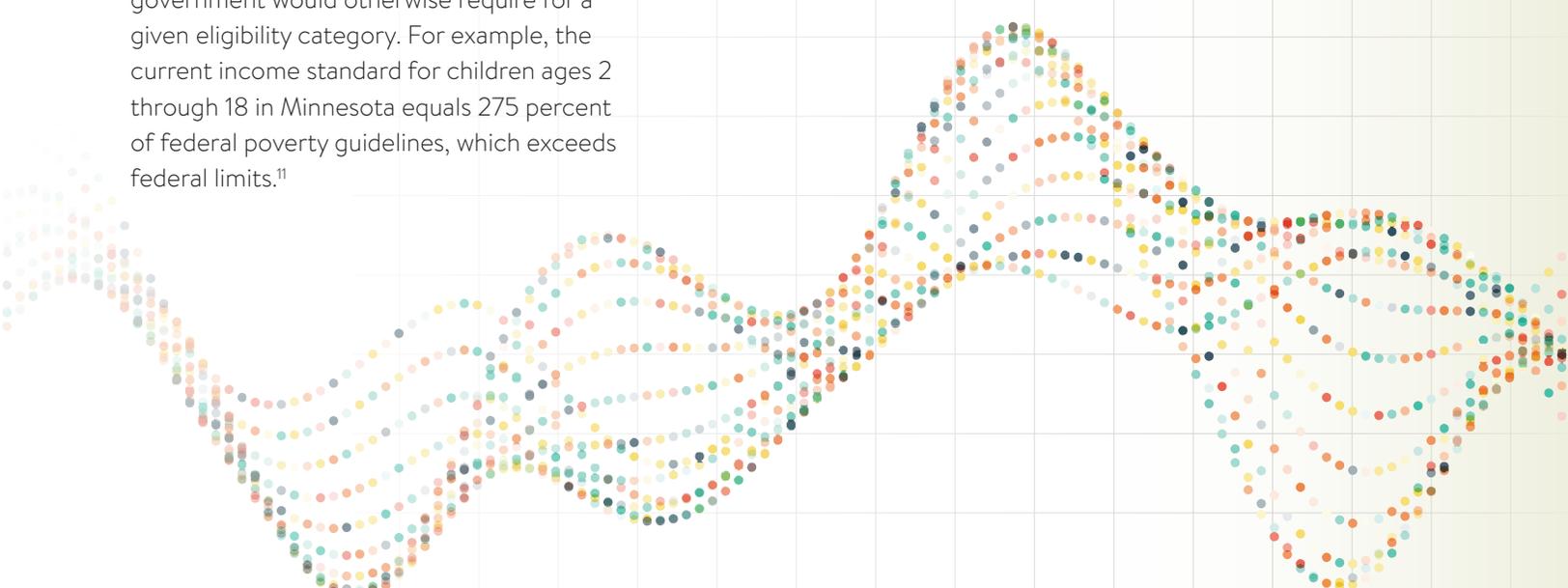
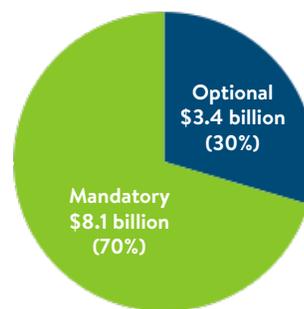
¹⁰ The \$11.5 billion figure reflected in this section includes roughly \$30 million in spending on optional state-funded populations, which are not included in the \$11.4 billion dollar figure reflected elsewhere in this report.

Minnesota is one of 19 states that allows parents who have a child with a disability the option to obtain Medicaid through the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) if they are unable to meet the Medicaid income limit. Parents may have to pay a parental fee.

Additionally, the state has chosen to include an optional “medically needy” category for parents, children, pregnant women and those eligible due to age, blindness or disabilities. The medically needy category allows people with incomes above current eligibility limits to reduce their income by paying incurred medical expenses. Medicaid coverage begins after the person’s income is reduced to the medically needy income standard.

The state also has raised income eligibility levels for Medicaid above what the federal government would otherwise require for a given eligibility category. For example, the current income standard for children ages 2 through 18 in Minnesota equals 275 percent of federal poverty guidelines, which exceeds federal limits.¹¹

Figure 13: Estimated Medicaid spending by optional and mandatory populations



¹¹ In accordance with federal Medicaid maintenance of effort rules, Minnesota must maintain the current income standards for children and pregnant women until October 2019 at which time the state may adopt a lower income eligibility limit for these two populations.

Figure 14: Enrollment and spending for optional and mandatory populations

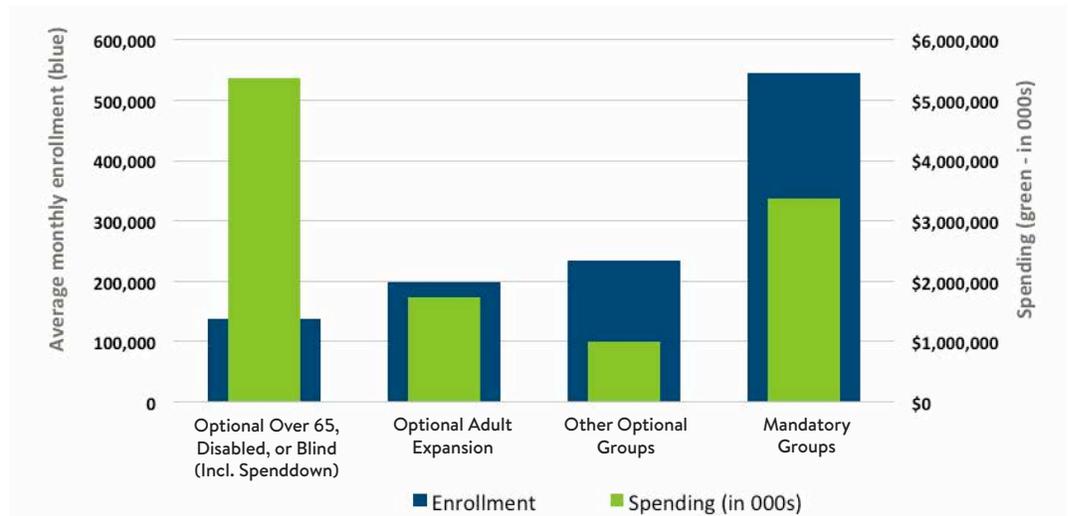


Table 3: Minnesota Medicaid enrollment and spending for mandatory and optional groups: 2016**

Mandatory groups	Enrollment	Spending (estimated, in 000s)
Children, parents, pregnant women with incomes at or below maintenance of effort (MOE)	485,929	\$1,874,233
People 65 or older, blind or with disabilities below required income standard	43,089	\$1,430,454
Other mandatory groups	17,297	\$59,538
Mandatory groups total	546,315	\$3,364,225
Optional groups	Enrollment	Spending (estimated, in 000s)
Children, parents, pregnant women with incomes above maintenance of effort	217,975	\$946,306
Adults	201,457	\$1,726,798
People 65 or older, blind or with disabilities above required income standard	91,102	\$2,951,724
People 65 or older, blind or with disabilities with a spenddown	45,861	\$2,411,727
Other optional groups*	13,400	\$54,384
Optional groups total	569,795	\$8,090,939

* See Appendix B for a detailed table on spending and enrollment by mandatory and optional groups.

** Enrollment and spending totals in this table include optional state-funded populations, which are not included in the \$11.4 billion figure reflected elsewhere in the report.

MEDICAID SPENDING AND ENROLLMENT INFORMATION

The numbers and data contained in this section provide information about the state’s investments and spending on services received through Minnesota’s Medicaid program. The data in this section includes Medicaid payments to providers for health care services rendered during the year indicated regardless of when the claim was paid. This includes services for enrollees in the fee-for-service system and those served by managed care organizations. **The total spending presented in this report does not align with data reflected in the DHS program forecast, which reflects the timing of payments (i.e., cash basis) consistent with the state budget.** It does not provide projections of future spending on Medicaid in Minnesota.

This section includes detail showing the change in Medicaid spending, spending per enrollee and spending per enrollee for specific health care services for the period between 2012 and 2016.

These data show the following trends:

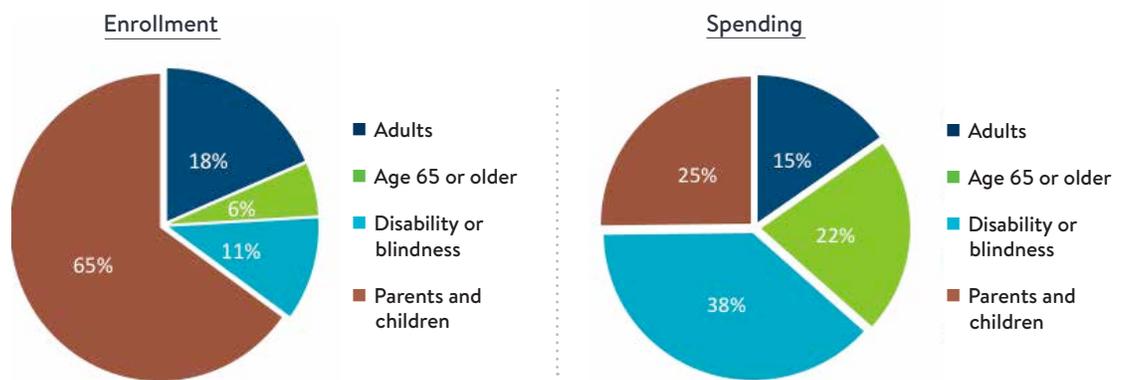
- Lower health care spending per enrollee
- Lower utilization of health care services
- Higher spending on specific health care services per enrollee served.

Total 2016 spending on health care services for the state’s 1.1 million Medicaid enrollees was approximately \$11.4 billion. Although 65 percent of Medicaid enrollees were in the “parents and children” eligibility category, they accounted for only 25 percent of total spending. Enrollees with a disability or blindness made up 11 percent of the total enrollee population but accounted for 38 percent of health care spending. People 65 or older were roughly 6 percent of the total population and accounted for 22 percent of spending. Adults were approximately 18 percent of total enrollees and 15 percent of spending on health care services.





Figure 15: Minnesota Medicaid enrollment and spending by eligibility category



Average annual Medicaid spending per person by population

Enrollment in the program increased by 47 percent between 2012 and 2016, outpacing the spending growth of 35 percent during the period. The net result is an 8.2 percent drop in spending on health care services per person and an overall decrease in utilization, attributed largely to an influx of enrollees. Much of the growth in the enrollee population followed eligibility changes authorized by the Legislature in 2013, including the Medicaid expansion in Minnesota. Purchasing strategies, including competitive bidding for managed care contracts and the development and growth of a new health care delivery model, also limited the growth in per capita Medicaid spending during this period.

Higher need enrollees and higher provider payment rates have contributed to an increase in per capita spending for people whose basis of eligibility is blindness, having a disability or being age 65 or older. Minnesota has continued its commitment to ensure seniors and people with disabilities have services and supports to remain in the community, increasing the proportion of higher-need waiver enrollees requiring more services. Among people receiving community alternative care, community access for disability inclusion and brain injury waivers, the proportion of people in the highest need categories increased from 78.8 percent to 80.5 percent from state fiscal year 2012 to 2016. Among alternative care and elderly waiver participants, the proportion of people in the highest need categories increased from 57.7 percent to 66.8 percent from state fiscal year 2012 to 2016.

The Legislature increased provider payment rates to ensure continued access to community-based services. Between 2013 and 2015, the Minnesota Legislature enacted three separate rate increases for home and community-based services, eliminated a rate cut passed during a 2011 budget shortfall, and increased payment rates for personal care assistant services.

Nationwide, the total spending on health care services per person increased by just more than \$1,200 per person, or 16.4 percent, between 2012 and 2016 from around \$7,600 to \$8,800.

Figure 16: Minnesota Medicaid spending by major eligibility category (in 000s): 2012-2016

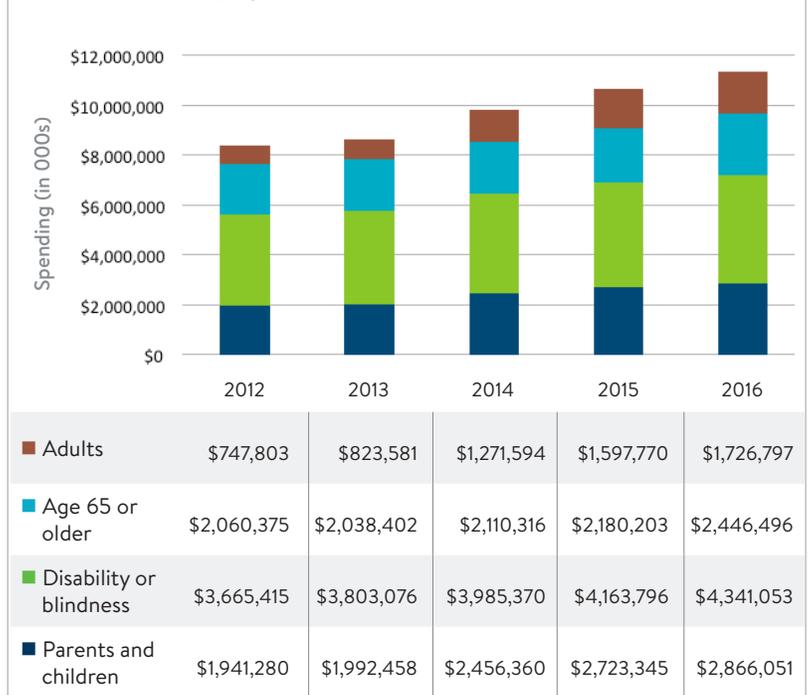
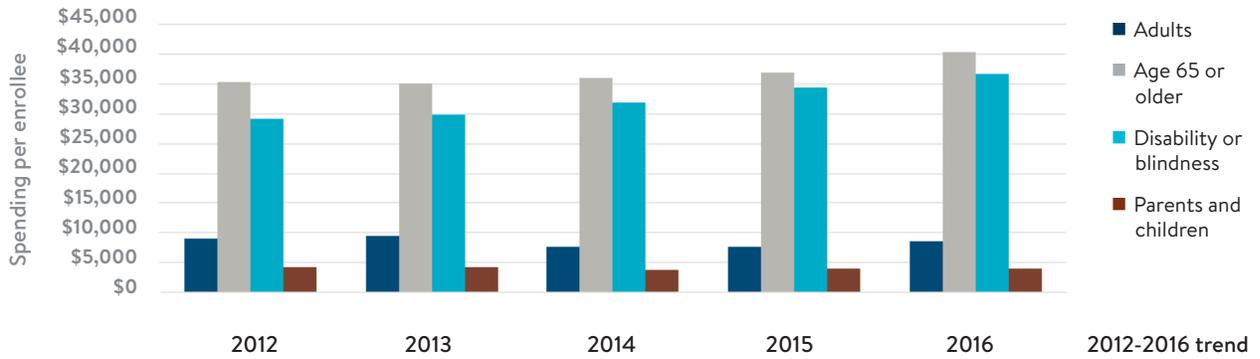


Figure 17: Minnesota Medicaid expenditures per enrollee by eligibility category: 2012-2016



	2012	2013	2014	2015	2016	2012-2016 trend
Adults	\$9,020	\$9,514	\$7,564	\$7,695	\$8,572	-5.0%
Age 65 or older	\$35,479	\$35,091	\$36,067	\$36,992	\$40,515	14.2%
Disability or blindness	\$29,245	\$29,891	\$31,926	\$34,529	\$36,765	25.7%
Parents and children	\$4,121	\$4,203	\$3,832	\$3,928	\$4,055	-1.6%
Medicaid expenditures per enrollee: all enrollees	\$11,411	\$11,607	\$9,898	\$9,871	\$10,473	-8.2%
Per capita health expenditures: U.S. average	\$7,551	\$7,720	\$8,050	\$8,479	\$8,788	16.4%

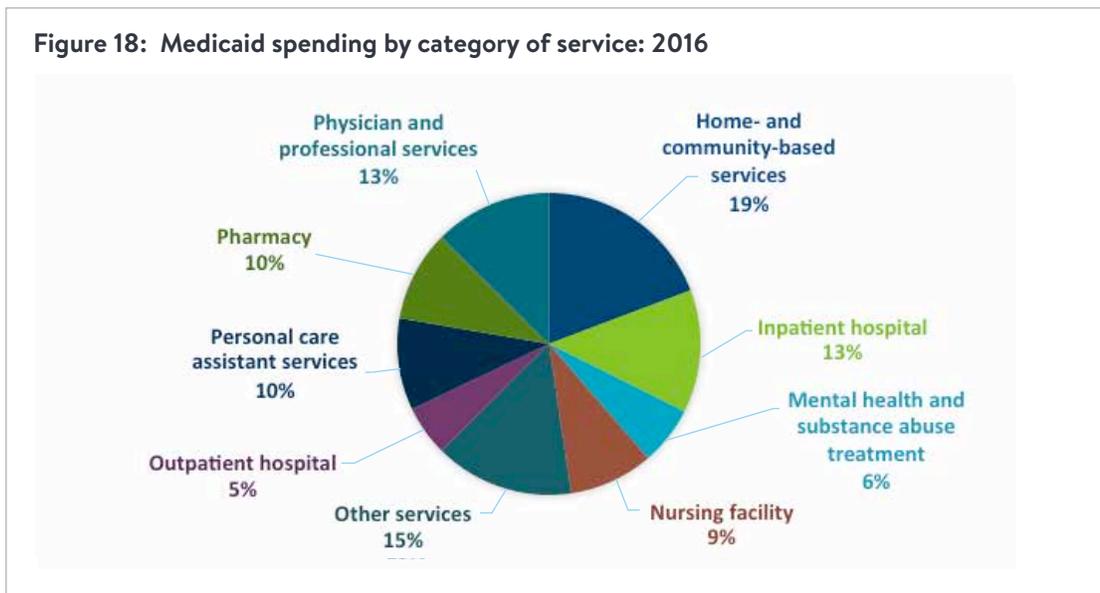


Medicaid spending by category of service

The total spending in this section includes amounts paid to providers for Medicaid services received within the calendar year by enrollees in the fee-for-service and managed care delivery systems.

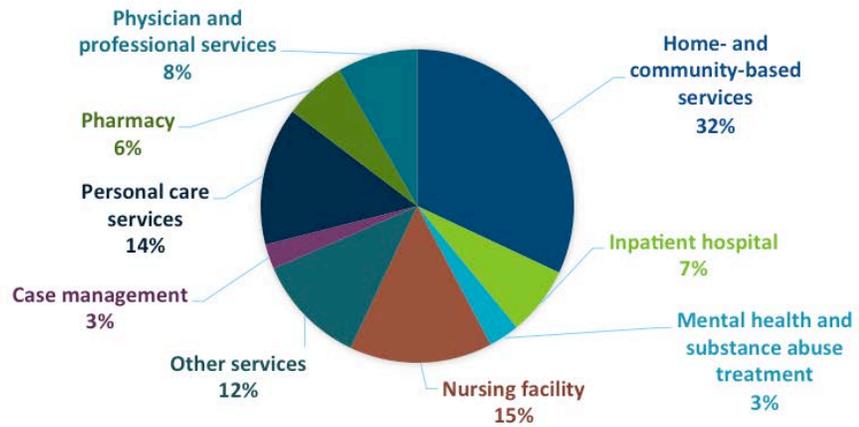
In Minnesota, total spending on Medicaid services provided to enrollees in 2016 reached approximately \$11.4 billion. The Medicaid program spent more on home and community-based services than any other category of service. Home and community-based services are generally more cost-effective and preferred by the people who rely on services. About \$3.3 billion, or 29

percent, was spent on home and community-based and personal care assistant services, which includes a range of critical care and support services that enable people to remain in the community instead of having to live in a facility or institution. Approximately \$2.1 billion, or 18 percent, was spent on hospital services, which includes inpatient admissions and outpatient facility charges for ambulatory surgeries and other services.



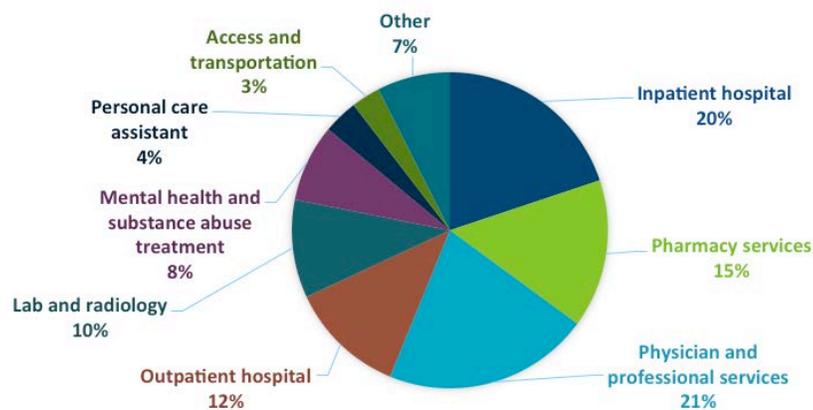
Total Medicaid spending on enrollees who are 65 or older, blind or eligible based on a disability reached around \$6.8 billion in 2016. Of that total, about \$2.1 billion, or 32 percent, was spent on home and community-based services. About \$1 billion, or 15 percent, was spent on nursing facilities while spending for personal care assistant services totaled approximately \$970 million, or 14 percent.

Figure 19: Minnesota Medicaid spending by category of service for people 65 or older, with a disability or blindness: 2016

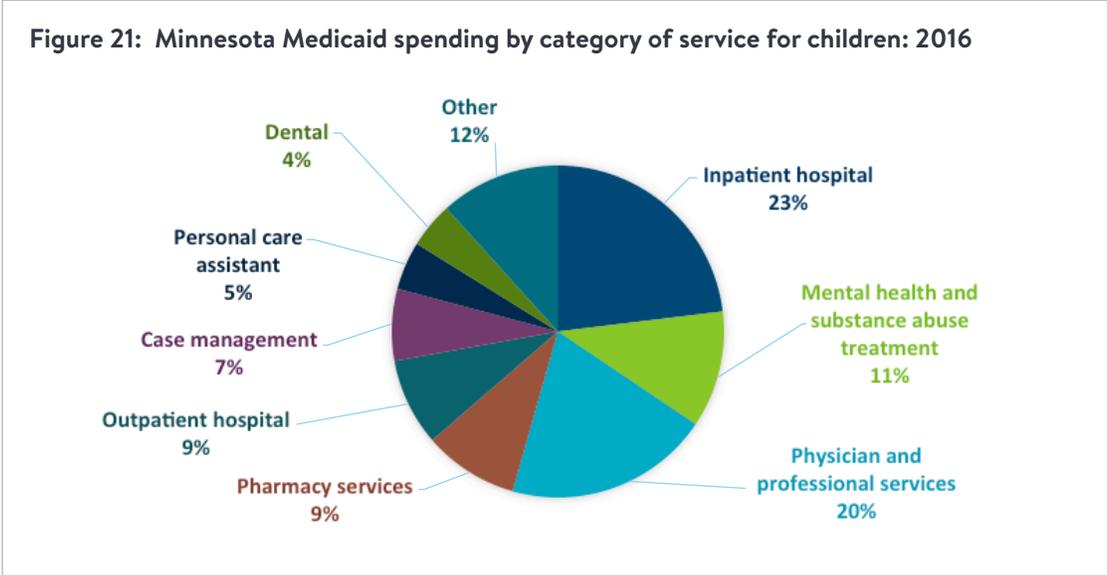


Total Medicaid spending for the approximately 195,000 parents and pregnant women enrolled in Medicaid during 2016 reached around \$1.3 billion. Of that total, about \$401 million, or 32 percent, was spent on hospital services, which includes inpatient admissions and outpatient facility charges for ambulatory surgeries and other services. Physician and professional services accounted for another 21 percent of total spending, or around \$266 million.

Figure 20: Minnesota Medicaid spending by category of service for parents: 2016



Total Medicaid spending on the nearly half million children enrolled in Medicaid during 2016 reached around \$1.6 billion. Of that total, about \$506 million, or 32 percent, was spent on hospital services, which includes inpatient admissions and outpatient facility charges for ambulatory surgeries and other services. Physician and professional services accounted for another 20 percent of total spending, or around \$320 million.



Total spending on the approximately 200,000 adults in 2016 reached over \$1.7 billion. Of that amount, about \$574 million, or 33 percent, was spent on hospital services, which includes inpatient admissions and outpatient facility charges for ambulatory surgeries and other services. Payments to outpatient pharmacy services for prescription drugs reached \$334 million, or 19 percent of the total. Physician and professional services accounted for another 16 percent of total spending, or around \$280 million, while spending on mental health and chemical dependency made up 13 percent of the total, or \$216 million.

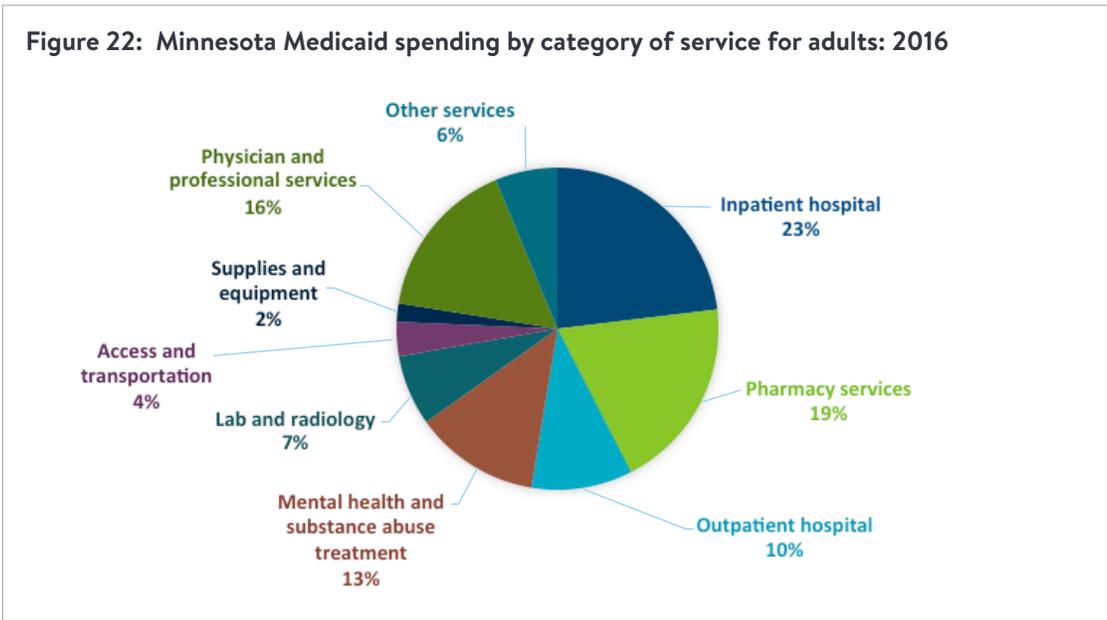


Table 6: Minnesota Medicaid spending by category of service: 2016

Category of service	Total expenditures
Home and community-based services	\$2,190,572,310
Inpatient hospital	\$1,492,849,422
Personal care assistant services	\$1,114,716,409
Pharmacy services	\$1,106,859,420
Nursing facility	\$1,027,105,836
Physician services	\$760,990,439
Professional services	\$667,156,364
Outpatient hospital	\$613,587,307
Mental health and substance use disorder treatment	\$710,175,565
Other services:	
Case management	\$312,490,136
Medical equipment, prosthetics and orthotics	\$231,591,603
Laboratory services	\$210,022,862
Radiology services	\$180,057,041
Dental	\$172,520,759
Nonemergency transportation and interpreter services	\$146,737,798
Intermediate care facility services for persons who have developmental disabilities	\$134,208,884
Ambulance services	\$104,885,277
Miscellaneous	\$108,516,316
Special education services	\$95,354,513
Total	\$11,380,398,261

Table 7 displays Medicaid spending data for 17 separate categories of health care services in both 2012 and 2016. The table includes total spending by category of service, the number of enrollees with claims for each service category and the total amount paid to providers per enrollee receiving the service. Total Medicaid spending on covered health care services increased during the five-year period by 35 percent, from \$8.4 billion in 2012 to \$11.4 billion in 2016. Total spending on most categories of health care service during the period increased more than the number of enrollees receiving those same services. The net result is an increase in the amount spent per enrollee across 15 of the 17 categories of service detailed in the table.

Changes to health care spending may result from:

- Changes to the makeup of the covered population
- Changes in the way services are delivered
- Changes to covered services or provider payment rates.

A portion of the increased spending on inpatient and outpatient hospital services may be related to a national trend toward providing more care in outpatient settings. Moving less acute patients from inpatient to outpatient settings may be less expensive overall, but the change increases the relative patient acuity within both the inpatient and outpatient settings, resulting in higher spending in both categories. (Patient acuity measures the intensity of care and services a patient requires.)

Similarly, the increase in both personal care assistant and nursing facility spending per enrollee illustrated in Table 6 may result from more people being cared for in their home and out of institutional settings. This increases the average patient acuity of the nursing facility resident and the recipient of personal care assistant services.

Finally, the nearly 30 percent increase in per enrollee spending on dental services may be a result of the Legislature restoring certain dental benefits for adults, expiring rate reductions and enacting rate increases for dental providers.



Table 7: Minnesota Medicaid spending per enrollee by category of service: 2012-2016

Category of service	2012 spending	2016 spending	Change	2012 unique enrollee count	2016 unique enrollee count	2012 per enrollee spending	2016 per enrollee spending	Change
Home and community-based services (no personal care assistant)	\$1,764,042,528	\$2,190,572,310	24.2%	59,930	67,417	\$29,435	\$32,493	10.4%
Inpatient hospital	\$1,197,325,218	\$1,492,849,422	24.7%	113,693	122,548	\$10,531	\$12,182	15.7%
Nursing facility	\$891,165,923	\$1,027,105,836	15.3%	27,666	26,084	\$32,212	\$39,377	22.2%
Personal care assistant (waiver and state plan)	\$725,578,905	\$1,114,716,409	53.6%	39,676	47,042	\$18,288	\$23,696	29.6%
Pharmacy services*	\$706,592,639	\$1,106,859,420	56.6%	610,276	821,649	\$1,158	\$1,347	16.3%
Physician services	\$552,840,850	\$760,990,439	37.7%	685,386	921,113	\$807	\$826	2.4%
Professional services	\$427,277,877	\$667,156,364	56.1%	509,861	772,599	\$838	\$864	3.1%
Outpatient hospital	\$380,391,469	\$613,587,307	61.3%	401,130	523,871	\$948	\$1,171	23.5%
Mental health	\$331,408,415	\$490,252,951	47.9%	163,150	203,349	\$2,031	\$2,411	18.7%
Lab and radiology	\$304,609,596	\$390,079,903	28.1%	543,291	716,146	\$561	\$545	-2.9%
Case management	\$243,561,503	\$312,490,136	28.3%	102,051	109,938	\$2,387	\$2,842	19.1%
Access and transportation	\$170,539,509	\$251,623,075	47.5%	165,712	196,094	\$1,029	\$1,283	24.7%
Equipment and supplies	\$164,008,383	\$231,591,603	41.2%	209,149	269,469	\$784	\$859	9.6%
Substance use disorder treatment	\$159,577,190	\$219,922,613	37.8%	24,332	32,015	\$6,558	\$6,869	4.7%
Dental	\$100,719,581	\$172,520,759	71.3%	317,851	423,576	\$317	\$407	28.4%
Special education services	\$73,787,205	\$95,354,513	29.2%	25,297	39,216	\$2,917	\$2,432	-16.6%
Other	\$221,219,664	\$242,725,200	9.7%	197,674	220,257	\$1,119	\$1,102	-1.5%

* Excludes pharmacy rebates

Chronic disease prevalence and spending

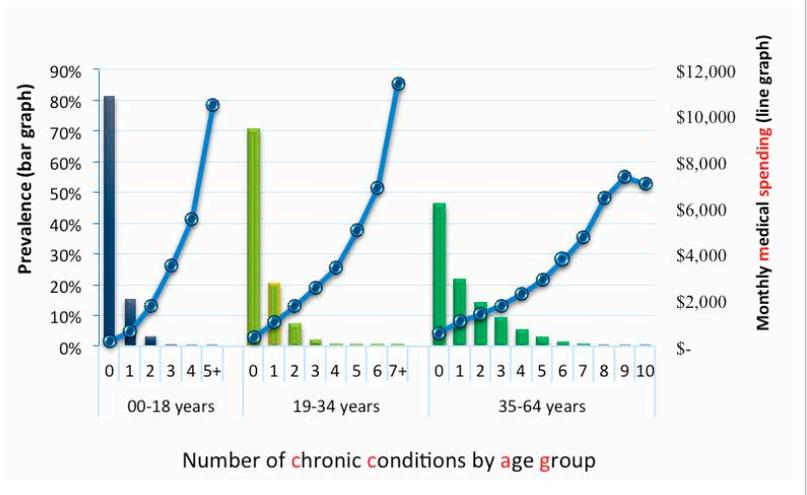
Figure 23 shows prevalence rates for the following chronic conditions: diabetes, lipid disorders, metabolic disorder, renal failure, heart disease, asthma, congestive heart failure, depression, rheumatoid arthritis, chronic obstructive pulmonary disease and high blood pressure.¹² **More than half of all enrollees age 35 to 64 had a chronic illness in 2016. About 32 percent of Medicaid enrollees under age 65 had at least one chronic condition in 2016 compared with 31 percent in 2012.** Fewer than two in 10 children had a chronic illness in 2016.

Figure 23: Prevalence of chronic conditions among Minnesota Medicaid enrollees by age: 2012-2016



Figure 24 shows the frequency distribution of these 10 chronic conditions among Medicaid enrollees under age 65 in 2016 and the average per-member-per-month spending associated with each increase in the number of chronic conditions. **Data show that with each chronic condition overall health care spending increases considerably. For example, in 2016, each additional chronic condition experienced¹³ by enrollees under age 65 resulted in an increase of nearly \$8,700 in health care claims. The increase in spending for children with multiple conditions rises much more precipitously with each additional chronic illness than with adults. Adults are more likely to receive treatment for less expensive chronic conditions such as depression and high blood pressure.**

Figure 24: Number of chronic conditions and spending among Minnesota Medicaid enrollees: 2016



¹² Prevalence rates are identified through health care claims data and only include people with claims for each specific condition. Medicaid enrollees over 65 are also covered by Medicare and were excluded from this analysis.

¹³ Data sourced from enrollees experiencing at least one and no more than five chronic conditions.

Utilization of Medicaid services

Figure 25 shows the utilization of select covered services per 1,000 enrollees and the average number of prescription drug claims per enrollee in the five-year period between 2012 and 2016. **On average in 2016, each enrollee had approximately six visits to a primary care provider, three outpatient mental health visits, and filled more than 15 prescriptions.** Dental visits averaged less than one per enrollee during the year as did emergency room visits not resulting in an admission.

The data show that over the period between 2012 and 2016, Medicaid enrollees, on average, utilized less hospital inpatient, dental, emergency room, mental health, and primary care services and filled fewer prescriptions. The most significant change appears between 2013 and 2014 and is in part due to legislative changes to the program enacted in 2013. These changes included the movement of nearly 70,000 children from MinnesotaCare to Medicaid and an increase in the income eligibility limit for adults from 75 to 133 percent of federal poverty guidelines. On average, the newly added children and adults with a higher income level utilized less care than the existing enrollee population.

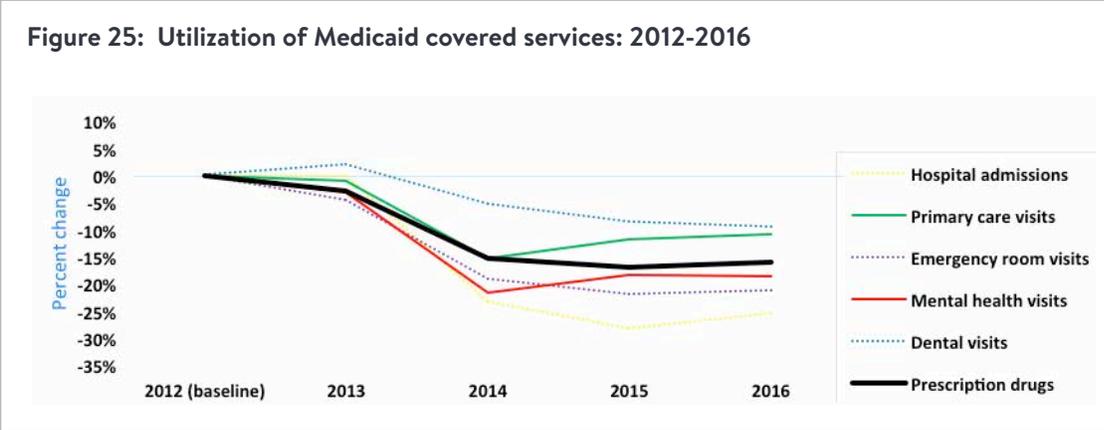


Table 8: Utilization of Medicaid services by all enrollees 2012-2016

Measure	2012	2013	2014	2015	2016	2015 to 2016 Change	2012 to 2016 Change
Hospital admissions per 1,000 enrollees	194	194	149	139	145	4.3%	-25.3%
Primary care visits per 1,000 enrollees	7010	6948	5941	6190	6257	1.1%	-10.7%
Emergency room visits per 1,000 enrollees	832	794	674	650	657	1.1%	-21.0%
Mental health visits per 1,000 enrollees	3683	3573	2882	3005	2998	-0.2%	-18.6%
Dental visits per 1,000 enrollees	935	953	884	854	845	-1.1%	-9.6%
Average prescriptions per enrollee	18	18	16	15	15	1.3%	-15.8%

Table 8 displays a decline from 2012-2016 in health care claims for emergency room visits, hospital admissions and prescription drugs across all eligibility categories and that:

- Data for both the adult and parent groups showed decreased utilization across all six service categories included in the analysis.
- Children, people age 65 or older, and those eligible based on a disability utilized more primary care and outpatient behavioral health services than parents and other adults enrolled in the program.
- Children have the highest rate of emergency room visits and utilize more dental services than the rest of the covered population.
- Adults 65 or older and people with disabilities had significantly higher hospital admission rates and filled more prescriptions than other groups.

Children’s higher use of primary care is likely related to well-baby and child visits, while the higher utilization for people with disabilities or age 65 or older is likely correlated with age or care and management of a disability that is the basis of Medicaid eligibility.

Looking at the most recent year, data show an increase in hospital utilization between 2015 and 2016 for all groups except children.

MEASURING SUCCESS

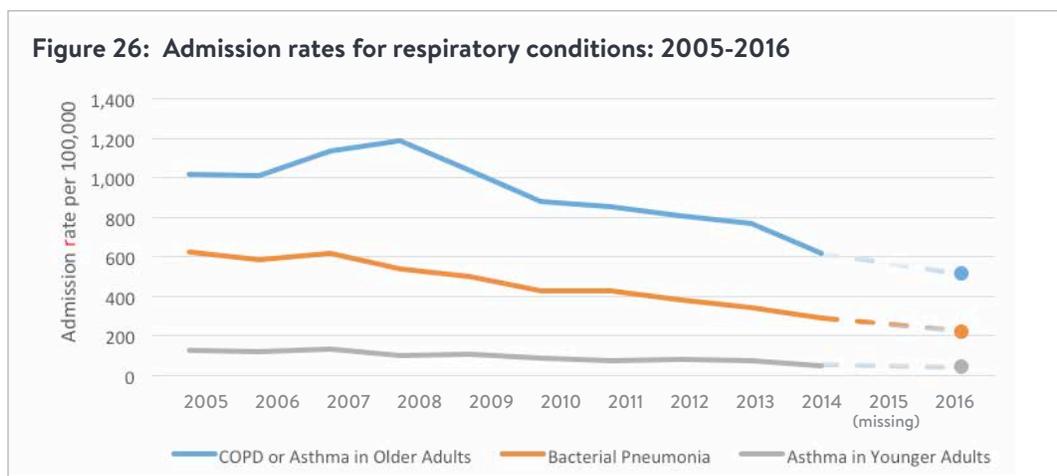
DHS uses a number of different tools to monitor the quality of health care services delivered to Medicaid and MinnesotaCare program enrollees. A combination of health care claims data and enrollee surveys allows DHS to review trends in health care access and quality in order to respond to enrollee needs. Data displayed in this section are from the DHS data warehouse and enrollee surveys and include both the Medicaid and MinnesotaCare programs.

DHS analyzes hospital inpatient data to identify admissions for certain chronic conditions that may be prevented through early intervention. The Prevention Quality Indicators identify hospital admissions for those that may be ambulatory-care sensitive, meaning they may be prevented with good outpatient care. This provides insight regarding enrollee access to quality care available outside the hospital setting.¹⁴

Figure 26 shows hospital admission rates for enrollees with respiratory-related conditions as identified through health care claims. **Between 2005 and 2016, the admission rates for asthma**

and chronic obstructive pulmonary disease for older adults with those conditions declined from 1,020 per 100,000 enrollees to 516 per 100,000 enrollees, a nearly 50-percent drop. People with bacterial pneumonia and younger adults with asthma also had a reduction in admission rates for these conditions during the period. Data from 2015 are excluded due to a mid-year change in medical coding used on health care claims.¹⁵

DHS also collects consumer feedback on how satisfied enrollees are with their health care experience. An important survey conducted annually by DHS is the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The survey instrument includes questions about provider communication, appointment waiting times, the helpfulness of administrative staff and health plan customer service. Responses are scored on a 10-point scale with 10 indicating the most satisfied. The data in Table 9 show the percentage of enrollees satisfied with specific aspects of their health care experience by providing a score of 8, 9, or 10 for each of the metrics.



¹⁴ The Prevention Quality Indicators are developed by the Agency for Healthcare Research and Quality (AHRQ), the federal agency charged with improving the safety and quality of America's health care system.

¹⁵ This refers to the International Classification Diagnosis (ICD) codes used by providers to classify diagnoses, symptoms and procedures. The codes were expanded in 2015.

Table 9: Utilization of Medicaid services by enrollee group: 2012-2016

Population/Measure	2012	2013	2014	2015	2016	2015 to 2016 change	2012 to 2016 change
Adults							
Hospital admissions per 1,000 enrollees	229	235	163	150	164	9.3%	-28.4%
Primary care visits per 1,000 enrollees	7668	7842	6466	6517	6862	5.3%	-10.5%
Emergency room visits per 1,000 enrollees	1286	1212	810	764	809	5.9%	-37.0%
Mental health visits per 1,000 enrollees	3926	4045	2683	2872	3014	4.9%	-23.2%
Dental visits per 1,000 enrollees	988	1000	807	746	735	-1.5%	-25.6%
Average prescriptions per enrollee	24.0	25.0	21.1	20.4	21.6	6.1%	-10.1%
Parents							
Hospital admissions per 1,000 enrollees	247	250	197	183	194	6.0%	-21.5%
Primary care visits per 1,000 enrollees	7776	7669	6547	6887	7010	1.8%	-9.9%
Emergency room visits per 1,000 enrollees	1038	992	830	804	796	-1.0%	-23.3%
Mental health visits per 1,000 enrollees	2137	2008	1618	1767	1790	1.3%	-16.2%
Dental visits per 1,000 enrollees	886	886	820	803	784	-2.4%	-11.5%
Average prescriptions per enrollee	15.0	15.1	14.4	14.0	13.9	-0.7%	-7.3%
Children							
Hospital admissions per 1,000 enrollees	121	119	96	90	88	-2.2%	-27.3%
Primary care visits per 1,000 enrollees	9631	9518	8819	9449	9728	3.0%	1.0%
Emergency room visits per 1,000 enrollees	1248	1181	1081	1048	1074	2.5%	-13.9%
Mental health visits per 1,000 enrollees	4003	3828	3466	4055	4093	0.9%	2.2%
Dental visits per 1,000 enrollees	1873	1956	1873	1852	1928	4.1%	2.9%
Average prescriptions per enrollee	4.6	4.4	4.3	4.1	4.1	0.0%	-10.9%
Age 65 or older, disability, blindness							
Hospital admissions per 1,000 enrollees	259	256	208	203	226	11.3%	-12.7%
Primary care visits per 1,000 enrollees	9771	9774	8783	9500	9821	3.4%	0.5%
Emergency room visits per 1,000 enrollees	804	796	719	737	787	6.8%	-2.1%
Mental health visits per 1,000 enrollees	7058	6861	6556	6611	6830	3.3%	-3.2%
Dental visits per 1,000 enrollees	929	952	947	980	971	-0.9%	4.5%
Average prescriptions per enrollee	41.6	93.5	38.1	39.3	40.6	3.3%	-2.4%

CAHPS enrollee survey results for 2016

	Overall rating of all health care	Rating for personal physician	Rating for personal specialist	Overall rating of health plan
Fee-for-service	73%	70%	69%	72%
Managed care	77%	78%	79%	80%

In addition, DHS works with other state agencies and external quality review organizations to improve quality reporting methods and help validate and analyze quality results. The Health Care Disparities Report

provides health care performance rates for people enrolled in Medicaid and MinnesotaCare through managed care plans compared to people enrolled in other health insurance coverage.

Relative to the general population, Medicaid enrollees have low incomes and are disproportionately people of color, American Indian or Alaskan Natives, people with disabilities, and older adults. These data provide insight into Medicaid enrollees' access to quality health care relative to the general population.

Table 10 details differences in health care best practices, including screening rates and rates of optimal care for several chronic health conditions, for Medicaid and MinnesotaCare enrollees relative to Minnesotans enrolled in other health insurance coverage. The results

show that 10 of the 12 statewide performance rates for Medicaid and MinnesotaCare enrollees were significantly lower than for patients insured by other health care purchasers. The performance gap between payers over time has narrowed in six of the reported measures and has grown larger in three.

Optimal care and screening rates for Medicaid and MinnesotaCare enrollees increased in most quality measures from 2015 to 2016 with statistically significant increases in the percentage of children receiving optimal asthma control.¹⁶

Table 10: Differences in optimal care and screening rates

Quality measure	2015 Medicaid, MinnesotaCare statewide average	2016 Medicaid, MinnesotaCare statewide average	2016 other purchasers* statewide average	2016 difference: Medicaid, MinnesotaCare vs. other purchasers
Chlamydia screening in women	56%	56%	48.6%	7.4%
Appropriate treatment for children with upper respiratory tract infections	92%	93.2%	89.6%	3.6%
Appropriate testing for children with pharyngitis	88.2%	89.6%	91.3%	-1.7%
Controlling high blood pressure	69.6%	70.1%	76.1%	-5.9%
Childhood immunization status (combo 3)	69.2%	71%	82.6%	-11.6%
Optional asthma control: children ages 5-17	53%	58.3%	70.5%	-12.3%
Optional asthma control: adults 18-50	41.7%	44.6%	60%	-15.4%
Breast cancer screening	61.5%	61.8%	77.9%	-16.1%
Colorectal cancer screening	53.9%	55.6%	74.7%	-19.1%
Depression remission at six months	N/A	4.8%	9.1%	-4.3%
Optimal diabetes care	N/A	33.6%	48.9%	-15.3%
Optimal vascular care	N/A	52.3%	68.2%	-15.9%

* Other purchasers: Medicare plans, employer-based coverage and other commercial insurance.

Source: Health Care Disparities Report available at <http://mncm.org/wp-content/uploads/2017/03/2016-Disparities-Report-Final-2.28.2017.pdf>, DHS and Minnesota Community Measurement.

¹⁶ Health Care Disparities Report available at <http://mncm.org/wp-content/uploads/2017/03/2016-Disparities-Report-Final-2.28.2017.pdf>, DHS and Minnesota Community Measurement.

MINNESOTA INNOVATIONS

Minnesota has long been a leader in health care from its pioneering payment-and-delivery reform efforts to its continued commitment to supporting a comprehensive and affordable health care system for people regardless of their income. For more information about this proud history in Medicaid, see the timeline on page 50. This report highlights two important innovations in Minnesota’s health care system: the Integrated Health Partnerships program and MinnesotaCare.

1. The Integrated Health Partnerships program

This nation-leading reform effort has saved the state \$212 million in three years and continues to show how financial incentives and value-based payment can lower costs and maintain or improve health care quality and outcomes. Providers participating in the program currently serve more than 460,000 Minnesotans.

The program originated from the Minnesota Legislature’s direction to DHS in 2010 to develop and implement a demonstration testing alternative health care delivery systems, including accountable care organizations (ACOs). Minnesota was one of the first states in the country to implement an ACO to improve care for people in its Medicaid program. This led to the development of the Integrated Health Partnerships (IHP) program in 2013. The goal of the program is to improve the quality and value of care provided to Medicaid and MinnesotaCare enrollees while lowering the cost through innovative approaches to care and payment.

The program structure allows participating providers to enter into an arrangement with DHS to care for enrollees under a payment model that holds the participants accountable for the costs and quality of care their Medicaid patients receive. Providers who participate work together to better coordinate and manage care, resulting in better outcomes.

IHP providers have experienced better health outcomes for their Medicaid and MinnesotaCare populations, reducing inpatient admissions by 14 percent and emergency room visits by 7 percent. They also rank highly on statewide quality benchmarks.

What is an accountable care organization?

Accountable care organizations (ACOs) are groups of doctors, hospitals and other health care providers who come together voluntarily to give coordinated, high-quality care to their Medicaid patients. This coordinated care aims to ensure that patients, especially the chronically ill, get the right care at the right time while avoiding unnecessary duplication of services and preventing medical errors.

When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it shares in the savings it achieves for the Medicaid program.

The IHP program continues to expand. Providers that deliver care for less than the targeted cost are eligible to share in the savings; some providers also share the downside risk if costs are higher than targeted. As IHPs progress into their second and third contract years, a portion of their payment is tied to their performance on quality metrics.

In 2016, IHP savings totaled more than \$45 million. This comes on top of savings of \$87.5 million in 2015, \$65.3 million in 2014 and \$14.8 million in 2013.

DHS is exploring ways to accommodate a diverse set of provider systems, add a quarterly population-based payment to providers to support their care coordination and infrastructure needs, modify the quality measurements methodology, and increase accountability for nonmedical social factors affecting the health of and disparities found within the IHP population.

2. MinnesotaCare: The first Basic Health Program

Minnesota lead the nation, as one of the earliest states to cover uninsured populations. In 1992, Gov. Arne Carlson signed into law bipartisan legislation establishing MinnesotaCare to improve the affordability of health care coverage for people ineligible for Medicaid but unable to afford other health insurance. In 1995, Minnesota received a federal waiver under section 1115 of the Social Security Act, which allowed the state to receive Medicaid matching funds to help lower the cost of coverage for this population. It provided a subsidized program for children and parents and later expanded to include adults. For more than 20 years, this signature achievement allowed hundreds of thousands of working Minnesotans to purchase affordable insurance for themselves and their families.

When Congress passed the Affordable Care Act, it created a new landscape for health care coverage. Under the law, many MinnesotaCare enrollees, along with other low- to middle-income Minnesotans, became eligible for

Maria's story

People served by providers participating in the IHP program may have stories similar to Maria's (not her real name). Maria was 27, morbidly obese and sedentary. Her diabetes was out of control. She felt stressed, anxious and angry. Then she enrolled in the care coordination program at Lake Region Healthcare in Fergus Falls. Just one year later, Maria was on her way to achieving a healthy weight, had lowered her blood sugar and felt good about life.

"I have become the person I always wanted to be and that is a person in charge of her health. That is all due to this program and (care coordinator) Nicole. I hope care coordination stays a part of the health care system forever."

-Maria

Medicaid. The law also offered states the option to implement supports for people who were still ineligible for Medicaid but did not make enough money to comfortably afford health care, even with the law's new subsidies. In 2015, Minnesota became the first state to take up the Basic Health Plan option for people with incomes up to 200 percent of federal poverty guidelines. This became Minnesota's federal funding mechanism for MinnesotaCare and the state was therefore required to sunset the existing MinnesotaCare Medicaid waiver that provided the foundation of the program before the Affordable Care Act.

Minnesota no longer receives Medicaid funding for MinnesotaCare; instead, it receives federal funds equal to 95 percent of the advanced premium tax credits that would otherwise be available to eligible people enrolled in commercial health care coverage through MNsure.

Minnesota carried MinnesotaCare forward through this new federal financing mechanism. In fiscal year 2016, federal Basic Health Plan funding covered 70 percent of MinnesotaCare's costs.

Stories of Minnesota's entrepreneurs and farmers

MinnesotaCare serves many entrepreneurs, farmers, part-time employees and other low-income workers.

Today, MinnesotaCare provides comprehensive health care coverage for more than 89,000 Minnesotans who pay no more than \$80 a month in premiums. It also helps families access care with low out-of-pocket costs compared to private market plans. The program also includes additional benefits not necessarily available or as affordable on MNsure, including dental, vision and a broad array of behavioral health benefits.

Leslea Hodgson, who raises beef cattle with her husband near Fountain, Minn., told the Star Tribune that MinnesotaCare has been a good plan, even better than an employer plan she once had. It has been essential for her and her husband, especially since farming includes a risk of injury.

"When he [her husband] didn't have any insurance, that was walking a thin line."

-Leslea Hodgson

Star Tribune, Oct. 6, 2017

As a musician, Sorum, 35, works three jobs and likes them all – but none provide benefits. She pays about \$70 a month for MinnesotaCare premiums, which are based on a sliding income scale.

"It is the best policy I've ever had. I haven't had any trouble finding care, and all of the providers that I have needed to see have accepted it."

-Sorum

TELLING THE MEDICAID STORY

1. Seniors with disabilities: Minnesota Senior Health Options

Individuals who are eligible for both Medicaid and Medicare represent the most chronically ill segments of the population. Because two programs cover them, they are often known as “dual eligible.” These dually eligible individuals account for a disproportionate share of state and federal spending for both programs. They often receive fragmented or episodic care, resulting in poor health outcomes, unnecessary spending and an inefficient system of care. Aligning Medicare and Medicaid policy and financial incentives along with further integration of service delivery is widely recognized as critical to improving the efficiency and quality of care for people with dual eligibility.

The Minnesota Senior Health Options (MSHO) program has been recognized as a national leader in aligning Medicare and Medicaid financing since 1995. MSHO combines the separate health care programs and support systems into one package, providing members the benefits they have under Medicare and Medicaid from one health plan. Instead of juggling a Medicare card, a Medicare Part D prescription drug card and a Medicaid card, MSHO members have one card for all services. Instead of receiving separate and sometimes confusing information from Medicare and Medicaid, MSHO members receive one set of materials about all their benefits. MSHO members are also assigned a care coordinator who makes it easier for them to get the health care and related support services they need.

In 2016, approximately 36,466 MSHO enrollees benefitted from a simplified and coordinated program structure.

A care coordinator’s story

Julie Serbus from Lutheran Social Services was assigned to coordinate care for an enrollee who had experienced a stroke. Before that, the enrollee lived independently in her own home. To begin work on the case, Julie arranged for an enrollee assessment when the enrollee’s son could be present because his mother’s speech was impaired from the stroke and it was difficult to understand her.

The son explained that since his mother’s discharge, he had been trying to oversee her care, ensuring she took her medications on time and helping with housekeeping and meal preparation. The enrollee had become very tearful and depressed since her stroke.

When first discharged to her home, the enrollee received temporary services such as skilled nursing for her medications and therapy. However, as a very private person, accepting services proved difficult for her. She had formed a bond with a particular nurse, and Julie was able to request that services continue from that same nurse to set up her weekly medications and ensure that her vitals were stable. Julie also arranged home-delivered meals, homemaking and home health aide services for showers.

During the assessment, Julie noticed that the woman drank Ensure as a supplement as it was easier for her to swallow. It was also convenient to drink when she felt hungry during the day and nobody was available to prepare a meal. Julie contacted the doctor for a prescription so insurance paid for the Ensure drinks because her family had been paying for it out-of-pocket.

Care coordination was instrumental to help this woman recover from the stroke. Although she had family members to help out, they all lived out of town. The woman's son was especially grateful for the services that were available through the elderly waiver. Julie continued to collaborate with the enrollee, her son, the visiting nurse and primary care doctor to ensure the enrollee got the services she needed and could continue to live in her home independently while her family also had the support they needed to take care of her.

2. Higher earning families with a child with disabilities: TEFRA option

Before 1981, a child with disabilities who needed Medicaid coverage but wanted care at home faced significant eligibility barriers because the eligibility determination process considered the income and assets of the child's parents. However, if the same child was institutionalized in a hospital, nursing home or intermediate care facility for people with developmental disabilities for 30 days or more, the parent's income was not counted under Medicaid eligibility requirements. This meant that parents had to place their child with a disability in an institutional setting in order to obtain medical care through Medicaid if their household income was above eligibility requirements.

In 1981, the Reagan Administration created the Katie Beckett waiver, which changed the Medicaid rules to make an exception allowing children with disabilities to receive care at home and receive Medicaid coverage. In 1982,

Congress created a new state plan option, known as the Katie Beckett provision, under the Tax Equity and Fiscal Responsibility Act (TEFRA). This provision created an eligibility pathway for children with disabilities or complex medical needs to receive services at home instead of in an institution. Under TEFRA, Medicaid eligibility considers only the child's income. Minnesota implemented the option in 1988.

In Minnesota, children with family incomes less than 275 percent of the federal poverty guidelines qualify for health care coverage through Minnesota's Medicaid program. They receive comprehensive coverage designed to support all children, including those with disabilities and complex medical conditions.

Higher-income families raising a child with a disability can access Medicaid services by paying a fee. This allows families to supplement services delivered through other coverage to better meet their children's needs. The payment amount is determined using a sliding scale that begins at 1.94 percent of a family's annual adjusted gross income. Fees do not exceed the cost of services delivered. If parents overpay, a credit is applied to the following year's fee or they receive a refund. Children are not refused services because their parents fail to pay the fee. However, the state may take action to recover the fee.

Approximately 2,893 children on average benefited from the TEFRA option in 2016.



An invitation in closing...

The core values Minnesota has long demonstrated – creating more secure lives for Minnesotans through innovation and partnership – will be more crucial than ever in the coming months and years. Minnesotans will be called upon to sustain the progress made while working to address new and complex challenges. More Minnesotans than ever before have health coverage, for example, but health disparities across racial and ethnic lines persist. The cost-effectiveness of Minnesota’s Medicaid program has increased while uncertainty surrounding federal Medicaid funding has become the new normal.

Join the conversation and DHS’ efforts: Use this report to talk about Medicaid in your community; help improve next year’s report with your suggestions or send DHS your Medicaid story.

APPENDIX A: Covered services in Minnesota’s Medicaid program

Benefit	Federally required	Citations (Social Security Act and 42 Code of Federal Regulations)
Certified pediatric or family nurse practitioner services	Mandatory	1905(a)(21), 440.166Appendix A: Optional and mandatory services
Cessation of tobacco use by pregnant women	Mandatory	1905(a)(4)(D)
Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)	Mandatory	1905(a)(4)(B), 1902(a)(43), 1905(r)
Emergency transportation (ambulance)	Mandatory	1905(a)(29), 440.170(a)
Family planning services and supports	Mandatory	1905(a)(4)(c), 441 Subpart F
Freestanding birth center services	Mandatory*	1905(a)(28)
Home health services: nursing services, home health aide, durable medical equipment	Mandatory	1905(a)(7), 440.70(b), 441.15
Inpatient hospital services	Mandatory	1905(a)(1), 440.10
Laboratory and X-ray services	Mandatory	1905(a)(3), 440.30
Nursing facility services	Mandatory	1905(a)(4)(A), 440.40(a), 1905(a)(29), 440.170(d)
Nurse midwife services	Mandatory	1905(a)(17), 440.165
Outpatient hospital services	Mandatory	1905(a)(2)(A), 440.20(a)
Physician services, including medical and surgical services performed by a dentist	Mandatory	1905(a)(5)(A) - (B), 440.50(a)
Rural health clinics and Federally Qualified Health Centers	Mandatory	1905(a)(2)(B), 1905(a)(2)(C), 440.20(b) and (c), 1910(a)
Clinic services	Optional	1905(a)(9), 440.90
Community first services and supports provided under 1915(i or k) and 1115 waiver	Optional	1915(k)
Dental services	Optional	1905(a)(10), 440.100
Dentures	Optional	1905(a)(12), 440.120(b)
Emergency hospital services	Optional	1905(a)(29), 440.170(e)
Eyeglasses	Optional	1905(a)(12), 440.120(d)
Diagnostic, screening and preventive Services	Optional	1905(a)(13), 440.130
Home and community-based services (1915(c) waivers)	Optional	1915(c)
Home health: physical therapy, occupational therapy, and speech, hearing and language	Optional	1905(a)(7), 440.70(b), 441.15
Hospice	Optional	1905(a)(18)
Inpatient psychiatric services for people 21 and younger	Optional	1905(a)(16), 440.160
Intermediate care facility services for people who have developmental disabilities	Optional	1905(a)(15), 440.150
Other services by licensed practitioners**	Optional	1905(a)(6), 440.60

* When licensed under state law.

** Podiatry, optometry, chiropractic, acupuncture, mental health, public health, nurse practitioners and medication therapy management.

Outpatient physical therapy, occupational therapy, and speech, hearing and language	Optional	1905(a)(11), 440.110
Personal care assistant services	Optional	1905(a)(24), 440.167
Prescribed drugs	Optional	1905(a)(12), 440.120(a)
Private duty nursing services	Optional	1905(a)(8), 440.80
Prosthetic devices	Optional	1905(a)(12), 440.120(c)
Rehabilitative services: substance use and mental health	Optional	1905(a)(13), 440.130(d)
Respiratory care services	Optional	1905(a)(20), 1902(e)(9)(A)-(C), 440.185
Services for people age 65 and older in institutions for mental diseases	Optional	1905(a)(14), 440.140
Targeted case management	Optional	1915(g), 440.169
Tuberculosis-related services, including case management	Optional	1905(a)(19)

APPENDIX B: Optional and mandatory Medicaid eligibility groups

Description	Average enrollment in 2016	Total spending in 2016	Percent above optional standards	Estimated optional spending
Federally funded mandatory groups				
People up to age 26 who were formerly in foster care	699	\$4,719,171	N/A	N/A
People who receive IV-E foster care or adoption assistance	10,422	\$138,200,810	N/A	N/A
Parents and children with incomes above eligibility limits receiving months of transitional Medicaid	4,217	\$15,883,480	N/A	N/A
Employed people eligible under their Supplemental Security Income status but who do not receive a cash benefit	4,373	\$131,717,276	N/A	N/A
People who receive subsidies for Medicare savings plans	14,557	\$22,540,580	N/A	N/A
People who have an emergency medical need and are ineligible for Medicaid due to their immigration status	2,042	\$32,278,396	N/A	N/A
Federally funded mandatory groups with incomes above federal requirements				
Children younger than 2	39,392	\$118,423,899	4.70%	\$5,589,608
Children ages 2 to 18	404,293	\$1,009,619,035	20.30%	\$204,649,778
Pregnant women	20,541	\$200,850,395	11.20%	\$22,495,244
Children to age 1 who are born to women enrolled in Medicaid	31,381	\$296,756,633	11.20%	\$33,236,743
Parents and relative caretakers of children age 18 or younger (133 percent of federal poverty guidelines)	166,897	\$921,210,658	60.90%	\$560,740,928
People 65 or older with incomes at or below 100 percent of federal poverty guidelines	24,231	\$589,023,791	67.10%	\$394,999,355

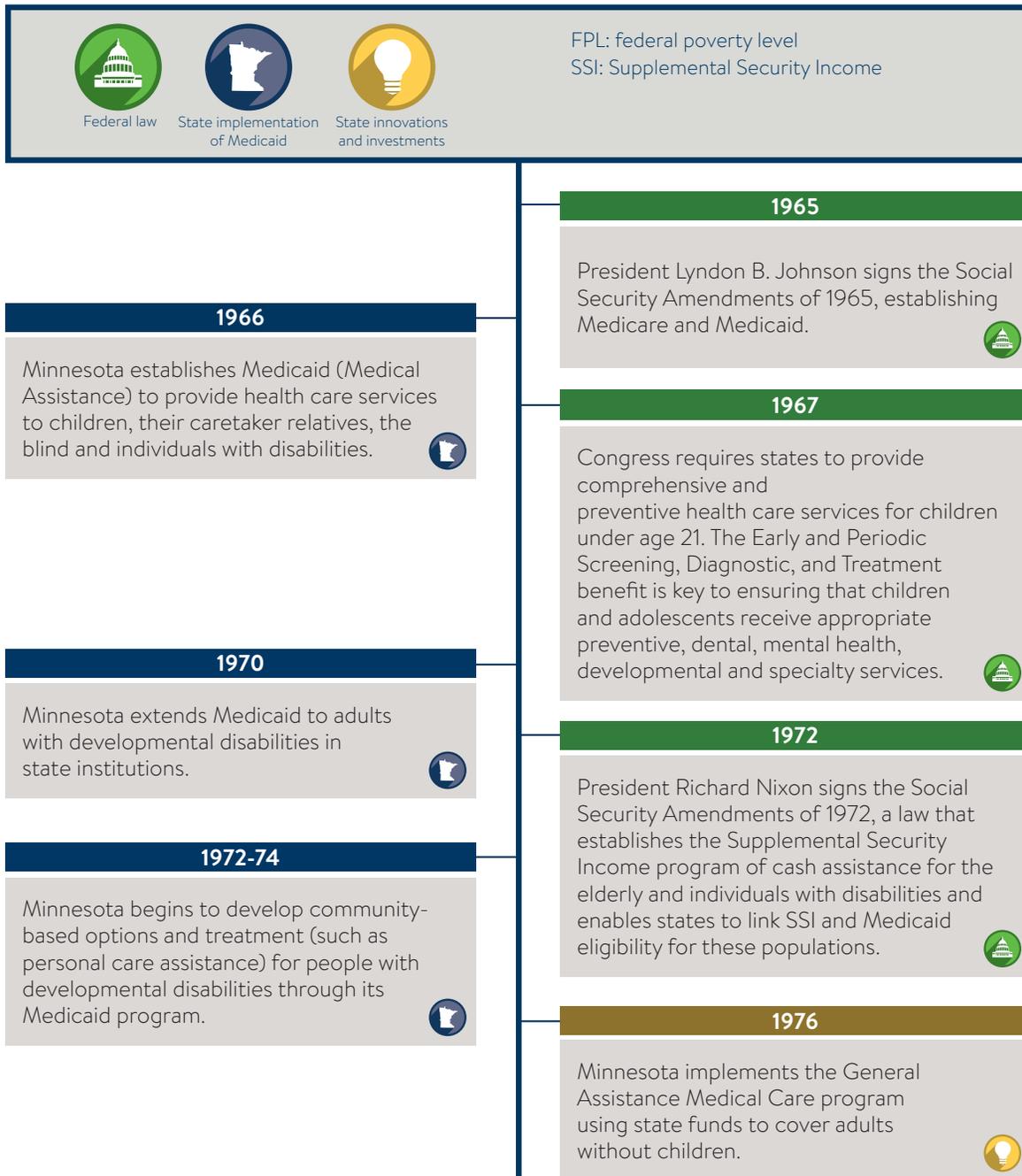
People who are blind or who have a disability with incomes at or below 100 percent of federal poverty guidelines	87,938	\$3,160,836,134	65.10%	\$2,056,123,905
Optional groups receiving federal funding				
Women receiving treatment for breast and cervical cancer	260	\$4,932,804	100%	\$4,932,804
Adults ages 21-64 who do not live with their children under age 21	198,997	\$1,726,797,677	100%	\$1,726,797,677
People ages 19 and 20 who have a disability	2,684	\$126,570,027	100%	\$126,570,027
Employed people with disabilities (MA-EPD)	9,540	\$275,359,045	100%	\$275,359,045
Children with a disability who are ineligible for Medicaid when counting their parents income (TEFRA)	2,893	\$71,862,865	100%	\$71,862,865
Children receiving state-funded adoption assistance	2,254	\$21,484,781	100%	\$21,484,781
Children ages 19 and 20	22,748	\$78,440,071	100%	\$78,440,071
People age 65 or older who are ineligible for Medicaid but who are receiving home and community-based services	2,533	\$26,808,671	100%	\$26,808,671
Coverage of family planning services and related health care services for people who are not on Medicaid	11,023	\$9,119,445	100%	\$9,119,445
Pregnant women who are ineligible for Medicaid due to their immigration status	1,758	\$19,669,318	100%	\$19,669,318
Medicaid for people who are age 65 or older, blind or who have a disability who qualify with a spenddown	45,861	\$2,411,727,047	100%	\$2,411,727,047
Medicaid for parents and caretakers, children and pregnant women who qualify with a spenddown	422	\$8,743,033	100%	\$8,743,033
State-funded optional groups				
Coverage of HIV and AIDS medications for people who are HIV-positive	1,410	\$7,648,375	100%	\$7,648,375
Coverage for people who receive services through the Center for Victims of Torture	215	\$1,537,899	100%	\$1,537,899
Coverage for people living in institutions for mental diseases	2,530	\$22,402,674	100%	\$22,402,674
Total (all groups)	1,116,111	\$11,455,163,990	71%	\$8,090,939,293

APPENDIX C: Medicaid in Minnesota: 1965-2017



MEDICAID IN MINNESOTA

1965–1979: The beginning of Medicaid



MEDICAID IN MINNESOTA

1980–1990: Expanding Medicaid coverage for pregnant women, children and other vulnerable populations

 Federal law	 State implementation of Medicaid	 State innovations and investments	<p>EPSDT: Early and Periodic Screening, Diagnostic, and Treatment</p> <p>FPL: federal poverty level</p> <p>OBRA: Omnibus Budget Reconciliation ACT</p>
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1980

Minnesota establishes a basic application form for all financial assistance programs – the state’s first attempt to simplify the application process for all human services and establish a “one-door” policy. 

1982

Minnesota receives federal approval for the elderly waiver to provide home and community-based services to older adults who would otherwise live in nursing homes. 

1986

President Ronald Reagan signs the OBRA of 1986 requiring states to provide Medicaid coverage for treatment of emergency medical conditions for individuals otherwise eligible for Medicaid, but who do not qualify based on their immigration status.



To address the issue of “patient dumping” and refusal by some hospitals to treat patients without insurance, Congress enacts the Emergency Medical Treatment and Labor Act to ensure public access to emergency services regardless of ability to pay. 

1987

Minnesota establishes its federally mandated Emergency Medical Assistance program, allowing Medicaid to cover emergency medical care provided to noncitizens. 

1981

The OBRA of 1981 establishes freedom of choice waivers and home and community-based services waivers and allows states to start making additional payments to hospitals serving a disproportionate share of Medicaid and low-income patients, also known as disproportionate share hospital (DSH) payments. 

1986

Minnesota receives federal waiver approval to provide home and community-based services to additional individuals who would otherwise live in hospitals or nursing homes. 

1987

President Reagan signs the OBRA of 1987 giving states the option of extending coverage to pregnant women and infants with family income at or below 185 percent FPL.

The act also adds quality standards and revises monitoring and enforcement procedures for nursing homes in response to well-documented problems facing Medicaid-eligible seniors in nursing homes. 

Continued on next page

1988

Tax Equity and Fiscal Responsibility Act or “Katie Beckett” option goes into effect in higher income families with a child with a disability to enroll in Medicaid. Parents contribute by paying a parental fee. The law is designed to allow children to be cared for at home rather than in an institution and address affordability and coverage gaps in the commercial insurance market for families with children with disabilities.



1988

The Medicare Catastrophic Coverage Act of 1988 requires states to use Medicaid funds to pay Medicare premiums and cost sharing for low-income Medicaid beneficiaries with incomes at or below 100 percent FPL, known as the Qualified Medicare Beneficiary program. The act also requires states to phase in Medicaid coverage for pregnant women and infants in families with incomes at or below 100 percent FPL by July 1, 1990.



1989

Minnesota enacts spousal impoverishment policies to protect the income and assets of people living in the community with spouses residing in long-term care facilities.



1989

President George H. W. Bush signs the OBRA of 1989 requiring states to provide Medicaid coverage to pregnant women and children up to age 6 with family incomes at or below 133 percent FPL.

The act also expands the EPSDT Medicaid benefit for children under 21 to include needed diagnostic and treatment services even if the services are not covered for adults.

In addition, the act requires states to cover services provided by Federally Qualified Health Centers.



MEDICAID IN MINNESOTA

1990–2010: New innovations and investments
in expanding coverage through Medicaid



Federal law



State implementation
of Medicaid



State innovations
and investments

FPL: federal poverty level
OBRA: Omnibus Budget
Reconciliation Act

1992

Gov. Arne Carlson signs into law bipartisan legislation establishing MinnesotaCare to improve the affordability of health coverage for people ineligible for Medicaid but unable to afford other health insurance. This legislation follows several years of efforts to expand coverage under the Children’s Health Plan. MinnesotaCare begins as a subsidized coverage program for children, their parents and siblings and later expands to include adults without dependents.

In 1995, Minnesota receives federal funding to operate MinnesotaCare as a federal Medicaid waiver program.



Minnesota receives authorization for the brain injury waiver which provides funding for home and community-based services for children and adults who have an acquired or traumatic brain injury. The goal of the program is to make it possible for people with a brain injury to live safely in their community rather than in an institution.



1990

President George H.W. Bush signs the OBRA of 1990 requiring states to provide Medicaid coverage to children ages 6 through 18 in families with income at or below 100 percent FPL, with coverage phased in one year at a time and completed by 2002.

The act also requires states to use Medicaid funds to pay Medicare premiums for Medicare beneficiaries with incomes between 100 percent and 120 percent FPL, also known as Specified Low-Income Medicare Beneficiary (federal) and Service Limited Medicare Beneficiary (Minnesota).

In addition, the act establishes the Medicaid prescription drug rebate program, requiring pharmaceutical manufacturers to give “best price” rebates to states and the federal government.



1994

The Legislature invests in MinnesotaCare by requiring providers to pay a 2 percent provider tax. Along with federal waiver funding, this new state revenue source is used to provide coverage for low- and moderate-income working families.



1995

Minnesota implements the Minnesota Senior Health Option, becoming the first state with a program that allows seniors to get all of their benefits from the same health plan for Medicare and Medicaid, including elderly waiver and nursing facility coverage.



1995

Congress passes and President Bill Clinton vetoes legislation converting Medicaid to a block grant to states.



Continued on next page

1996

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 repeals the individual entitlement to cash assistance and replaces it with the Temporary Assistance for Needy Families block grant to states, ending the formal link between cash assistance and Medicaid eligibility.

The act also prohibits states from using federal Medicaid funds to cover nonemergency services for many lawfully present immigrants entering the United States. on or after Aug. 22, 1996, during their first five years after establishing legal residence in the country.



1997

President Clinton signs the Balanced Budget Act of 1997 establishing the Children's Health Insurance Program, which gives states the option to cover uninsured children with family income at or below 200 percent FPL who are ineligible for Medicaid. Minnesota implemented this option in 1997.

The law also provides states with a new state option to mandate Medicaid beneficiary enrollment into managed care.

In addition, the law creates an optional Medicaid buy-in eligibility group to allow working individuals with disabilities to have higher incomes and maintain their Medicaid coverage.



1999

The Ticket to Work and Work Incentives Improvement Act of 1999 gives states the option to extend Medicaid coverage to employed individuals with disabilities with incomes above 250 percent FPL and impose income-related premiums for the coverage for individuals between ages 16 and 65.



The U.S. Supreme Court rules in *Olmstead v. L.C.* that the ADA can, under certain circumstances, require states to provide community-based services to individuals when institutional care is inappropriate.



1999

Minnesota implements Medical Assistance for Employed Persons with Disabilities, allowing people with disabilities to receive Medicaid coverage and work while earning any level of income.



2000

Congress passes the Breast and Cervical Cancer Treatment and Prevention Act, giving states the option to extend Medicaid coverage to uninsured women with breast or cervical cancer regardless of income or resources.

Minnesota implemented this option in 2002.



2001

The Centers for Medicare and Medicaid Services approve the state's request to extend Minnesota Senior Health Option coverage to people under the age of 65 with disabilities. The Minnesota Disability Health Options expansion program provides flexible alternative services beyond the scope of Medicaid and waiver services. A key feature of the program assigns all members a health coordinator to help them navigate the health care system and get the services they need. The program ended in 2010.



2002

Minnesota expands mental health benefits, enabling Medicaid to cover certain services previously deemed "nonmedical" in nature but essential to mental health care including Intensive Residential Treatment Services and Adult Rehabilitative Mental Health Services.



2003

Minnesota provides state-funded Medicaid to people ineligible for federally funded Medicaid if they receive care and rehabilitation services at the Center for Victims of Torture, a one-of-a-kind program in the country with no immigration-related requirements or income or asset limits.



2006

Minnesota implements the Minnesota Family Planning Program through a Medicaid waiver demonstration project providing family planning and related services to men and women ages 15 to 50, who have family income at or below 200 percent FPL and are not enrolled in Medicaid or MinnesotaCare.



2007

Gov. Tim Pawlenty creates the Health Care Transformation Task Force and charges it with developing a statewide action plan for transforming the health care system to improve affordability, quality, access and the health of Minnesotans.



Gov. Pawlenty signs a bipartisan mental health act making Minnesota one of the first states to develop a model mental health benefit set that covers a comprehensive set of mental health benefits under its Medicaid program.



The Great Recession begins in the United States.

2008

The Health Care Transformation Task Force recommends the following state health care reforms:

- Establishing guaranteed issue in the individual market and phasing out the Minnesota Comprehensive Health Association (Minnesota's high-risk pool)
- Eliminating insurers' ability to charge different rates based on health status
- Requiring all Minnesotans to obtain health insurance by 2011
- Establishing a health insurance exchange for consumers in the individual and small group markets to purchase health insurance
- Establishing an independent board to define an essential health benefit
- Creating a premium subsidy program for people who cannot afford insurance and establishing an affordability threshold for people below 400percent FPL.

Many of these innovations and health care reform concepts become part of the Affordable Care Act in 2010.



2008

The Legislative Commission on Health Care Access issues its recommendations related to coverage:

- Establishing a health insurance exchange
- Providing premium or insurance subsidies or another form of financial assistance to people with incomes below 400 percent of FPL
- Subsidizing coverage for those with employer-sponsored insurance to ensure that employee costs do not exceed 6 percent of household income
- Increasing the MinnesotaCare income limit to 300 percent FPL for families and households without children and restricting premiums to 6 percent of household income
- Rationalizing affordability definition for MinnesotaCare recipients with access to employer-sponsored insurance and eliminating the insurance barrier
- Eliminating the limited hospital benefit in MinnesotaCare



Minnesota establishes Special Needs Basic Care, a voluntary managed care program that combines Medicaid and Medicare financing and services for people with disabilities ages 18 through 64 enrolled in Medicaid. Enrollees may have a care coordinator or navigator to help them get health care and support services.



2009

President Barack Obama signs the Children's Health Insurance Program Reauthorization Act of 2009 to bolster funding for CHIP and related program outreach. It gives states the option to expand coverage for lawfully present immigrant children and pregnant women. Minnesota implements this option in 2010.

President Obama signs the American Recovery and Reinvestment Act:

- Providing a temporary increase in the federal matching rate for Medicaid.
- Providing funding for health information technology and community health centers.
- Including a provision subsidizing 65 percent of the COBRA premium for certain individuals and their families. Minnesota implements the COBRA Premium Subsidy program requiring the Department of Human Services to pay the remaining 35 percent of the premium for people who would otherwise be financially eligible for Medical Assistance or MinnesotaCare.



2009

Due to a significant budget deficit, Gov. Tim Pawlenty vetoes General Assistance Medicare funding for 2011. Additionally, he reduces the GAMC budget by \$15 million for 2010.

As a result, Minnesota creates the Coordinated Care Delivery Systems program to retain much of the eligibility of the GAMC program and find a new way to fund and deliver care to this population. GAMC recipients can enroll in CCDS to receive all medically necessary services from a participating hospital system.

CCDS was designed as limited block grant-type funding to eligible hospitals to provide services and coordinate care for enrollees. CCDS hospitals provided services to 70 percent of the total GAMC population for nine months – from June 2010 through February 2011 – until Gov. Mark Dayton signed an executive order instructing the Department of Human Services to implement Medicaid expansion.



The Great Recession begins in the United States.

2008

The Health Care Transformation Task Force recommends the following state health care reforms:

- Establishing guaranteed issue in the individual market and phasing out the Minnesota Comprehensive Health Association (Minnesota's high-risk pool)
- Eliminating insurers' ability to charge different rates based on health status
- Requiring all Minnesotans to obtain health insurance by 2011
- Establishing a health insurance exchange for consumers in the individual and small group markets to purchase health insurance
- Establishing an independent board to define an essential health benefit
- Creating a premium subsidy program for people who cannot afford insurance and establishing an affordability threshold for people below 400percent FPL.

Many of these innovations and health care reform concepts become part of the Affordable Care Act in 2010.



2008

The Legislative Commission on Health Care Access issues its recommendations related to coverage:

- Establishing a health insurance exchange
- Providing premium or insurance subsidies or another form of financial assistance to people with incomes below 400 percent of FPL
- Subsidizing coverage for those with employer-sponsored insurance to ensure that employee costs do not exceed 6 percent of household income
- Increasing the MinnesotaCare income limit to 300 percent FPL for families and households without children and restricting premiums to 6 percent of household income
- Rationalizing affordability definition for MinnesotaCare recipients with access to employer-sponsored insurance and eliminating the insurance barrier
- Eliminating the limited hospital benefit in MinnesotaCare



Minnesota establishes Special Needs Basic Care, a voluntary managed care program that combines Medicaid and Medicare financing and services for people with disabilities ages 18 through 64 enrolled in Medicaid. Enrollees may have a care coordinator or navigator to help them get health care and support services.



MEDICAID IN MINNESOTA

2010–2017: Implementation of the Affordable Care Act
in Minnesota

 Federal law	 State implementation of Medicaid	 State innovations and investments	CCDS: Coordinated Care Delivery Systems FPL: federal poverty level GAMC: General Assistance Medical Care
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2010

President Obama signs into law the Patient Protection and Affordable Care Act of 2010. Important Medicaid provisions include:

- Expanding Medicaid eligibility to adults without children with family income at or below 133 percent FPL.
- Simplifying Medicaid application and enrollment
- Increasing the federal match rate for the newly eligible
- Innovative opportunities to improve care and control costs

The law also creates the Center for Medicare and Medicaid Innovation to test, evaluate and share innovative payment and service delivery models across the country.

- New funding for community-based long-term services and supports
- New investments in information technology and data, as well as program transparency



2010

Minnesota is one of the first states to implement an accountable care organization model in its Medicaid program, which later became the Integrated Health Partnerships program. The program strives to deliver higher quality and lower cost health care through innovative approaches to care and payment.



2011

Gov. Dayton moves forward with implementation of the Affordable Care Act and makes Minnesota one of six states to implement Medicaid expansion early for certain adults without children who have incomes at or below 75 percent FPL. As a result of the expansion, the Department of Human Services terminates CCDS and enrolls all GAMC enrollees in Medicaid.



2011

The Department of Human Services conducts procurement for managed care organizations to serve the seven county metropolitan area's families and children. For the first time, the state includes a competitive price bid as part of the process, requiring health plans to compete on quality and price to achieve better value for the state and public program enrollees.

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Jensen Settlement: The Jensen Settlement Agreement is the result of a lawsuit alleging that residents of the former Minnesota Extended Treatment Options program were unlawfully and unconstitutionally secluded and restrained. The comprehensive plan of action outlines the path that the Department of Human Services will take to come into compliance to meet the terms of the agreement. Part of this agreement is to develop and implement an Olmstead Plan that uses measurable goals to increase the number of people with disabilities receiving services in the most integrated setting appropriate to their individual needs.



Continued on next page

2013

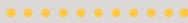
Minnesota establishes a state-based exchange called MNsure for people to apply for health insurance and assistance, including Medicaid, MinnesotaCare or advanced premium tax credits to purchase individual health insurance. Open enrollment for the Affordable Care Act begins Oct. 1.



Minnesota is the first state to enact a Basic Health Program under the Affordable Care Act to improve and maintain its MinnesotaCare program.



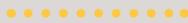
The Center for Medicare and Medicaid Innovation awards Minnesota, one of a handful of states, a State Innovation Model grant of more than \$45 million to improve health in communities, provide better care, and lower health care costs.



Minnesota expands the children's mental health benefit set to support children and their families in the community.



The first six provider groups begin participating in the Integrated Health Partnerships start participating on Jan. 1 covering more than 100,000 Medicaid beneficiaries and ultimately saving \$14.8 million in this year.



The Centers for Medicare and Medicaid Services approves Minnesota's Reform 2020 waiver, a five-year demonstration that provides federal financial support for Minnesota's Alternative Care program. The program helps seniors at risk of nursing home placement to stay in their homes, and prevents or delays a person from spending down resources and being eligible for Medicaid.



The 2015 legislature and governor created a task force on health care financing to advise them on strategies to increase access and improve the quality of health care for Minnesotans.



Procurement for the children and family contracts serving 27 counties in Greater Minnesota includes a competitive price bid in 2013.



2012

The Healthy Minnesota Contribution Program goes into effect for individuals previously in MinnesotaCare between 200-250 percent FPL. The individuals receive a state subsidy to help with the purchase of an individual health insurance plan in lieu of receiving coverage through MinnesotaCare.

The amount of the defined contribution is determined by applying a sliding fee scale based on age, household size and household income. The defined contribution is increased by 20 percent for people who were turned down coverage through the individual market so that they could purchase coverage through the Minnesota Comprehensive Health Association, the state's high-risk pool.



2014

The Affordable Care Act goes into effect nationwide.

In Minnesota, Medicaid expansion is fully phased in to cover adults without children up to 133 percent FPL. Individuals can no longer have overlapping Medicaid and MinnesotaCare coverage. People who apply for coverage are evaluated for eligibility in the following order: Medicaid, MinnesotaCare, tax credits to purchase individual health insurance or to purchase individual health insurance at full cost if ineligible for tax credits.



The state Legislature directs the Department of Human Services to seek federal authority to operate the Minnesota Family Planning Program as an option under the state's Medicaid plan. Minnesota implements this option in 2017.



2015

On Jan. 1, 2015, MinnesotaCare transitions from a Medicaid waiver program to a Basic Health Program under the Affordable Care Act, no longer covering parents with incomes of 200-275 percent FPL.



2016

Minnesota launches behavioral health home services, which is a model of care focused on integration of primary care, mental health services, and social services and supports for adults diagnosed with mental illness or children diagnosed with emotional disturbance.



In 2016, state health care financing task force makes recommendations for reducing the affordability cliff between public and individual coverage in Minnesota by expanding MinnesotaCare to 275 percent FPL and producing savings and improved outcomes through MNsure, the state's health insurance exchange, and the use of accountable care organizations.



2017

Minnesota extends MinnesotaCare coverage to individuals approved for the Deferred Action for Childhood Arrivals program.



Gov. Dayton signs comprehensive substance use disorder reform package that expands the array of substance use disorder services and begins the transformation of the substance use disorder system of care from an acute episodic model to a model focused on long-term health.



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Thank you to the many team members who devoted time, expertise and heart to this year's Medicaid Matters report.

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