MN HOUSE RESEARCH

Service Delivery Under Medical Assistance and MinnesotaCare

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Executive Summary

The Medical Assistance (MA) program funds covered services for a range of enrollee groups using fee-for-service and managed care delivery systems. The MinnesotaCare program funds covered services mainly for adults without children and parents and relative caretakers, using primarily a managed care delivery system.[1]

Certain provisions of Minnesota law apply fully or in part to both MA and MinnesotaCare, and to service delivery under both fee-for-service and managed care. This document provides an overview of shared statutory requirements that apply to varying degrees across programs or delivery methods, related to covered services, enrollee cost-sharing, provider reimbursement, and mandated insurance benefits. An appendix provides a table that summarizes these shared statutory requirements.

Contents

Managed care organization and related terms: In this document, ***managed care organization*** (MCO) is used to refer to managed care plans such as health maintenance organizations (HMOs), and also to county-based purchasing plans. MA and MinnesotaCare use a number of terms to refer to the entities eligible to perform the functions of an MCO and contract with DHS to provide services to enrollees under managed care. For example, the term ***demonstration provider*** as used under MA (Minn. Stat. § 256B.69, subd. 2) includes HMOs, community integrated service networks, accountable provider networks, and county-based purchasing plans. MinnesotaCare defines ***participating entity*** (Minn. Stat. § 256L.01, subd. 7) as including HMOs and other health carriers, county-based purchasing plans, integrated health partnerships, and other health care provider networks. At this time, HMOs and county-based purchasing plans are the only entities providing managed care services under MA and MinnesotaCare.

[1] MinnesotaCare services are delivered through fee-for-service only in limited circumstances – e.g. to Deferred Action for Childhood Arrivals (DACA) grantees, to comply with enrollee appeal decisions that require retroactive coverage, or in cases of agency or technology system errors.

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Covered Services

Overview

MCOs delivering services under MA managed care must generally provide the same preventive, acute, and basic care services that must be provided under MA fee-for-service.[2] Some long-term care and other specified services are provided to MA managed care enrollees under fee-for-service.

MinnesotaCare covered services are based on those covered under MA, but vary by eligibility group. MinnesotaCare enrollees who are children under age 19 or pregnant women receive coverage for all or nearly all MA services. MinnesotaCare enrollees who are nonpregnant adults without children receive more limited coverage that includes most of the services provided under MA.

Medical Assistance

Minnesota Statutes, section 256B.0625 lists MA covered services and related requirements, and provides cross-references to other sections of law governing the provision of specific services. The coverage requirements of this section initially applied to MA fee-for-service delivery (the section being enacted at a time when fee-for-service was the only MA service delivery method) but now also generally apply to MCO services delivered through MA managed care.

MCOs (i.e., HMOs and county-based purchasing plans) are required to authorize and arrange for all needed health services, including but not limited to the services listed in section 256B.0625.[3] In addition, county-based purchasing plans are required to provide all services included in prepaid health care (i.e., managed care) programs under section 256B.69, subdivisions 1 to 22 (these are the services that HMOs and other MCOs must provide).[4]

In practice, this means that MCOs must provide most of the preventive, acute, and basic care services covered under fee-for-service. MCOs are also required to provide elderly waiver services and up to 180 days of nursing facility services (up to 100 days for adults with disabilities under age 65).[5] A number of long-term care and other services are not part of the MCO contract with DHS and are instead provided by MA to MCO enrollees under fee-for-service. These include, but are not limited to, the following: abortion, federally qualified health center

[2] Under fee-for-service MA, health care providers bill and are reimbursed by DHS for the services they provide to MA recipients. Reimbursement to a provider generally increases with the amount of services delivered by that provider to MA enrollees. Under MA managed care, MCOs receive a monthly capitated payment from DHS for each enrollee; this payment is fixed and does not vary with the actual services provided to the enrollee. The MCO, rather than DHS, contracts with and reimburses health care providers for services provided to MCO enrollees.

[3] Minn. Stat. § 256B.69, subd. 6.

[4] Minn. Stat. § 256B.692, subd. 1.

[5] Minn. Stat. § 256B.69, subds. 6a, 6b, and 28.

services, Indian Health Services, nursing facility services beyond 180 days, state-operated dental clinic services, and waivered services other than elderly waiver services.[6]

MCOs under MA may provide services that are in addition to, or provided as alternatives to (in lieu of), regular MA covered services, subject to federal requirements.[7]

MinnesotaCare

Minnesota Statutes, section 256L.03 specifies MinnesotaCare covered services and related requirements. MCOs and other participating entities[8] are required to authorize and arrange for the provision of the services specified in that section.[9] This section requires MinnesotaCare to cover the services reimbursed under chapter 256B (Medical Assistance), with the exception of: special education services, home care nursing services, adult dental care services other than the specified services under MA, orthodontic services, nonemergency medical transportation, personal care assistance and case management services, behavioral health home services, and nursing home and intermediate care facility services. This section also sets Minnesota requirements for several specific services.

The benefit set described above applies to enrollees who are adults without children or who are parents or caretakers. Enrollees who are children are eligible for coverage of all services covered by MA under chapter 256B, except that special education services are not covered and abortion services are covered under MinnesotaCare criteria.[10] Enrollees who are pregnant women are eligible for coverage of all services covered by MA under chapter 256B.[11]

The practical effect of these various statutory cross-references to services covered under MA is that expanding MA benefits generally results in a similar expansion of MinnesotaCare benefits, unless the enacting law or current law specifies otherwise.

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[6] DHS model contracts for families and children, seniors, and Special Needs Basic Care are available online at: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/contracts.jsp

[7] Alternative services are provided in place of regular MCO covered services, and can only be provided with the consent of the enrollee. Alternative services must be medically appropriate and cost-effective, and their provision must result in the same or better health status and quality of life as the provision of regular MCO covered services. The cost of alternative services must be taken into account when calculating capitation rates (while the cost of additional services is not considered in calculating capitation rates). See Code of Federal Regulations, title 42, section 438.3, paragraph (e).

[8] MinnesotaCare, as the state's Basic Health Program under the Affordable Care Act, is required by that act to contract with participating entities to provide standard health plans to MinnesotaCare enrollees. Participating entities are described in the text box on terminology on page 1. Standard health plans must cover the health care services specified in section 256L.03.

[9] Minn. Stat. § 256L.12, subd. 7, cl. (1), and 256L.121, subd. 1.

[10] Minn. Stat. § 256L.03, subd. 1a. The MinnesotaCare criteria for abortion coverage are listed in section 256L.03, subdivision 1, paragraph (b). Abortion coverage is provided under fee-for-service in both MinnesotaCare and MA.

[11] Minn. Stat. § 256L.03, subd. 1b.

As is the case under MA (see above), MCOs under MinnesotaCare may provide services that are in addition to, or provided as alternatives to, regular MinnesotaCare covered services, subject to federal requirements.

Cost-sharing

Overview

MA applies the same cost-sharing requirements[12] to both fee-for-service and managed care enrollees. The one exception is that MCOs are not required to charge a family deductible. MinnesotaCare cost-sharing is different from, and higher than, cost-sharing under MA.

Medical Assistance

MA cost-sharing requirements for enrollees are listed in section 256B.0631. Certain groups of eligible individuals, including but not limited to children under age 21, pregnant women, and American Indians, are exempt from cost-sharing. Specified services, including but not limited to emergency, family planning, and certain preventive services, are also exempt from cost-sharing.

MCOs are required to charge enrollees cost-sharing as specified in section 256B.0631, except that the family deductible is waived.[13]

The practical effect of this is that modifying MA cost-sharing will affect both the fee-for-service and managed care delivery systems.

MinnesotaCare

MinnesotaCare cost-sharing is governed by section 256L.03, subdivision 5. MinnesotaCare cost-sharing requirements for enrollees are different from, and higher than, those under MA. The specific dollar amounts for MinnesotaCare cost-sharing are not specified in law.[14] The commissioner of human services is instead required to adjust copayments, coinsurance, and

[12] Cost-sharing refers to the portion of health care costs for covered services for which an enrollee is responsible for paying out of pocket. Common methods of cost-sharing include coinsurance (under which the enrollee pays a percentage of costs), copayments (under which the enrollee pays a fixed dollar amount), and deductibles (the amount an enrollee must pay before their coverage takes effect).

[13] Minn. Stat. § 256B.0631, subd. 1, para. (c); DHS Model Contract for Prepaid Medical Assistance and MinnesotaCare – Families and Children, January 1, 2022, available online at https://mn.gov/dhs/assets/2022-fc-model-contract_tcm1053-515037.pdf.

[14] MinnesotaCare cost-sharing dollar amounts are listed in the contracts between MCOs and DHS, and in Department of Human Services, *Minnesota Health Care Programs Summary of Coverage, Cost Sharing and Limits*, https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3860-ENG.

deductibles to maintain the actuarial value[15] of the MinnesotaCare benefit set at 94 percent. Cost-sharing does not apply to children under age 21, pregnant women, and American Indians.

Provider Reimbursement

Overview

The MA program sets provider payment rates under fee-for-service. MCOs providing services under MA and MinnesotaCare may set their own provider payment rates for most services, but must use the same payment rates for a specific service under both MA and MinnesotaCare.

Medical Assistance

The MA statutes set fee-for-service provider payment rates and methodologies for various service categories. For example, requirements for pharmacy and nonemergency medical transportation reimbursement are specified in section 256B.0625 and requirements for physician and dental reimbursement are specified in section 256B.76.

MCOs may establish their own provider payment rates for most service categories. These payment rates may sometimes be based on the MA fee-for-service rates or set at a percentage of those rates, but this is at the discretion of the MCO and is not a requirement.

There are some services for which MCOs are required by law to reimburse providers at the MA fee-for-service rate. For example, managed care and county-based purchasing plans must reimburse dental providers and critical access mental health providers at a level at least equal to the fee-for-service payment rate, and are required to increase dental payment rates by at least the amount of the critical access dental provider rate increase.[16]

The practical effect of allowing MCOs to establish their own provider payment rates is that legislatively authorized increases to MA fee-for-service provider payment rates do not automatically result in increases to MCO provider payment rates, unless the legislation specifically requires this. Legislation sometimes directs DHS to increase MCO capitation payments to reflect a fee-for-service provider rate increase. Unless specified in the legislation, MCOs are not required to use the additional capitation payments to increase payment rates for those provider types targeted by the fee-for-service payment rate increase.[17]

[15] Actuarial value is the percentage of total average costs for covered benefits that will be paid by an enrollee's health insurance plan. For example, if a plan has an actuarial value of 70 percent, the plan will pay 70 percent of the costs and the enrollee is responsible for the remaining 30 percent.

[16] Minn. Stat. §§ 256B.76, subd. 4; 256B.763, para. (h).

[17] As part of the standard capitation rate-setting process, DHS evaluates MA fee-for-service rate changes to determine if they will have a material impact on capitation rates (e.g., if MCO provider payment rates are based on the fee-for-service rate), and may adjust capitation rates to reflect this impact.

MinnesotaCare

As is the case under MA, MCOs may establish their own provider reimbursement rates for most services, subject to specified exceptions and the general requirement in section 256L.11, subdivision 1, that provider reimbursement under MinnesotaCare be at the same rates and conditions as established for MA. This requirement has been interpreted by DHS to mean that an MCO must use the same provider payment rates and conditions across both MA and MinnesotaCare.[18] This also means that any MA fee-for-service provider payment requirements that apply to MA MCOs would also apply to MinnesotaCare MCO provider payment rates, unless an exception is provided in statute.

In addition, MinnesotaCare law includes provider reimbursement requirements related to specific services. For example, MCOs must reimburse dental providers at a level at least equal to the MA fee-for-service rate and must increase payment rates to critical access dental providers by at least the amount of the critical access dental provider rate increase.[19]

Mandated Insurance Benefits

Overview

HMOs delivering services to MA and MinnesotaCare enrollees must comply with mandated health benefit requirements that apply to HMOs generally, unless the enacting law provides an exemption for MA and MinnesotaCare. If there is no exemption for MA and MinnesotaCare, county-based purchasing plans delivering services to enrollees of these programs must comply with mandated health benefit requirements to the extent this is required in section 256B.692 (the law governing county-based purchasing plans). HMO benefit mandates are not normally applied to MA fee-for-service, unless the mandate is included in the laws governing MA covered services.

MA and MinnesotaCare

The MA and MinnesotaCare managed care delivery systems contract with HMOs and county-based purchasing plans to deliver services to enrollees. HMOs must generally comply with state laws that apply to private sector insurers (referred to in law as “health carriers” or “health plan companies”), including requirements that health insurers include coverage for specified benefits in the insurance plans they issue to enrollees. These benefit requirements are often referred to as mandated health insurance benefits. County-based purchasing plans, while not considered to be health carriers or health plan companies, are subject to mandated health insurance benefit requirements to the extent compliance with these requirements is required by section 256B.692.[20]

[18] DHS e-mail communication, July 14, 2022.

[19] Minn. Stat. § 256L.11, subds. 6a and 7.

[20] Section 256B.692, subdivision 2, paragraph (c), requires county-based purchasing plans to comply with specified provisions of law, and “all applicable” provisions of chapter 62Q, including specified sections of that chapter. The

In recent years, legislation establishing private sector insurance mandates has often specified whether or not the mandate applies to MA and MinnesotaCare. If the intent of the legislation is to apply the mandate to these state programs, the legislation will often include an amendment to section 256B.0625 that adds the mandated benefit as an MA covered service. Amending section 256B.0625 to add the mandated benefit as an MA covered service applies the requirement to MA fee-for-service delivery, and by statutory cross-references to MCOs providing services under MA and MinnesotaCare.

If legislation establishing a private sector insurance mandate is enacted without a specific reference to MA and MinnesotaCare, HMOs would be expected to include the service when delivering services to MA and MinnesotaCare enrollees. County-based purchasing plans would be expected to include the service to the extent compliance with the insurance mandate is required by section 256B.692. However, the cost to HMOs and county-based purchasing plans of delivering the service would not be counted by DHS when calculating MA and MinnesotaCare capitation rates, since the service would not be considered an MA or MinnesotaCare covered service.[21] MA fee-for-service would not be required to cover the service.

specified sections include, but are not limited to: section 62Q.50 (required coverage of prostrate screening); section 62Q.52 (required coverage of certain off-label drugs for treatment of cancer); and section 62Q.527 (required coverage for nonformulary antipsychotic drugs). Paragraph (d) of that subdivision also gives the commissioner of health all enforcement and rulemaking powers available under chapters 62D, 62J, 62N, and 62Q, with respect to the counties operating county-based purchasing plans. While discussions on this issue are ongoing, the Minnesota Department of Health and DHS at this time assume that section 256B.692, subdivision 2, requires county-based purchasing plans to comply with insurance benefit mandates in chapters 62D, 62J, 62N, and 62Q.

[21] DHS e-mail communication, July 14, 2022.

Appendix: Summary of Shared Statutory Requirements

Service Delivery Characteristic	MA: Fee-for-Service (FFS)	MA: HMOs	MA: County-based Purchasing (CBP) Plan	MinnesotaCare: HMOs	MinnesotaCare: CPB Plan
Covered Services	Specified in § 256B.0625 and other sections	Same as FFS (most services provided by the HMO; others under FFS)	Same as FFS (most services provided by the CBP plan; other under FFS)	Most or all MA services, depending upon eligibility group	Most or all MA services, depending upon eligibility group
Cost-Sharing	Specified in § 256B.0631	Same as FFS, except no family deductible	Same as FFS, except no family deductible	Different from and higher than MA	Different from and higher than MA
Provider Reimbursement	Set by DHS/state law	Set by the HMO for most services	Set by the CBP plan for most services	Set by HMO (at same rate as MA)	Set by CBP plan (at same rate as MA)
Mandated Insurance Benefits	Covered only if enacting law specifically includes MA	Covered unless enacting law specifically excludes MA	Covered only if enacting law specifically includes MA, or if the law governing CBP plans requires the coverage	Covered unless enacting law specifically excludes MA or MinnesotaCare*	Covered only if enacting law specifically includes MA or MinnesotaCare,* or if the law governing CBP plans requires the coverage

* If the law enacting a mandated benefit specifically includes MA in its scope, this usually has the effect of including MinnesotaCare, since MinnesotaCare law requires coverage of MA covered services (with specified exceptions for certain eligibility groups).

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