INFORMATION BRIEF
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Medical Assistance

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

Contents

Administration

Congress

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

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

Medicaid is administered at the federal level by the Center for Medicare and Medicaid Services (CMS), an agency within DHHS. CMS was formerly known as the Health Care Financing Administration (HCFA). CMS issues regulations and guidelines for Medicaid that states are required to follow. These regulations and guidelines are found in Title 42 of the Code of Federal Regulations and in the state Medicaid Manual.

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

Minnesota State Legislature

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

- eligibility requirements, including specific income and asset limits for MA recipients
- administrative requirements, such as the duties of the state Department of Human Services and the counties, and provisions for the central disbursement of MA payments to providers
- a listing of services provided under MA
- requirements for HMOs and other managed care plans participating in the Prepaid Medical Assistance Program (PMAP)
- provisions for establishing payment rates for MA providers (Provisions relating to hospital payment rates are found in Minnesota Statutes, chapter 256.)

Minnesota Department of Human Services (DHS)

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

Counties

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

Eligibility Requirements

MA pays for the cost of medical services provided to eligible needy persons who cannot afford the cost of health care. MA can retroactively pay for the cost of health care services provided to an individual up to three months before the month of application, if the individual would have been eligible for MA at the time the services were provided. Generally, MA is available to families, children, pregnant women, the elderly, and persons with disabilities, who meet the program's income and asset standards.

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

w.dhs.state.mn.us/main/groups/county_access/documents/pub/DHS_id_016958.hcsp).

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

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

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

Citizenship

In order to be eligible for MA, an individual must be a citizen of the United States or a noncitizen who meets specified immigration criteria (see MA Eligibility for Noncitizens table). The state has chosen to provide MA coverage for all groups of noncitizens for which MA eligibility is mandatory or optional under federal welfare law. The state has also chosen to provide MA coverage for noncitizens who would have been eligible for MA except for passage

of federal welfare reform legislation. MA coverage for this group of individuals is funded solely by state dollars, and the coverage is referred to as MA without federal financial participation (FFP). Nonimmigrants and undocumented persons are eligible only for MA coverage of emergency and pregnancy-related services.

MA Eligibility for Noncitizens

Immigration Status	MA with FFP	MA without FFP	Emergency MA with FFP[1]
Refugees, asylees, persons granted withholding of deportation, veterans/active duty military personnel and families, Cuban/Haitian entrants, Amerasians, American Indians born in Canada, American Indians born outside of the U.S. who are members of a federally recognized tribe	Yes	N/A	N/A
Following individuals residing in the U.S. prior to 8/22/96: lawful permanent residents,[2] noncitizens paroled into the U.S.[3] for at least one year, conditional entrants, battered noncitizens and their children	Yes	N/A	N/A
Following individuals who entered the U.S. on or after 8/22/96: lawful permanent residents,[4] noncitizens paroled into the U.S. for less than one year, conditional entrants, battered noncitizens and their children	No, until five years after entry	Yes, if not eligible for MA with FFP	Yes
Others lawfully residing in the U.S.[5] on 8/22/96 and receiving SSI	Yes	N/A	N/A
Others lawfully residing in the U.S.	No[6]	Yes	Yes
Nonimmigrants[7] and undocumented persons	No[6]	No, except for postnatal care for uninsured pregnant women	Yes

Source: Department of Human Services

[1] Emergency MA with FFP covers MA services necessary to treat an emergency medical condition, including labor and delivery. For noncitizens eligible for MA with FFP, the emergency MA with FFP category is not applicable because emergency services are included in the regular set of MA services for which FFP is received.

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

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

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

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

[6] The federal State Children's Health Insurance Program (SCHIP) provides an enhanced federal match for prenatal care and labor and delivery for uninsured pregnant women.

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

Residency

In order to be eligible for MA, an individual must be a resident of Minnesota. A Minnesota resident is a person who has established a residence in Minnesota, is determined to be a Minnesota resident under federal law,[8] or is a migrant worker as defined in Minnesota Statutes, section 256B.06, subdivision 3.

Eligible Categories of Individuals

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

- families with dependent children
- pregnant women
- children under age 21
- aged, blind, and disabled persons, including most persons eligible for either the Minnesota Supplemental Aid (MSA) or Supplemental Security Income (SSI) programs
- children eligible for or receiving state or federal adoption assistance payments
- individuals with excess income belonging to a group eligible for MA coverage who qualify by spending down their income (see page 7)

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

Income Limits

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

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

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

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

The table on pages 8 and 9 lists the income standard, asset standard, and covered benefits for each of the principal eligibility groups. (Eligibility criteria for other eligibility groups such as disabled adult children and disabled widows and widowers can be found in Minnesota Statutes, sections 256B.055 and 256B.057.) Tables showing allowable income by household size for the various eligibility groups are included at the end of this information brief.

Transitional MA[9]

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

Asset Limits

MA has two main asset limits. One applies to persons who are aged, blind, or disabled and the other to parents in MA-eligible families. Children under age 21 and pregnant women are exempt from any asset limit. In addition, different asset limits apply to some of the smaller MA eligibility groups (see table on pages 8 and 9).

Aged, blind, or disabled. Persons who are aged, blind, or disabled need to meet the asset limit specified in Minnesota Statutes, section 256B.056, subdivision 3. This asset limit is $3,000 for an individual and $6,000 for two persons in a household, with $200 added for each additional dependent. Certain items are not considered assets when determining MA eligibility for persons who are aged, blind, or disabled, including the following:

- the homestead
- household goods and personal effects
- personal property used as a regular abode
- a burial plot for each member of the household
- life insurance policies and assets for burial expenses, up to the limits established for the Supplemental Security Income (SSI) program
- capital and operating assets of a business necessary for the person to earn an income

[9] Transitional MA is contingent on federal funding. Federal funding is scheduled to expire on December 31, 2005, unless re-authorized by the U.S. Congress.

- insurance settlements for damaged, destroyed, or stolen property are excluded for nine months, and may be excluded for up to nine additional months under certain conditions
- a motor vehicle with a market value of less than $4,500; or that is necessary for obtaining health services, employment, or performing essential daily tasks; or that is modified for a handicapped person

Parents in MA-eligible families. Since July 1, 2002, a uniform asset limit, identical to that which is used for the MinnesotaCare program, has applied to parents in MA-eligible families (see Minnesota Statutes, section 256B.056, subdivision 3c). This asset limit is $10,000 in total net assets for a household of one person, and $20,000 in total net assets for a household of two or more persons. Certain items are not considered assets when determining MA eligibility for parents in MA-eligible families, including the following:

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

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

Eligibility on the Basis of a Spenddown

Individuals who, except for excess income, would qualify for coverage under one of the MA categories described above can qualify for MA through a "spenddown." Under a spenddown, an individual reduces his or her income by incurring medical bills in amounts that are equal to or greater than the amount by which his or her income exceeds the relevant spenddown standard for the spenddown period (see table below for the spenddown standards). Unpaid medical bills incurred before the time of application for MA can be used to meet the spenddown requirement.

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

MA Spenddown

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

MA Eligibility – Income and Asset Limits – Benefits

Eligibility Category	Income Limit	Asset Limit	Benefits
Children under age two	≤ 275% of FPG	None	All MA services
Children under age two [10]	> 275% and ≤ 280% of FPG	None	All MA services
Children two through 18 years of age	≤ 150% of FPG[11]	None	All MA services
Children 19 through 20 years of age	≤ 100% of FPG	None	All MA services
Pregnant women	≤ 275% of FPG[12]	None	All MA services
Parents or relative caretakers of dependent children on MA	≤ 100% of FPG	Uniform MA/ MinnesotaCare asset standard ($10,000 for households of one and $20,000 for households of two or more)	All MA services
Aged, blind, disabled	≤ 100% of FPG	MA asset standard ($3,000 for households of one and $6,000 for households of two, with $200 for each additional dependent)	All MA services
Qualified Medicare Beneficiaries (QMBs)	≤ 100% of FPG	$10,000 for households of one and $18,000 for households of two or more	Premiums, coinsurance, and deductibles for Medicare Parts A and B

[10] Funded through the federal State Children's Health Insurance Program (SCHIP) with an enhanced federal match.

[11] This income limit was reduced from 170 percent to 150 percent of FPG on July 1, 2004. (See Laws 2003, 1st spec. sess., ch. 14, art. 12, § 20, and rider in art. 13C, § 2, related to a federal appropriation.)

[12] This income limit was scheduled to be reduced to 200 percent of FPG on July 1, 2004. This reduction has not been implemented by DHS due to concerns related to federal maintenance of effort requirements and the potential loss of federal SCHIP funding. (See DHS bulletin 04-21-09, DHS Clarifies the Medical Assistance Income Standard for Pregnant Women, June 28, 2004; also see Laws 2003, 1st spec. sess., ch. 14, art. 12, § 19, and rider in art. 13C, § 2, related to a federal appropriation.)

Eligibility Category	Income Limit	Asset Limit	Benefits
Service Limited Medicare Beneficiaries (SLMBs)	> 100% but < 120% of FPG	$10,000 for households of one and $18,000 for households of two or more	Medicare Part B premium only
Qualifying Individuals (QI)–Group 1 [13]	≥ 120% but < 135% of FPG	$10,000 for households of one and $18,000 for households of two or more	Medicare Part B premium only
Qualified Working Disabled Adults	≤ 200% of FPG	Must not exceed twice the SSI asset limit	Medicare Part A premium only
Disabled children eligible for services under the TEFRA children's home care option[14]	≤ 100% of FPG[15]	None	All MA services
Employed persons with disabilities	No income limit	$20,000	All MA services

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Institutional Residence

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

[13] Eligibility for persons in this group is contingent on federal funding. Federal funding is scheduled to expire on September 30, 2007, unless re-authorized by the U.S. Congress.

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

[15] Only the income of the child is counted in determining eligibility.

Benefits

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

Federally Mandated Services Are Available to All MA Recipients

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

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

Optional Services Are Also Provided to Minnesota's MA Recipients

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

- Audiologist services
- Case management for seriously and persistently mentally ill persons and for children with serious emotional disturbances
- Case management and directly observed therapy for people with tuberculosis
- Chiropractor services
- Christian Science Sanitoria
- Clinic services
- Dental services[16]
- Other diagnostic, screening, and preventive services

[16] Coverage of dental services for adults who are not pregnant is subject to a $500 annual limit. Emergency services, dentures, and extractions related to dentures are excluded from the annual limit. Effective January 1, 2006, no annual limit will apply.

- Emergency hospital services
- Extended services to women
- Hearing aids
- Home and community-based waiver services
- Hospice care
- Some Individual Education Plan (IEP) services provided by a school district to disabled students
- Some services for residents of Institutions for Mental Diseases (IMDs)
- Inpatient psychiatric facility services for persons under age 22
- Intermediate care facility services, including services provided in an intermediate care facility for persons with mental retardation (ICF/MR)
- Medical equipment and supplies
- Medical transportation services
- Mental health services
- Nurse anesthetist services
- Certified geriatric, adult, OB/GYN, and neonatal nurse practitioner services
- Occupational therapy services
- Personal care assistant services
- Pharmacy services[17]
- Physical therapy services
- Podiatry services
- Private duty nursing services
- Prosthetics and orthotics
- Public health nursing services
- Rehabilitation services, including day treatment for mental illness
- Speech therapy services
- Vision care services and eyeglasses

Copayments

MA enrollees are subject to the following copayments:

- $3 per nonpreventive visit for services delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist
- $3 for eyeglasses
- $6 for nonemergency visits to a hospital emergency room

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

- $3 per brand-name prescription and $1 per generic prescription, subject to a $20 per month limit (effective January 1, 2006, the $20 per month limit is reduced to $12). Antipsychotic drugs are exempt from copayments when used for the treatment of mental illness.

Children and pregnant women are exempt from copayments; other exemptions also apply.

Health care providers are responsible for collecting the copayment from enrollees; MA reimbursement to a provider is reduced by the amount of the copayment. Providers cannot deny services to enrollees who are unable to pay the copayment, unless they routinely refuse services to individuals with uncollected debt. In this case, the provider may include unpaid copayments as uncollected debt and may deny services to an enrollee after giving advance notice.

Some Services Are Provided in Minnesota Under a Federal Waiver

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

The Elderly Waiver (EW) provides community-based care for elderly individuals who are MA eligible.

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

The Home and Community Based Waiver for Persons with Mental Retardation or Related Conditions (MR/RC) provides community-based care to persons diagnosed with mental retardation or related conditions who are at risk of placement in an ICF/MR.

The Community Alternative Care (CAC) waiver provides community-based care for chronically ill individuals who are under age 65 and are either residing in a hospital or at risk of inpatient hospital care.

The Community Alternatives for Disabled Individuals (CADI) waiver provides community-based care to disabled individuals under age 65 who are residing in, or are at risk of placement in, a nursing home.

The Traumatic Brain Injury (TBI) waiver provides community-based care to persons under age 65 diagnosed with traumatic or acquired brain injury who are residing in, or are at risk of placement in, a nursing home.

For each of the federally approved waiver programs, the costs of caring for an individual in the community cannot exceed the cost of institutional care.

Medicaid Managed Care

MA enrollees receive services under a fee-for-service system (described in the next section), through prepaid health plans under the Prepaid Medical Assistance Program (PMAP), or through a county-based purchasing initiative.

Under PMAP, health maintenance organizations (HMOs), and other prepaid health plans receive a capitated payment[18] from DHS for each MA enrollee, and in return are required to provide enrollees with all MA covered services, except for home and community-based waiver services, some nursing facility services, and intermediate care facility services for persons with mental retardation.[19]

Under PMAP, enrollees in participating counties select a specific prepaid plan from which to receive services, obtain services from providers in the plan's provider network, and follow that plan's procedures for seeing specialists and accessing health care services. Enrollees are allowed to switch health plans once a year during an open enrollment period.

Generally, MA recipients in participating counties who are in families with children or elderly are required to enroll in PMAP. Most persons who are blind or disabled, and persons belonging to other specific groups, are exempted from PMAP enrollment. As of September 2005, PMAP operated in 63 counties.

PMAP Reimbursement Rates

Prepaid health plans receive a capitation rate for each enrollee. Fifty percent of the capitation rate is based upon the enrollee's age, sex, Medicare status, institutional status, basis of eligibility, and county of residence. The remaining 50 percent of the rate is risk adjusted to reflect the overall health status of the plan's enrollees.

DHS does not regulate prepaid health plan reimbursement rates paid to health care providers under contract with or employed by a prepaid health plan to serve PMAP enrollees. These reimbursement rates are a matter of negotiation between the health care provider and the prepaid health plan.

County-based Purchasing

Counties implementing county-based purchasing are responsible for providing all covered services to enrollees, either through their own provider networks or by contracting with prepaid health plans and providers. DHS payments to counties cannot exceed PMAP payment rates to

[18] A capitated payment is a predetermined, fixed payment per enrollee that does not vary with the amount or type of health care services provided. A prepaid health plan reimbursed under capitation does not receive a higher payment for providing more units of service or more expensive services to an enrollee, nor does it receive a lower payment for providing fewer units of service or less expensive services to an enrollee.

[19] Prepaid health plans are responsible for up to 180 days of nursing home services for enrollees not residing in a nursing facility at the time of enrollment in PMAP. Beginning no earlier than July 1, 2006, prepaid health plans will also be responsible for covering elderly waiver services.

prepaid health plans. As of September 2005, three county-based purchasing initiatives (involving 20 counties) were operational. Another three counties are planning to participate in county-based purchasing initiatives.

Managed Care Enrollment

As of September 2005, 284,207 MA enrollees received services through either PMAP or county-based purchasing.

Fee-for-Service Provider Reimbursement

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

Under the fee-for-service system, MA recipients, with some exceptions, are free to receive services from any medical provider participating in the MA program. As a condition of participating in the MA program, providers agree to accept MA payment (including any applicable copayments) as payment in full. Providers in Minnesota are prohibited from requesting additional payments from MA recipients, except when the recipient is incurring medical bills in order to meet the MA spenddown (discussed earlier in the eligibility section).

DHS has established a central system for the disbursement of MA payments to providers. DHS uses different methods to reimburse different types of providers; the reimbursement methods for major provider groups are described below.

Physicians and Other Medical Services

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

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

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

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

Hospitals

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

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

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

Intermediate Care Facilities for Persons with Mental Retardation or Related Conditions (ICFs/MR)

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

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

Nursing Facilities

Nursing facilities participating in the MA program are reimbursed under two different reimbursement systems. As of October 1, 2005, 100 nursing facilities were reimbursed under a cost-based system (sometimes referred to as the Rule 50 system), and 302 nursing facilities were reimbursed under the alternative payment demonstration project (sometimes referred to as the contract system).

Under both systems, nursing facilities are reimbursed by MA on a resident-per-day basis. The nursing home reimbursement levels are adjusted under the Resource Utilization Groups (RUGS) case-mix system to reflect the varying care needs of residents. RUGS classifies nursing facility residents into 34 groups based on information collected using the federally required minimum

data set. RUGS replaced the Minnesota-specific 11-group case mix system on October 1, 2002. This new case-mix reimbursement system for nursing homes is described in Minnesota Statutes, sections 144.0724 and 256B.438.

Under the cost-based system, facilities file annual cost reports with DHS that document their spending during the past reporting year in various expenditure categories. (Reporting years run from October 1 to September 30, and rate years from July 1 to June 30.) Reimbursement to facilities for the coming rate year is based upon these reported costs. Facilities had been subject to limits on the rate of increase in operating costs (spend-up limits) and reimbursement reductions for high-cost facilities (high-cost limits). These limits were not applied during the July 1, 1998 rate year, and have not been recalculated since.

Under the contract system, facilities are no longer required to file cost reports. Facilities are instead reimbursed at the level of their payment rate in effect the day before signing the contract. These payment rates are adjusted annually for inflation, subject to limitations specified in law. For the rate years beginning July 1, 1999 through July 1, 2008, the inflation adjustment has been or will be applied only to the property-related payment rate.

Facilities in the cost-based system have a financial incentive to convert to the contract system. Beginning October 1, 2006, property payment rates will no longer be determined under the cost-based system and facilities not participating in the contract system will not be eligible for rate increases.

The 2005 Legislature directed the Commissioner of Human Services to establish a value-based nursing facility reimbursement system that will use facility-specific, prospective rates to reimburse nursing facilities under MA. The total payment rate will have four rate components—direct care services, support services, external fixed costs, and property-related costs. The commissioner is to begin phasing in the new reimbursement system October 1, 2007, with the full phase-in completed by October 1, 2011.

The commissioner is to provide recommendations to the legislature for a methodology for the direct care and support services payment rate by February 15, 2006, and is to present recommendations to the legislature on property reimbursement by February 15, 2007.

Funding and Expenditures

The federal and state governments jointly finance MA.

Federal Share

The federal share of MA costs for each state, referred to as the federal medical assistance percentage (FMAP), is determined by a formula included in Title XIX of the Social Security Act. The formula is based on the state's per capita income and is recalculated annually. For federal fiscal year 2006, Minnesota's federal share is 50 percent.

Nonfederal Share

The state, with some exceptions,[20] has been responsible for the nonfederal share of MA costs since January 1991. Through December 1990, the nonfederal share of MA costs was split between the state and the counties, with the state paying 90 percent of the nonfederal share, and the counties paying the remaining 10 percent.

MA Expenditures – State Fiscal Year 2005

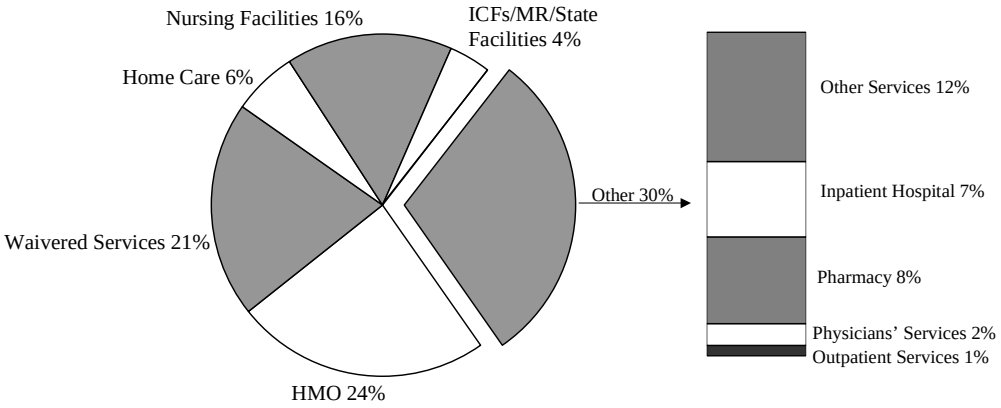
In fiscal year 2005, total MA expenditures for services were $5.193 billion. This total was distributed between the levels of government as follows:

Actual Expenditures — SFY 2005	
Federal	$2.596 billion
Nonfederal	$2.596 billion

The following chart shows the percentage of MA spending on the major service categories.

- HMO services was the largest single expenditure category (24 percent of MA spending).
- Waivered services and home care services together accounted for 27 percent of MA spending.
- Long-term institutional care (care provided in nursing homes, ICFs/MRs, and state facilities) accounted for 20 percent of MA spending.

MA Spending on Services – SFY 2005



[20] Counties are responsible for the nonfederal share of MA costs for selected services, as follows: 50 percent of the nonfederal share for the cost of placement of severely emotionally disturbed children in regional treatment centers, 20 percent for the cost of nursing facility placements of persons with disabilities under age 65 that exceed 90 days, 10 percent of the cost of placements in ICFs/MR with seven or more beds that exceed 90 days (reduced from 20 percent by the 2005 Legislature; see 2005 1st special session, chapter 4, article 2, section 14), and 20 percent of the costs of placements in nursing facilities that are institutions for mental diseases (IMDs) that exceed 90 days.

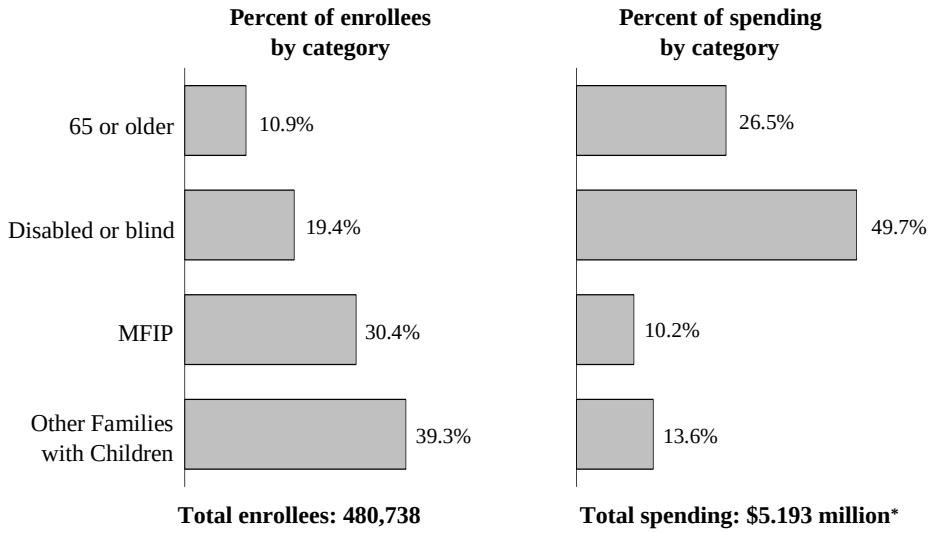
Recipient Profile

During fiscal year 2005, an average of 480,738[21] persons were eligible for MA services each month. The graph below shows the percentage of MA eligibles in each of the major eligibility groups. The table also shows the percentage of MA spending accounted for by individuals from each eligibility group.

- Minnesota Family Investment Program (MFIP) recipients make up the largest eligibility group, constituting 30.4 percent of eligibles. However, this group accounted for only 10.2 percent of MA spending.

- The elderly, and the disabled or blind, accounted for 76.2 percent of MA spending, although only 30.3 percent of eligibles are in these two groups.

Minnesota Medical Assistance Eligibles – SFY 2005



*does not include special funding items and adjustments

[21] All fiscal year 2005 recipient numbers in this section are preliminary and subject to slight adjustment.

MA Income Limit – Federal Poverty Guidelines[22] for 7/1/05 through 6/30/06 – 12-month Standard

Household Size	**100%**	**135%**	**150%**	**200%**	**275%**	**280%**
1	$9,816	$13,164	$14,364	$19,380	$26,328	$26,796
2	13,080	17,568	19,260	25,908	35,304	35,928
3	16,344	21,972	24,156	32,436	44,280	45,060
4	19,608	26,376	29,052	38,964	53,256	54,192
5	22,872	30,780	33,948	45,492	62,232	63,324
6	26,136	35,184	38,844	52,020	71,208	72,456
7	29,400	39,588	43,740	58,548	80,184	81,588
8	32,664	43,992	48,636	65,076	89,160	90,720
9	35,928	48,396	53,532	71,604	98,136	99,852
10	39,192	52,800	58,428	78,132	107,112	108,984
Each Additional Person	3,264	4,404	4,896	6,528	8,976	9,132

House Research Department

For more information about health care programs, visit the health and human services area of our web site, www.house.mn/hrd/issinfo/hlt_hum.htm.

[22] Federal poverty guidelines are updated every year, usually in February. New DHS income standards based on updated guidelines are effective July 1 of each year.