INFORMATION BRIEF
Research Department
Minnesota House of Representatives
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General Assistance Medical Care

General Assistance Medical Care (GAMC) is a state-funded program that pays for certain health care services for Minnesota residents whose income and resources are insufficient to cover their expenses and who are not eligible for other health care programs. This information brief describes eligibility, covered services, and other aspects of the program, and reflects the significant changes to the program made during the 2010 legislative session.

Contents

Administration

The GAMC program was established by the legislature in 1975 and was implemented on January 1, 1976. The GAMC law is codified in Minnesota Statutes, chapter 256D (see especially §§ 256D.03 and 256D.031). State law gives the Department of Human Services (DHS) the authority to administer the program and sets requirements related to eligibility, the provision of heath care services, state and county duties, and provider payments. County human services agencies determine eligibility for GAMC.

Background to 2010 Legislative Changes

On May 14, 2009, Governor Pawlenty line-item vetoed the $378 million fiscal year 2011 general fund appropriation for GAMC in the health and human services finance bill (Laws 2009, ch. 79/H.F. 1362). In June 2009, the governor announced that he would reduce the fiscal year 2010 general fund appropriation for GAMC by $15 million through unallotment. This reduction in funding would have required GAMC coverage to end beginning March 1, 2010, due to the lag in provider billing for services and the need to pay program expenditures out of the fiscal year 2010 appropriation.

In late 2009, the governor proposed that all GAMC enrollees be transitioned to the MinnesotaCare program,[1] with MinnesotaCare coverage for current GAMC enrollees taking effect on March 1, 2010. This proposal was an expansion of existing GAMC eligibility criteria, under which GAMC applicants who did not belong to a qualifying group were transitioned to MinnesotaCare. As was the case under the existing transition procedure, GAMC enrollees transitioned to MinnesotaCare under the governor's proposal would have been automatically eligible for MinnesotaCare and exempt from any MinnesotaCare insurance barriers and MinnesotaCare premiums until their six-month renewal (the enrollee share of premiums would have been paid by counties for the first six months). At the enrollees' six-month renewal, all MinnesotaCare eligibility criteria would apply and enrollees would be subject to premiums. Given the elimination of GAMC funding, persons applying for GAMC on or after March 1, 2010, would have had a delay in coverage for one or more months, until they could be transitioned into the MinnesotaCare program.[2]

Early in the 2010 session, the legislature passed legislation that would have established a modified GAMC program (Laws 2010, ch. 182). This legislation was vetoed by the governor on February 18, 2010. Following consultation with the governor, the legislature then passed a second piece of legislation establishing a modified GAMC program (Laws 2010, ch. 200). This legislation was signed by the governor on March 26, 2010. Selected provisions of chapter 200

[1] MinnesotaCare is a jointly funded, federal-state program that provides subsidized health coverage to families, children, and pregnant women with incomes up to 275 percent of the federal poverty guidelines (FPG), and adults without children with incomes up to 250 percent of FPG. MinnesotaCare enrollees pay premiums based on a sliding scale.

[2] Under the existing transition procedure, GAMC enrollees received fee-for-service coverage under GAMC for about one to two months before enrollment in a MinnesotaCare managed care plan became effective. With the elimination of funding, this GAMC fee-for-service coverage would not be available.

were modified by the omnibus budget bill (Laws 2010, 1st spec. sess., ch. 1) that was signed by the governor on May 21, 2010. This information brief describes the modified GAMC program enacted in chapter 200 and modified by chapter 1. Major differences between the "old" GAMC program and the new modified program are described in the appendix.

Eligibility Requirements

General Requirements

In order to be eligible for GAMC, an individual must:

1. not be eligible for Medical Assistance (MA);
2. either be: (a) receiving payments under General Assistance (GA) or Group Residential Housing (GRH); or (b) a resident of Minnesota with a gross countable income that does not exceed 75 percent of the federal poverty guidelines (FPG) and with nonexempt assets whose value does not exceed $1,000 per assistance unit; and
3. not belong to an ineligible group (see list below).

Table 1 displays income and asset limits for the main eligibility groups.

Table 1
GAMC Eligibility Groups

Eligibility Group	Income Limit	Asset Limit
1. GA recipient	GA limit ($203/month for one person; $260 for married couple)	GA limit ($1,000 per assistance unit)
2. GRH recipient	GRH limit (equal to the GRH assistance standard – $846 per month plus any supplemental rate, effective July 1, 2010)	GRH limit ($2,000 for aged, blind, or disabled, and $1,000 for all other recipients, after applicable asset exclusions)
3. Other individuals	75 percent of FPG	$1,000 per household

Ineligible groups

An individual is not eligible for GAMC coverage if he or she:

1. meets eligibility requirements for MA but fails to verify assets;
2. is an adult in a family with children as defined under MinnesotaCare (this group includes parents and stepparents);
3. is enrolled in private health care coverage;

4. is in a correctional facility, including a county correctional or detention facility as an individual accused or convicted of a crime, or is admitted to an inpatient hospital on a criminal hold order;
5. resides in the Minnesota sex offender program;
6. does not cooperate with the county agency to meet MA eligibility requirements;
7. does not cooperate with a county or state agency or the state medical review team in determining a disability or determining eligibility for Supplemental Security Income or Social Security Disability Insurance;
8. is an undocumented noncitizen or nonimmigrant; or
9. is ineligible for MA due to the deeming of a sponsor's income and resources.

Eligibility Periods

GAMC eligibility can begin no earlier than the date of application. Eligibility must be redetermined every six months. During each six-month eligibility period, GAMC recipients who continue to meet the GAMC eligibility criteria are not eligible for MinnesotaCare.

Residency

To be eligible for GAMC, an individual must be a resident of Minnesota. A "resident" is defined as a person living in the state for 30 days, with the intention of making a home here and not for any temporary purpose. County agencies are required to waive the 30-day residency requirement in cases of medical emergencies. Migrant workers who have worked in Minnesota within the last 12 months and have earned at least $1,000 in wages from this employment are exempt from the 30-day residency requirement. (See Minn. Stat. § 256D.02, subd. 12a)

Asset Limits

To be eligible for GAMC, the nonexcluded assets of applicants or enrollees cannot exceed $1,000 per household. Asset exclusions are determined using the standards of the MA program.

Certain items are not considered assets when determining GAMC eligibility, 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
- Insurance settlements for damaged, destroyed, or stolen property, which are excluded for nine months and may be excluded for up to nine additional months under certain conditions

- One automobile that is used for transportation of the enrollee or a household member of the enrollee

Income Limits

The GAMC income limits for persons who are not receiving either GA or GRH payments are specified in Table 2.

Table 2
Annual Household Income Limits for GAMC
(Effective April 1, 2010, through June 30, 2011)

Household Size	75% of FPG
1	$8,124
2	10,932
Each Additional Person	2,808

In determining whether an applicant or enrollee meets the program income limits, specified types of income, such as federal and state tax refunds and food support benefits, are excluded from gross income.

MinnesotaCare for Persons Also Eligible for GAMC

The MinnesotaCare program is a potential coverage option for individuals who would otherwise be covered under GAMC. One reason is that the MinnesotaCare income and asset limits are higher than the respective limits for GAMC. However, some MinnesotaCare program features may make that program less than an ideal fit for the former GAMC population, in part because MinnesotaCare: (1) requires enrollees to pay a monthly premium; (2) does not allow coverage from the date of application as does GAMC; and (3) applies a $10,000 annual limit on inpatient hospital services provided to adults without children.

In addition, under the modified GAMC program, GAMC enrollees are not eligible for MinnesotaCare during a six-month GAMC eligibility period, as long as they continue to meet GAMC eligibility criteria.

Covered Services

Fee-for-Service Transition Period

GAMC enrollees received coverage under fee-for-service for the services specified in Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 4, during the two-month transition period from April 1, 2010, through May 31, 2010. These were the services required to be covered under the "old" GAMC program. Managed care plan enrollment for GAMC enrollees ended March 31, 2010.

Coordinated Care Delivery Systems

Beginning June 1, 2010, GAMC enrollees have been able to receive services through a coordinated care delivery system (CCDS). A CCDS must either: (1) provide a standard set of services specified in law (a modification of the benefit set required under the "old" GAMC program); or (2) develop an alternative set of services that meets more general criteria specified in law. The four CCDSs that began operating June 1, 2010, have each chosen to provide an alternative set of services. (See Table 3 for a list of CCDSs.)

The alternative benefit set is "a set of comprehensive and medically necessary health services that the recipients might reasonably require to be maintained in good health and that has been approved by the commissioner…." These services include, but are not limited to, the following:

- Emergency care
- Medical transportation services
- Inpatient hospital and physician services
- Outpatient health services
- Preventive health services
- Mental health services
- Prescription drugs administered in a clinic or other outpatient setting

Outpatient prescription drug coverage and medication therapy management are provided on a fee-for-service basis and funded through the prescription drug pool (see below).

Chemical dependency services reimbursed through the Consolidated Chemical Dependency Treatment Fund under chapter 254B are not reimbursed through GAMC.

The standard set of services under the modified GAMC program consists of the following services[3]:

- Inpatient hospital services
- Outpatient hospital services
- Services provided by Medicare-certified rehabilitation agencies
- Prescription drugs
- Equipment necessary to administer insulin and monitor blood sugar level for treatment of diabetes
- Eyeglasses and eye examinations
- Hearing aids
- Prosthetic devices, if not covered by veterans benefits
- Laboratory and x-ray services
- Physician services

[3] The following services covered by the "old" GAMC program under section 256D.03, subdivision 4, paragraph (a), are not covered by the standard set of services of the modified GAMC program (see § 256D.031, subd. 4): (1) medical supplies and equipment, and Medicare premiums and cost-sharing; and (2) medical equipment not specifically listed when their use will prevent the need for costlier services.

- Medical transportation, except special transportation
- Chiropractic services as covered under MA
- Podiatric services
- Dental services
- Mental health services covered under MA
- Certain nurse practitioner services
- Services provided by a certified public health nurse or registered nurse practicing in a public health nursing clinic
- Telemedicine consultations, to the extent covered under MA
- Care coordination and patient education services provided by a community health worker as allowed under MA
- Sign language interpreter services when provided by a health care provider during the course of treatment

Cost-Sharing

GAMC recipients are subject to the following copayments:

- $25 for nonemergency visits to an emergency room
- $3 per brand-name prescription and $1 per generic prescription, subject to a $7 per-month limit. Antipsychotic drugs are exempt from copayments.

Health care providers are responsible for collecting the copayment; GAMC reimbursement to a provider is reduced by the amount of the copayment. A provider cannot withhold services from an enrollee who does not pay the copayment.[4]

Service Delivery

Beginning April 1, 2010, through May 31, 2010, all GAMC recipients received services through a fee-for-service system. Prior to April 1, 2010, most GAMC recipients received services through managed care and county-based purchasing plans.

Since June 1, 2010, GAMC recipients have been able to enroll in a coordinated care delivery system. GAMC recipients who do not enroll in a CCDS have the option of obtaining services from hospitals not participating in a CCDS. For the period June 1, 2010, through February 28, 2011, these hospitals can receive payment for these services from a temporary uncompensated care pool.

[4] Minnesota Statutes, section 256B.0631, subdivision 4, allowed providers who routinely refused services to individuals with uncollected debt to include uncollected copayments as bad debt and deny services to enrollees. The Ramsey County District Court in *Dahl et al. v. Goodno*, court file number C9-04-7537, ruled that this provision was preempted by federal law. This provision was repealed January 1, 2009.

Since June 1, 2010, all GAMC recipients, whether or not they are enrolled in a CCDS, receive GAMC fee-for-service coverage for outpatient prescription drugs and medication therapy management. Providers are reimbursed for these services from a prescription drug pool.

Fee-for-Service Transition Period

For the period April 1, 2010, through May 31, 2010, GAMC was paid for under fee-for-service, with payments rates for services other than outpatient prescription drugs paid for at 37 percent of the rate in effect on March 31, 2010. During this period, outpatient prescription drugs were paid for at the MA fee-for-service payment rate.

Coordinated Care Delivery Systems

CCDS requirements. Since June 1, 2010, GAMC recipients have been able to receive services from hospitals that have developed and implemented coordinated care delivery systems. A CCDS is required to: (1) provide the required covered services to enrollees of the CCDS; (2) establish a process to monitor enrollment and ensure the quality of care; (3) in cooperation with counties, coordinate the delivery of health care services with specified housing-related services; and (4) adopt innovative and cost-effective methods of care delivery and coordination. A CCDS hospital may contract with clinics and other providers to deliver services, and is required to contract with certain essential community providers[5] to the extent practicable.

Recipient enrollment. GAMC recipients are allowed to enroll in any available CCDS statewide and may choose among systems if more than one CCDS is available. Enrollees must agree to receive all nonemergency services through the CCDS. If a GAMC recipient does not choose a CCDS, DHS may assign that recipient to a CCDS. However, in its agreements with the four CCDSs that began delivering services June 1, 2010, the state agreed not to assign recipients to a CCDS during the first six months of the modified program.

Enrollment in a CCDS is for six-month periods, except that the initial enrollment period is for six months or until the end of the recipient's GAMC eligibility period, whichever occurs first. A recipient who continues to meet GAMC eligibility criteria is not eligible to enroll in MinnesotaCare during a period of CCDS enrollment.

CCDS contracts. The authorizing legislation allowed hospitals meeting specified criteria related to GAMC net patient revenue[6] to contract with the Commissioner of Human Services to provide CCDS services beginning June 1, 2010. The commissioner was also given the authority to

[5] These essential community providers are those defined in section 62Q.19, subdivision 1, paragraph (a), clauses (1) and (2); they are entities that have demonstrated ability to integrate supportive and stabilizing services with medical care for uninsured populations and high-risk, special needs, and underserved populations, and that demonstrate a commitment to serving low-income and underserved populations by having nonprofit and tax-exempt status, charging for services based on a sliding scale, and not restricting access or services due to client financial limitations.

[6] A hospital qualified to provide services beginning June 1, 2010, if: (1) during calendar year 2008, its fee-for-service GAMC payments were equal to or greater than $1.5 million or 1.3 percent of net patient revenue; or (2) a contract with the hospital was necessary to provide geographic access or ensure that at least 80 percent of enrollees have access to a CCDS.

contract with additional hospitals if this was necessary to provide geographic access or to ensure that at least 80 percent of GAMC enrollees have access to a CCDS. Beginning December 1, 2010, any Minnesota hospital will be allowed to contract with the commissioner to establish a CCDS.

Hospitals can enter into CCDS contracts on a quarterly basis on June 1, September 1, December 1, and March 1. Participation is effective for a 12-month period and may be renewed for successive 12-month periods.

The commissioner included GAMC enrollment limits in contracts with the CCDSs that had applied to implement CCDS services beginning June 1, 2010. The enrollment limit provision essentially requires a CCDS to serve, at a minimum, a proportion of GAMC recipients equal to the proportion of GAMC fee-for-service inpatient and outpatient hospital payments it received in calendar year 2008, relative to the total of these payments for all hospitals for calendar year 2008. Enrollment limits are recalculated at the beginning of each contract quarter, based on current GAMC enrollment.

More specifically, the enrollment limit provision in the contracts allows a CCDS, no sooner than 60 days after the effective date of the contract, to notify DHS if its CCDS enrollment is greater than the its pro rata share of enrollment for the entire program. The pro rata share of enrollment for a CCDS is the proportion of GAMC inpatient and outpatient fee-for-service payments paid to the grantee for calendar year 2008 relative to inpatient and outpatient fee-for-service payments made by the entire GAMC program for calendar year 2008. This pro rata share is applied to the average monthly total of GAMC program recipients for the most recent calendar quarter for which the information is available. Once DHS verifies that this enrollment limit has been reached, DHS is required to suspend further enrollment of GAMC recipients into the CCDS. If this does not eliminate the inequitable enrollment distribution within 30 days, DHS is required to consult with the CCDS to determine additional actions to be taken. DHS can reopen enrollment for a CCDS if GAMC enrollment in the CCDS is at least 10 percent below its enrollment limit.

The table below lists the hospitals that are delivering services to GAMC enrollees through a CCDS and their respective enrollment limits. Each of these hospitals began delivering CCDS services on June 1, 2010.

Table 3
CCDS Hospitals and Enrollment Limits

CCDS	Enrollment Percentage	Second Quarter Enrollment Limit–Number of Enrollees*
Hennepin County Medical Center	26.08%	8,249
North Memorial Medical Center	5.34	1,689
Regions Hospital	9.36	2,961
University of Minnesota Medical Center, Fairview	6.61	2,091

* This enrollment limit applies for the contract quarter September 1, 2010, through November 30, 2010. The limit is calculated by multiplying the average monthly GAMC enrollment for the most recent calendar quarter for which the information is available (in this case, 31,630 for the calendar quarter ending June 30, 2010) by the enrollment percentage. This compares to an average monthly GAMC enrollment of 37,023 for the calendar quarter ending March 31, 2010, which was used to calculate enrollment limits for the contract quarter that began June 1, 2010.

While all four of these CCDSs are located in the seven-county metropolitan area, enrollment in a CCDS is open to all enrollees statewide, subject to the enrollment limits. As of September 3, 2010, Hennepin County Medical Center was accepting new enrollees, Regions Hospital was accepting new enrollees only until September 8, 2010, and North Memorial Medical Center and University of Minnesota Medical Center, Fairview had reached their enrollment limits and were not accepting new enrollees.[7]

The 2010 Legislature directed the commissioner to offer, to hospitals that plan to participate as a CCDS beginning September 1, 2010, the same contract terms related to an enrollment limit and financial liability protections as offered to hospitals that began CCDS participation on June 1, 2010.

Payments to CCDSs. Payments for CCDS services are allocated to participating CCDSs on a quarterly basis and are subject to the limits of the annual appropriation for this purpose. Payment to a specific CCDS is based on the pro rata share of the CCDS hospital's calendar year 2008 GAMC fee-for-service payments compared to all hospitals participating in the CCDS system, except that the pro rate share of GAMC payments is increased by 10 percent when calculating the allocations for four hospitals—Hennepin County Medical Center, Regions Hospital, St. Mary's Medical Center, and the University of Minnesota Medical Center, Fairview (St. Mary's Medical Center chose not to implement a CCDS beginning June 1). Allocations to hospitals not eligible for the higher payment percentage are to be reduced by a pro rata amount to keep allocations within the limits of available appropriations.

[7] More detailed information on current CCDS enrollment limits, and on whether a specific CCDS is still accepting new enrollees, can be found on the Department of Human Services website (www.dhs.state.mn.us/GAMC).

The commissioner may prospectively reallocate payments to hospitals twice a year to reflect actual CCDS enrollment. In addition, the 2008 base year for GAMC payments is to be updated by one calendar year each June 1, beginning June 1, 2011.

Temporary Uncompensated Care Pool

A temporary uncompensated care pool is operational from June 1, 2010, through February 28, 2011. Payments from the pool are distributed, subject to the limits of the available appropriation, to hospitals that are not part of a CCDS, for inpatient and outpatient hospital expenses incurred serving GAMC recipients who have not enrolled in a CCDS. At this time, DHS plans to make uncompensated care payments to hospitals in December 2010 and May 2011.

The payment amount from the pool received by each hospital will be equal to the ratio of admissions and services provided by that hospital to GAMC recipients not enrolled in a CCDS, compared to the total of GAMC admissions and services provided by all hospitals to these recipients, multiplied against the amount of money in the uncompensated care pool. DHS is required to apply for federal matching funds for payments from the pool.

Outpatient prescription drugs are not eligible for payment through the temporary uncompensated care pool and are instead reimbursed by GAMC on a fee-for-services basis through the prescription drug pool.

Prescription Drug Pool

An outpatient prescription drug pool was established June 1, 2010. Money in the pool is used to reimburse pharmacies and other pharmacy service providers for covered outpatient prescription drugs and medication therapy management provided to both GAMC recipients enrolled in a CCDS and to GAMC recipients who are not enrolled in a CCDS. Payment is on a fee-for-service basis at current MA payment rates and is subject to the availability of funding.

If the commissioner forecasts that expenditures from the pool will exceed the appropriation, the commissioner may bring recommendations for resolving the shortfall to the Legislative Advisory Commission.

A CCDS is required to pay to the commissioner quarterly assessments equal to 20 percent of payments for prescribed drugs provided to its enrollees.

Funding and Expenditures

The GAMC program is funded solely by state dollars. There is no federal funding for GAMC. Beginning January 1, 1991, the state assumed responsibility for the historic county share of 10 percent of GAMC costs.

During state fiscal year 2009, the state spent $288,133,272 in payments to health care providers for GAMC services, provided to an average of 31,961 enrollees per month.

Table 4 displays the amounts appropriated by the 2010 Legislature for the modified GAMC program.

Table 4
Legislative Appropriations for the Modified GAMC Program

	FY 2010[8]	FY 2011	FY 2012	FY 2013
Fee-for-Service Transition Period	$28,000,000	$0	$0	$0
CCDS Payments	5,500,000	65,500,000	65,500,000	65,500,000
Temporary Uncompensated Care Pool	1,538,000	28,462,000	0	0
Prescription Drug Pool (net of drug rebates)	2,800,000	33,200,000	33,200,000	33,200,000
Total	$37,838,000	$127,162,000	$98,700,000	$98,700,000

Source: House Fiscal Analysis Department

Unlike the "old" GAMC program, the modified GAMC program is not an entitlement. Enrollment is subject to CCDS enrollment limits. Funding for the CCDS system, temporary uncompensated care pool, and prescription drug pool is fixed, and absent legislative action, will not increase with additional enrollment or the provision of additional services.

[8] This appropriation is in addition to the $344 million for fiscal year 2010 appropriated by the 2009 Legislature (which the 2010 Legislature reduced by $15.879 million).

Appendix: Major Differences Between the Old and Modified GAMC Programs

Comparison of the Old and Modified GAMC Programs

Old GAMC	Modified GAMC
General eligibility	
Must: (1) receive either GA or GRH; or	Same
(2) meet income (75% FPG) and asset ($1,000 per assistance unit) limits and be a Minnesota resident (30-day durational residency); and	Same on income, asset, and eligibility criteria
(3) be a member of a qualifying group[9]	Qualifying group requirement eliminated and the following individuals are not eligible: those who have private health coverage, are in a correctional facility or admitted to a hospital on a criminal hold order, and those residing in the sex offender program[10]
Persons with income >75% and ≤ 175% FPG eligible for hospital-only coverage	Eliminated
Other eligibility criteria	
Must also meet other criteria, including: (1) are not MA eligible (2) cooperate with county agencies to apply for MA (3) are not undocumented persons or nonimmigrants (4) are not ineligible for MA due to deeming of sponsor income and resources	Same
	Additional criteria: GAMC coverage is also not available for persons who: • are otherwise eligible for MA who fail to verify assets • are adults in a family with children as defined under MinnesotaCare • do not cooperate in a disability determination

[9] Qualifying groups are persons: (1) awaiting a disability determination; (2) unable to meet the MinnesotaCare residency requirement; (3) who are homeless; (4) who are Medicare eligible due to end-stage renal disease; (5) enrolled in private health coverage; (6) detained by law who met other criteria, or in a hospital on a criminal hold order; (7) receive treatment paid for by the Consolidated Chemical Dependency Treatment Fund; or (8) are residents of the Minnesota sex offender program.

[10] These were three of the eight qualifying groups under the old GAMC program (see footnote 9).

Old GAMC	Modified GAMC
Transitional MinnesotaCare (persons not in qualifying group enrolled in MinnesotaCare)	
Yes	Eliminated
Method of service delivery	
Managed care for most enrollees; fee-for-service for initial coverage for transitional MinnesotaCare enrollees (for period prior to MinnesotaCare enrollment) and for persons receiving GAMC hospital-only coverage	Enrollment in CCDS or services funded through temporary uncompensated care pool
Covered services	
Benefit set specified in Minn. Stat. § 256D.03, subd. 4 (2008)	GAMC recipients enrolled in a CCDS receive either (1) most benefits covered under old GAMC program;[11] or (2) an alternative set of services GAMC recipients not enrolled in a CCDS may receive inpatient and outpatient services provided by hospitals that are not part of a CCDS. These services are eligible for payment through the temporary uncompensated care pool for services provided during the period 6/1/10 through 2/28/11, subject to the availability of funding. All GAMC recipients (both CCDS and GAMC recipients not enrolled in a CCDS) receive outpatient prescription drug coverage and medication therapy management funded through a prescription drug pool.
Funding	
Increases or decreases to reflect changes in enrollment, utilization of services, and provider payment rates	Limited to the amount appropriated and does not increase as enrollment, service utilization, or provider payment rates increase

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/hrd.htm.

[11] The following services that are part of the benefit set for the "old" GAMC program listed in section 256B.03, subdivision 4, paragraph (a), are not covered under the modified GAMC program: (1) medical supplies and equipment, and Medicare premiums and cost-sharing; and (2) medical equipment not specifically listed, when their use will prevent the need for costlier services.