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INFORMATION BRIEF
Research Department
Minnesota House of Representatives
600 State Office Building
St. Paul, MN 55155

Randall Chun, Legislative Analyst
651-296-8639

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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

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Administration

Congress

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

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

Medicaid is administered at the federal level by the Center for Medicare and Medicaid Services (CMS), an agency within DHHS. CMS issues regulations and guidelines for Medicaid that states are required to follow. These regulations and guidelines are found in Title 42 of the Code of Federal Regulations, in the state Medicaid Manual, and in State Medicaid Director letters from CMS.

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

Minnesota State Legislature

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

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

Minnesota Department of Human Services (DHS)

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

Counties

County human services agencies and tribal governments choosing to participate are responsible for determining if applicants meet state and federal eligibility standards.[1] 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 low-income persons who cannot afford the cost of health care. MA can retroactively pay for the cost of health care services provided to an individual up to three months before the month of application, if the individual would have been eligible for MA at the time the services were provided. Generally, MA is available to 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 DHS website).

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[2]

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

Citizenship

To be eligible for MA, an individual must be a citizen of the United States or a noncitizen who meets specified immigration criteria (see MA Eligibility for Noncitizens table on page 4). The

[1] The DHS central office determines MA eligibility for some individuals who lose MinnesotaCare coverage due to failure to pay the premium and who want to apply for MA without submitting a new application.

[2] Certain exceptions to this limitation apply (e.g., for individuals placed in an IMD by a managed care plan). Individuals may also qualify for state-only funded MA.

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[3]
Refugees, asylees, persons granted withholding of deportation, veterans/active duty military personnel and families, conditional entrants, 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, certain Iraqi and Afghani special immigrants, victims of trafficking	Yes	N/A	N/A
The following individuals residing in the U.S. prior to 8/22/96: lawful permanent residents,[4] noncitizens paroled into the U.S.[5] for at least one year, battered noncitizens and their children	Yes	N/A	N/A
The following individuals who entered the U.S. on or after 8/22/96: lawful permanent residents,[6] noncitizens paroled into the U.S. for less than one year, battered noncitizens and their children	Yes, for children and pregnant women[7]; No for all others, until five years after entry	Yes, if not eligible for MA with FFP	Yes
Others lawfully residing in the U.S.[8] on 8/22/96 and receiving SSI	Yes	N/A	N/A
Others lawfully residing in the U.S.	Yes, but only for children and pregnant women[9]	Yes	Yes

[3] 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.

[4] 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.

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

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

[7] Since July 1, 2010, children and pregnant women who are qualified noncitizens or otherwise lawfully present have been eligible for MA with FFP.

[8] 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, applicants for asylum, and other groups.

[9] Since July 1, 2010, children and pregnant women who are qualified noncitizens or otherwise lawfully present have been eligible for MA with FFP for all MA-covered services.

Immigration Status	MA with FFP	MA without FFP	Emergency MA with FFP[3]
Nonimmigrants[10] and undocumented persons	Yes, but only for MA services provided to uninsured pregnant women through the period of pregnancy, including labor and delivery and 60 days postpartum[11]	No, except as described in footnote 11	Yes

Source: Department of Human Services

Residency

To be eligible for MA, an individual must be a resident of Minnesota, as determined under federal law,[12] or a migrant worker as defined in Minnesota Statutes, section 256B.06, subdivision 3.

Eligible Categories of Individuals

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

- parents or caretakers of dependent children
- pregnant women
- children under age 21
- persons age 65 or older
- persons with a disability or who are blind, as determined by the Social Security Administration or the State Medical Review Team (This category includes most persons eligible for either the Minnesota Supplemental Aid (MSA) or Supplemental Security Income (SSI) programs.)
- children eligible for or receiving state or federal adoption assistance payments

[10] A nonimmigrant is a person who is lawfully present in the United States, but who is not permanently 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).

[11] These services are funded through the federal Children's Health Insurance Program (CHIP), rather than MA. CHIP provides an enhanced federal match of 65 percent for these services. As of October 12, 2010, Minnesota was waiting for federal approval to use CHIP to fund services during the postpartum period; these services are currently funded through MA without FFP.

[12] 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).

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

Individuals with excess income belonging to a group eligible for MA coverage may be able to qualify by spending down their income (see page 10).

Medicaid Expansion for Low-Income Adults

Note: The information below is based upon what is known of federal requirements as of October 2010 and is subject to revision based upon implementation details to be provided in forthcoming federal guidance letters.

New Eligibility Group

The federal health care reform bill—the Affordable Care Act (ACA)—requires state Medicaid programs to cover, effective January 1, 2014, individuals with incomes not exceeding 133 percent of federal poverty guidelines (FPG) who are not: (1) elderly; (2) pregnant; (3) entitled to or enrolled in Medicare Part A or Medicare Part B; or (4) described in an already existing group for which Medicaid coverage is mandatory, such as certain parents, children, or disabled persons receiving Supplemental Security Income (SSI) benefits.

In Minnesota, these newly eligible individuals will include adults without dependent children—for example, persons enrolled in General Assistance Medical Care and MinnesotaCare enrollees who are adults without children with incomes not exceeding 133 percent of FPG. The newly eligible group may also include certain parents and persons with disabilities who are not otherwise eligible for services through MA or an MA waiver. Minnesota and other states will have a better idea of who specifically qualifies as newly eligible when the federal government further defines this new eligibility group.

Income and Asset Methods

When determining Medicaid eligibility for persons in the newly eligible group and certain existing Medicaid eligibility groups, the ACA requires states to: (1) use a new income methodology based on modified adjusted gross income (MAGI) and household income (this is the income methodology used under the ACA to determine eligibility for premium tax credits for coverage purchased through state health insurance exchanges); (2) apply a standard 5 percent income disregard that would replace any state-specific income disregards; and (3) eliminate the use of asset tests. These income and asset requirements do not apply to individuals who are disabled, over age 65, or meet other criteria for exemption specified in the federal law.

Benefit Changes

The ACA also requires states to provide individuals in the newly eligible group who are not otherwise exempt with benchmark or benchmark-equivalent benefits—an alternative benefit set authorized by federal law in 2005 as a state benefit option that can be different than a state's regular Medicaid benefit set. Under this alternative benefit set, coverage provided to Medicaid enrollees must be equal to one of three specified benchmark plans, be actuarially equivalent as

specified in federal law to one of the benchmark plans, or be coverage that is approved by the Secretary of Health and Human Services. One of the options for secretary-approved coverage is a state's regular Medicaid benefit set. The ACA also requires benchmark or benchmark-equivalent coverage to cover the essential health benefits that will be required for coverage offered through state health insurance exchanges, and to meet other specified requirements.

Certain eligibility groups are exempt from the alternative benefit set requirement, including but not limited to pregnant women, blind or disabled individuals, dual eligibles (persons eligible for both MA and Medicare), and persons who are institutionalized or who qualify for long-term care services.

Enhanced Federal Match

The federal government will provide an enhanced federal match for the cost of covering the newly eligible group. This federal match is 100 percent of the cost for calendar years 2014 through 2016. The matching rate phases down over the next four years, such that the federal match will be 90 percent for 2020 and future years. This match is not available to states that meet the definition of an "expansion state." Expansion states will instead receive an enhanced federal match calculated according to a formula based on a state's regular matching rate that gradually increases over six years, and then is set at 90 percent for 2020 and future years. DHS is seeking clarification from the federal government as to whether Minnesota meets the definition of an expansion state.

Early Expansion Option

The ACA allows states to expand Medicaid coverage to include newly eligible persons prior to January 1, 2014. States that implement early expansion must comply with the prohibition on asset tests and the benchmark or benchmark-equivalent benefit requirements. States are not required to initially use MAGI and household income for an early expansion group, but must use these methods beginning with the January 1, 2014, mandatory expansion date. Under early expansion, states are allowed to phase in coverage based upon income, as long as lower-income individuals are covered before higher-income individuals. States will at first receive their regular federal Medicaid match for individuals covered through early expansion, but will receive the enhanced federal match for these individuals beginning January 1, 2014.

The 2010 Legislature authorized the current or succeeding governor to implement early expansion for eligible adults without dependent children, with incomes not exceeding 75 percent of FPG, by issuing an executive order. Gov. Pawlenty, in a June 22, 2010, letter to the Commissioner of Human Services, stated that he would not be issuing an executive order to implement early expansion. The succeeding governor may issue an executive order to implement early expansion at any time from the start of that governor's term until January 15, 2011.

Income Limits

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

MA income limits are based on the federal poverty guidelines (FPG). The 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.

The table on page 11 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[13]

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.

Extended Coverage for Children

On October 31, 2008, the federal Centers for Medicare and Medicaid Services (CMS) denied a request by the state to allow children age one through 18 who become ineligible for MA due to excess income to be eligible for two additional months of MA (in addition to transitional MA coverage) and be automatically eligible for MinnesotaCare until the next MinnesotaCare renewal. The coverage extension was authorized by the 2007 Legislature. DHS resubmitted the request on September 30, 2009.

[13] Transitional MA is contingent on federal funding. Federal funding is scheduled to expire on January 1, 2011, unless reauthorized by the U.S. Congress.

Asset Limits

MA has two main asset limits. One applies to persons who are aged, blind, or disabled and the other to parents in MA-eligible families.[14] 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 page 11).

Aged, blind, or disabled. Persons who are aged, blind, or disabled need to meet the asset limit specified in Minnesota Statutes, section 256B.056, subdivision 3. This asset limit is $3,000 for an individual and $6,000 for two persons in a household, with $200 added for each additional dependent. Certain assets are excluded when determining MA eligibility for persons who are aged, blind, or disabled, including the following:

- the homestead
- household goods and personal effects
- personal property used as a regular abode
- a burial plot for each member of the household
- life insurance policies and assets for burial expenses, up to the limits established for the SSI program[15]
- capital and operating assets of a business necessary for the person to earn an income
- funds for damaged, destroyed, or stolen property, which are excluded for nine months, and may be excluded for up to nine additional months under certain conditions
- motor vehicles to the same extent allowed under the SSI program[16]

Parents in MA-eligible families. A uniform asset limit, identical to that used for the MinnesotaCare program, applies to parents and caretakers 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 excluded 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 SSI program
- capital and operating assets of a business up to $200,000

[14] The Minnesota Long-term Care Partnership (LTCP) program allows individuals with qualified long-term care insurance policies to qualify for MA payment of long-term care services, while retaining assets above the regular MA asset limit equal in value to the amount paid for care by the policy. For more information on the LTCP program, see DHS Bulletin 08-21-08, "DHS Introduces Long-Term Care Partnership (LTCP)," August 8, 2008.

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

[16] The SSI program excludes as an asset one vehicle per household, regardless of value, if it is used for transportation by the recipient or a member of the recipient's household.

- funds received for damaged, destroyed, or stolen property are excluded for three months if held in escrow
- a motor vehicle for each person who is employed or seeking employment
- court-ordered settlements of up to $10,000
- individual retirement accounts and funds
- assets owned by children

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

Eligibility on the Basis of a Spenddown

Individuals who, except for excess income, would qualify for coverage under 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[17]	≤ 280% of FPG	None	All MA services
Children two through 18 years of age	≤ 150% of FPG	None	All MA services
Children 19 through 20 years of age	≤ 100% of FPG	None	All MA services
Pregnant women	≤ 275% of FPG	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
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[18]	≥ 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[19]	≤ 100% of FPG[20]	None	All MA services
Employed persons with disabilities	No income limit	$20,000	All MA services

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[17] Children with incomes greater than 275 percent and less than or equal to 280 percent of FPG are funded through the federal State Children's Health Insurance Program (SCHIP) with an enhanced federal match.

[18] Eligibility for persons in this group is contingent on federal funding. Federal funding is scheduled to expire on January 1, 2011, unless reauthorized by the U.S. Congress.

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

[20] Only the income of the child is counted in determining eligibility. Child support and Social Security disability payments paid on behalf of the child are excluded.

Institutional Residence

Individuals living in public institutions, such as secure correctional facilities, are 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 inpatient psychiatric hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or they are age 65 or older, or otherwise qualify for an exception. An IMD is a hospital, nursing facility, or other institution of 17 or more beds that primarily provides diagnosis, treatment, and care to persons with mental illness.

Benefits

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

Federally Mandated Services 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 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
- Care coordination and patient education services provided by a community health worker

- Case management for seriously and persistently mentally ill persons and for children with serious emotional disturbances
- Case management and directly observed therapy for people with tuberculosis
- Chiropractor services
- Clinic services
- Dental services[21]
- Other diagnostic, screening, and preventive services
- Emergency hospital services
- Extended services to women
- Hearing aids
- Home and community-based waiver services
- Hospice care
- Some Individual Education Plan (IEP) services provided by a school district to disabled students
- Some services for residents of Institutions for Mental Diseases (IMDs)
- Inpatient psychiatric facility services for persons under age 22
- Intermediate care facility services, including services provided in an intermediate care facility for persons with developmental disabilities (ICF/DD)
- Medical equipment and supplies
- Medical transportation services
- Mental health services
- Nurse anesthetist services
- Certified geriatric, adult, OB/GYN, and neonatal nurse practitioner services
- Occupational therapy services
- Personal care assistant services
- Pharmacy services[22]
- 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

[21] Since January 1, 2010, coverage of dental services for adults who are not pregnant has been limited to specified services (see Minn. Stat. § 256B.0625, subd. 9 (Supp. 2009)).

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

Copayments

MA enrollees are subject to the following copayments:

- $6 for nonemergency visits to a hospital emergency room[23]
- $3 per brand-name prescription and $1 per generic prescription, subject to a $7 per-month limit. Antipsychotic drugs are exempt from copayments when used for the treatment of mental illness.

Children and pregnant women are exempt from copayments; other exemptions also apply. Total monthly copayments for persons with incomes not exceeding 100 percent of FPG are limited to 5 percent of family income.

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.[24]

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 Developmental Disabilities (DD) provides community-based care to persons diagnosed with developmental disabilities who are at risk of placement in an ICF/DD.

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

[23] This copayment will be reduced to $3.50 beginning January 1, 2011.

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

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) or through a managed care system. Some managed care programs require federal waivers from CMS, others may be operated under the Medicaid State Plan which outlines the MA services states are providing under agreement with CMS.

Under the managed care system, MA enrollees who are families and children receive services from prepaid health plans through the Prepaid Medical Assistance Program (PMAP) or through county-based purchasing initiatives. Enrollees who are elderly (age 65 and over) receive services from prepaid health plans through Minnesota Senior Care Plus or through Minnesota Senior Health Options (MSHO). Enrollees with disabilities have the option of receiving services through the Minnesota Disability Health Options program (through December 31, 2010) if they reside in the seven-county metropolitan area or the Special Needs BasicCare (SNBC) program, a statewide program for persons with disabilities.

Programs for Families and Children

Under PMAP, prepaid health plans contract with DHS to provide services to MA enrollees. Plans receive a capitated payment from DHS for each MA enrollee, and in return are required to provide enrollees with all MA covered services, except for some home and community-based waiver services, some nursing facility services, and intermediate care facility services for persons with developmental disabilities. PMAP operates under a federal waiver; one of the terms of the waiver allows the state to require certain MA enrollees to receive services through managed care.

Enrollees in participating counties select a specific prepaid health plan from which to receive services, obtain services from providers in the plan's provider network, and follow that plan's procedures for seeing specialists and accessing health care services. Enrollees are allowed to switch health plans once per year during an open enrollment period. PMAP has contracts with prepaid health plans to provide services in all 87 counties.

County-based purchasing provides an alternative method of health care service delivery. County boards that elect to implement county-based purchasing are responsible for providing all PMAP services to enrollees, either through their own provider networks or by contracting with prepaid health plans. DHS payments to counties cannot exceed PMAP payment rates to prepaid health

plans. As of January 2010, three county-based purchasing initiatives involving 28 counties were operational.

Programs for the Elderly

The Minnesota Senior Care waiver replaced PMAP for elderly enrollees on June 1, 2005. This federal waiver provides continued authority for mandatory enrollment of people age 65 or older into managed care. Minnesota Senior Care covered all the same services as PMAP, except that prescription drugs for MA enrollees also eligible for Medicare were covered by Medicare Part D (see footnote 22 on page 13).

The Minnesota Senior Care benefit package was replaced by a broader Minnesota Senior Care Plus benefit package, on January 1, 2009. Minnesota Senior Care Plus first began providing services on June 1, 2005, to elderly enrollees enrolled in county-based purchasing initiatives. It was expanded to 80 nonmetro counties in January 2008 and was further expanded to include the seven metro-area counties in January 2009. In addition to covering all basic Minnesota Senior Care services, Minnesota Senior Care Plus also covers elderly waiver services and 180 days of nursing home services for enrollees not residing in a nursing facility at the time of enrollment.

Elderly enrollees in Minnesota Senior Care Plus must enroll in a separate Medicare plan to obtain their prescription drug coverage under Medicare Part D. However, elderly enrollees also have the option of receiving managed care services through the Minnesota Senior Health Options (MSHO), rather than Minnesota Senior Care Plus. MSHO includes all Medicare and MA prescription drug coverage under one plan. MSHO provides a combined Medicare and MA benefit and is available statewide. MSHO was first implemented in 1997 as part of a federal demonstration project; the program has operated since 2006 under federal Medicare Advantage Special Needs Plan (SNP) authority.[25] DHS also contracts with SNPs to provide MA services. Enrollment in MSHO is voluntary. As is the case with Minnesota Senior Care Plus, MSHO also covers elderly waiver services and 180 days of nursing home services. Most elderly MA enrollees are enrolled in MSHO rather than Minnesota Senior Care Plus because of the integrated Medicare and MA prescription drug coverage. As of August 2010, MSHO enrollment was 36,180, compared to enrollment in Minnesota Senior Care Plus of 12,198.

Programs for Persons with Disabilities

The Minnesota Disabilities Health Options (MnDHO) program is a voluntary managed care program for persons with disabilities under age 65 that also operates under combined Medicare SNP and MA managed care authority. MnDHO provides all Medicare primary, acute, and long-term care services and also includes all Medicare and MA prescriptions drugs under one plan. MnDHO has been operating since 2001 and as of August 2010, served 1,233 enrollees in the seven-county metropolitan area. MnDHO will not operate after December 31, 2010.

[25] A Medicare SNP is a Medicare-managed care plan that is allowed to serve only certain Medicare populations, such as institutionalized enrollees, dually eligible enrollees, and enrollees who are severely chronically ill and disabled. SNPs must provide all Medicare services, including prescription drug coverage.

Special Needs Basic Care (SNBC) is a voluntary integrated Medicare and Medicaid plan for persons with disabilities that was implemented statewide beginning January 2008. The program also works through contracts with Medicare SNPs and provides all Medicare and Medicaid prescription drugs under one plan. SNBC provides some long-term care services. The program served 4,290 individuals as of August 2010. DHS continues to work with a stakeholders' advisory group on implementation of the program.

Managed Care Enrollment

Generally, MA recipients in participating counties who are in families with children are required to enroll in PMAP or county-based purchasing. As noted above, recipients who are elderly are required to enroll in Minnesota Senior Care Plus, but a majority have chosen to participate instead in the voluntary MSHO program.

Most persons who are blind or disabled, and persons belonging to other specific groups, are exempt from managed care enrollment.

As of August 2010, 396,044 MA enrollees received services through PMAP, county-based purchasing, Minnesota Senior Care Plus, MSHO, MnDHO, or SNBC.

Managed Care Reimbursement Rates

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

MnDHO and SNBC rates are based on historical fee-for-service costs and are paid through a separate risk adjustment system designed for people with disabilities. MSHO, Minnesota Senior Care, and Minnesota Senior Care Plus rates are adjusted for age, sex, institutional status, and geographical area and are identical across programs.[26] Rates for elderly waiver services are based on historical fee-for-service costs.

DHS does not regulate prepaid health plan and county-based purchasing payment rates to health care providers under contract to serve MA enrollees. These payment rates are a matter of negotiation between the health care provider and the prepaid health plan or county boards.

[26] Rates for elderly recipients enrolled in Minnesota Senior Care, Minnesota Senior Care Plus, and MSHO are determined using historical data and are not risk-adjusted, since most of the services used to determine risk-adjustment values are covered by Medicare.

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.

Basic Care Services

The 2009 Legislature reduced payment rates for basic care services by 3 percent, effective July 1, 2009, and made proportional reductions in managed care and county-based purchasing plan capitation rates. This reduction does not apply to physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, and medical transportation. Gov. Pawlenty, as part of unallotment, increased this reduction by an additional 1.5 percentage points (to a total of 4.5 percent) for fiscal years 2010 and 2011.[27] The 2010 Legislature voided this allotment reduction and reduced basic care payment rates by an additional 1.5 percentage points for fiscal years 2010 and 2011.

The 2010 Legislature prohibited reimbursement for basic care services and physician and professional services (see below) from exceeding the Medicare payment rate for the applicable services, effective July 1, 2010. Services provided by advanced practice registered nurse midwives, traditional midwives, and certain mental health services, were exempted from this payment limit. The legislature also reclassified physical therapy, occupational therapy, and speech language pathology services as basic care services, effective July 1, 2010 (they had previously been classified under physician and professional services). This has the effect of applying the lower percentage rate reduction that applies to basic care to these therapy providers.

[27] This unallotment, and others described in this information brief, was part of a package of unallotment actions taken by the governor in 2009. One of these unallotments, related to funding for a special diet program, was the subject of a court challenge. The Minnesota Supreme Court ruled, on May 5, 2010, that this unallotment was "unlawful and void." The opinion stated that since the "legislative and executive branches never enacted a balanced budget for the 2010-2011 biennium, use of the unallotment power to address the unresolved deficit exceeded the authority granted to the executive branch . . . " (*Brayton, et al. v. Pawlenty, et al.*, 781 N.W.2d 357, 368 (Minn. 2010).

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, physical therapist, occupational therapist, speech therapist, 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.)

The 2009 Legislature reduced physician and professional service payment rates for specialty services by 5 percent effective July 1, 2009, and made proportional reductions in managed care and county-based purchasing plan capitation rates. The reductions do not apply to office and outpatient services, preventive medicine, and family planning services provided by certain primary care providers. Gov. Pawlenty, as part of unallotment, increased the percentage reduction by an additional 1.5 percentage points (to a total of 6.5 percent) for fiscal years 2010 and 2011. The 2010 Legislature voided this allotment reduction and reduced payment rates for physician and professional services by an additional 1.5 percentage points for fiscal year 2010.

The 2010 Legislature also reduced reimbursement rates for physician and professional services, effective July 1, 2010, by an additional 7 percent (over the 5 percent reduction made in 2009).

Prescription Drug Reimbursement

Under the MA fee-for-service program, pharmacies are reimbursed for most drugs at the lower of: (1) average wholesale price (AWP) minus 15 percent[28] plus a fixed dispensing fee; (2) the maximum allowable cost set by the federal government or DHS plus a fixed dispensing fee; or (3) the pharmacy's usual and customary price charged to the public. The fixed dispensing fee in most cases is $3.65 per prescription; higher dispensing fees are allowed for intravenous solutions compounded by a pharmacist, cancer chemotherapy products, and total parenteral nutritional products (see Minn. Stat. § 256B.0625, subd. 13e).

[28] MA reimbursement based on the AWP was reduced from AWP minus 14 percent to AWP minus 15 percent, effective July 1, 2009 (Laws 2009, ch. 79, art. 5, § 30).

1. **AWP formula.** The MA program uses the AWP minus 15 percent formula to reimburse pharmacies for most brand-name drugs. AWP is generally a drug wholesaler's list price to pharmacies for a prescription drug. (In practice, most pharmacies purchase prescription drugs for an amount less than AWP, at a percentage above the wholesaler's cost.) The AWP is based on national pricing data compiled by drug price publishing companies, using data self-reported by drug manufacturers. A recent federal district court class action settlement[29] has modified the formula used to calculate AWP for many brand-name drugs. The settlement lowered the AWP for many brand-name prescription drugs effective September 26, 2009, and thereby reduced the reimbursement pharmacies receive from MA for those brand-name drugs.

   The two drug pricing companies involved in the settlement have also voluntarily agreed to stop publishing AWP price data within two years of the date of the settlement. The practical effect of this will be to require Minnesota, and other states that use AWP in their Medicaid drug reimbursement formulas, to modify these formulas by incorporating a measure of drug costs that is not based on AWP.

2. **Maximum allowable cost.** MA reimbursement to pharmacies for multiple-source drugs (drugs for which at least one generic exists) may be subject to a maximum allowable cost (MAC). The purpose of a MAC price is to set the reimbursement rate closer to the actual acquisition cost of the generic drug. Federal law requires CMS to set a MAC (referred to as a federal upper limit or FUL) for certain multiple-source drugs. Each state's Medicaid program must meet an aggregate FUL for all drugs for which CMS has set a FUL. States can also set state MACs for multiple-source drugs that are lower than any FUL and for drugs for which CMS has not set a FUL. Minnesota has chosen to set state MACs for a large number of multiple-source drugs.

3. **Usual and customary price.** MA reimburses pharmacies at the usual and customary price charged to the public, if this is lower than the payment rate under the AWP formula or the MAC price. This provision allows the MA program to reimburse large chain pharmacies for generic drugs provided to MA recipients at their discounted price for the general public (e.g., $4.00 per prescription).

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[29] See *New England Carpenters Health Benefits Fund, et al. v. First DataBank, Inc. and McKesson Corp.*, 602 F.Supp.2d 277 (D.Mass. 2009) (see also, Final Order and Judgment, March 30, 2009). The terms of the settlement, as approved by the court, in part required First DataBank and Medi-Span (two publishers of drug pricing information), beginning September 26, 2009, to calculate AWP for a large number of brand-name drugs at the level of wholesale acquisition cost (WAC) plus 20 percent, rather than WAC plus 25 percent, as had been their recent practice. (WAC is generally a drug manufacturer's price charged to drug wholesalers for a product.) This has the effect of reducing the AWP for those brand-name drugs. Minnesota's MA program uses First DataBank as its source for AWP data. DHS has calculated AWP using the revised lower values since September 29, 2009 (see Provider Update PRX-09-02, August 27, 2009).

A complaint was filed in federal court by several pharmacy groups seeking an injunction to enjoin the use of the lower AWP value, and also requesting the court to overturn the July 1, 2009, rate change that reduced reimbursement based on AWP from AWP minus 14 percent to AWP minus 15 percent. (See *Minnesota Pharmacists Ass'n et al. v. Pawlenty et al.*, complaint for injunctive and declaratory relief filed with the U.S. District Ct. (Minn.), October 2, 2009.) The court denied the plaintiff's request for an injunction and also did not overturn federal approval of the payment rate reductions. (See *Minnesota Pharmacists Ass'n et al. v. Pawlenty et al.*, U.S. District Ct. (Minn.), 690 F.Supp.2d 809 (D.Minn. 2010).)

In addition, the MA program has negotiated payment rates lower than those described above for specialty pharmacy products, defined as those used by a small number of recipients or by recipients with complex and chronic diseases requiring expensive and challenging drug regimens (see Minn. Stat. § 256B.0625, subd. 13e, para. (e)).

Hospitals

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

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

Hospital payment rates are not automatically adjusted for inflation, but under Minnesota law are required to be rebased (recalculated using more current cost data) at least every two years. Rebasing has the effect of adjusting payment rates for inflation.

In response to budget shortfalls, the legislature has at times delayed rebasing or set the rebasing formula at less than full value. Most recently, the 2010 Legislature eliminated a provision in current law that would have instituted rebasing at less than full value beginning January 1, 2011, and full rebasing beginning April 1, 2012. The legislature instead prohibited rebasing until January 1, 2013, at which time rebasing would be at full value. The 2010 Legislature also exempted a Minnesota long-term care hospital from the delay in rebasing.

The legislature has also at times reduced inpatient hospital payment rates and made related changes. The 2009 Legislature reduced inpatient hospital payment rates by 1 percent, effective July 1, 2009, and delayed a portion of inpatient hospital payments to the next fiscal year (Gov. Pawlenty, through unallotment, delayed the full amount of the payments). The 2010 Legislature voided this allotment reduction and authorized a delay in the full June 2011 payment until fiscal year 2012. The 2010 Legislature also reduced inpatient hospital rates by an additional 1.96 percent, effective July 1, 2011.

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 Developmental Disabilities (ICFs/DD)

ICFs/DD 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, plus

any inflation adjustments authorized by the legislature in law. 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/DD is described in Minnesota Statutes, sections 256B.5011 to 256B.5015.

The 2009 Legislature reduced ICF/DD payments rates by 2.58 percent, effective July 1, 2009. Gov. Pawlenty, through unallotment, prohibited the granting of new variable rate adjustments for fiscal year 2010, suspended existing variable rate adjustments for fiscal year 2011, and also suspended occupancy rate adjustments for fiscal years 2010 and 2011. The 2010 Legislature voided these allotment reductions and prohibited new variable rate adjustments for fiscal year 2010 and suspended occupancy rate adjustments for fiscal years 2010 and 2011.

Nursing Facilities

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. The RUGS case-mix reimbursement system for nursing homes is described in Minnesota Statutes, sections 144.0724 and 256B.438.

MA rates and private pay rates do not vary within a facility. This is due to Minnesota's equalization law, which prohibits nursing facilities from charging private pay residents more than residents whose care is paid for by MA.

Since October 1, 2006, all nursing facilities participating in MA have been reimbursed under the alternative payment system (APS), sometimes referred to as the contract system. APS was developed as an alternative to an existing cost-based system (sometimes referred to as Rule 50). Under the cost-based system, reimbursement to facilities was based upon their reported costs, and at times, certain limits applied to the rate of increase in operating costs. Under APS, facilities are exempt from certain requirements of the cost-based system and are reimbursed at the level of their payment rate in effect just prior to entering into an APS contract with the commissioner. These payment rates are adjusted annually for inflation, subject to limitations specified in law. Effective July 1, 1999, through September 30, 2013, the automatic inflation adjustment has been or will be applied only to the property-related rate; inflation adjustments for operating costs must be authorized by the legislature.

The 2007 Legislature required DHS to rebase nursing facility rates. Rebasing will allow nursing facilities to have new or currently unreimbursed expenditures recognized in the facility payment rate, subject to certain limits. The rebased operating cost payment rates took effect October 1, 2008, and will be phased in over eight years, through the rate year beginning October 1, 2015. Property rates will be rebased beginning October 1, 2014. During the phase-in period, facilities

will be held harmless—a facility cannot receive an operating cost payment rate that is less than what the facility would have received without rebasing.

The 2008 Legislature set a rebasing floor for the rate year beginning October 1, 2008, of 1 percent, funded by setting a limit on the maximum increase a facility can receive under rebasing. The 2008 Legislature also increased nursing facility operating payment rates by 1 percent effective October 1, 2008, and also provided a temporary rate increase of an additional 1 percent that applies only for the period October 1, 2008, through September 30, 2009.

The 2009 Legislature suspended the phase-in of rebased rates October 1, 2010, through September 30, 2013, but retained (and did not delay) the phase-in formula currently in law, so that rebasing will resume October 1, 2013, with 65 percent of the payment rate reflecting rebased costs. The governor, through unallotment, suspended the phase-in of rebasing for fiscal year 2010. This had the effect of eliminating an increase of 1 percent (from 13 percent to 14 percent) in the proportion of a nursing facility's payment rate that uses rebased costs. The 2010 Legislature voided this allotment reduction and eliminated the phase-in of rebasing for fiscal year 2010.

Funding and Expenditures

The federal and state governments jointly finance MA.

Federal Share

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

For the period October 1, 2008, through December 31, 2010, the American Recovery and Reinvestment Act (ARRA)—the federal stimulus bill—provided Minnesota with a higher FMAP. For the period October 1, 2008, through March 31, 2009, Minnesota's FMAP was 60.19 percent, rather than 50 percent as calculated under the regular formula. For the period April 1, 2009, through December 31, 2010, Minnesota's FMAP is 61.59 percent. Minnesota's FMAP was projected to return to its regular level of 50 percent beginning January 1, 2011.

The Education, Jobs, and Medicaid Assistance Act, signed into law on August 10, 2010, provides states with an increase in their regular FMAP of 3.2 percentage points for the period January 1, 2011, to March 31, 2011, and an increase of 1.2 percentage points for the period April 1, 2011, to June 30, 2011 (after which a state's FMAP will revert to its regular percentage). In order for a state to receive the higher FMAP, the governor of a state must request from the federal government the additional funding by September 24, 2010. Gov. Pawlenty requested the additional funding in a September 7, 2010, letter to the Secretary of Health and Human Services.

Nonfederal Share

The state, with some exceptions, has been responsible for the nonfederal share of MA costs since January 1991.[30]

MA Expenditures – State Fiscal Year 2009

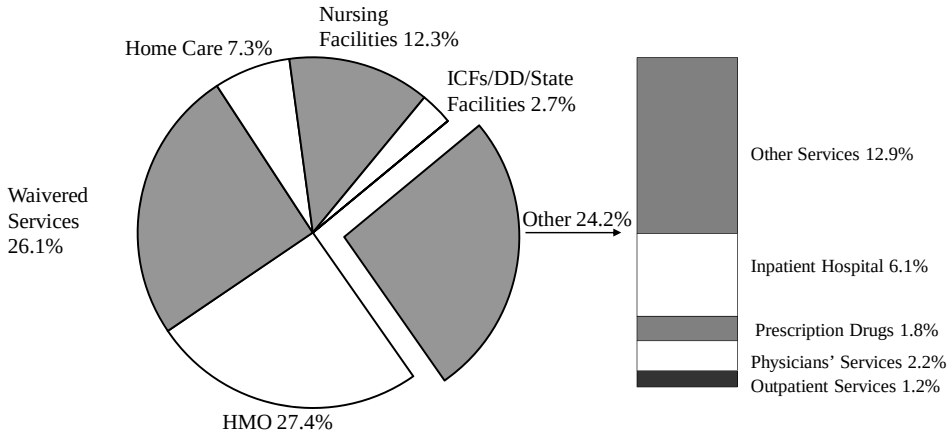
In fiscal year 2009, total MA expenditures for services were $6.755 billion. This total was distributed between the levels of government as follows:

Actual Expenditures — SFY 2009	
Federal	$3.871 billion
Nonfederal	$2.904 billion

The following chart shows the percentage of MA spending in fiscal year 2009 on the major service categories.

- HMO and waivered services were the largest single expenditure categories (each representing just over one-fourth of MA spending).
- Community-based long-term care (waivered services and home care services) accounted for about one-third of MA spending.
- Long-term institutional care (care provided in nursing homes, ICFs/DD, and state facilities) accounted for 15 percent of MA spending.

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



Note: The waivered services category includes waiver payments to HMOs.

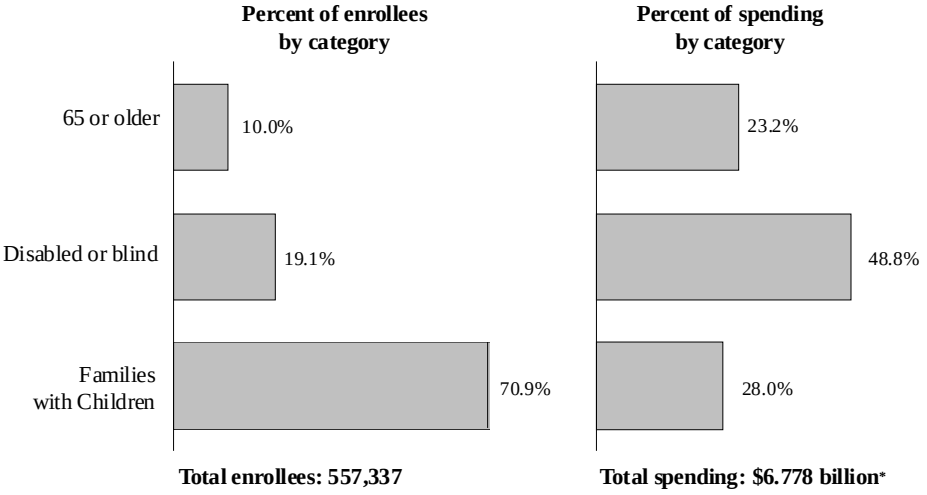
Source: Department of Human Services, February 2010 Forecast

Recipient Profile

During fiscal year 2009, an average of 557,337 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.

- Families with children make up the largest eligibility group, constituting 70.9 percent of eligibles. However, this group accounted for only 28.0 percent of MA spending.
- The elderly, and the disabled or blind, accounted for 72.0 percent of MA spending, although only 29.1 percent of eligibles are in these two groups.

Minnesota Medical Assistance Eligibles – SFY 2009



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

Source: Department of Human Services

MA Income Limit – Federal Poverty Guidelines[31]
for 4/1/10 through 6/30/11 – 12-month Standard

Household Size	**100%**	**135%**	**150%**	**200%**	**275%**	**280%**
1	$10,836	$14,868	$16,248	$21,900	$29,784	$ 30,324
2	14,580	19,920	21,864	29,388	40,080	40,800
3	18,324	24,972	27,480	36,876	50,376	51,276
4	22,068	30,024	33,096	44,364	60,672	61,752
5	25,812	35,076	38,712	51,852	70,968	72,228
6	29,556	40,128	44,328	59,340	81,264	82,704
7	33,300	45,180	49,944	66,828	91,560	93,180
8	37,044	50,232	55,560	74,316	101,856	103,656
9	40,788	55,284	61,176	81,804	112,152	114,132
10	44,532	60,336	66,792	89,292	122,448	124,608
Each Additional Person	3,744	5,052	5,616	7,488	10,296	10,476

House Research Department

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

[31] Federal poverty guidelines are updated every year, usually in February. New DHS income standards based on updated guidelines are effective later in the calendar year.