



Medical Assistance

November 2019

Overview

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 publication brief describes eligibility, covered services, and other aspects of the program.

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Administration

Federal Government

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.

Medicaid is administered at the federal level by the Center for Medicare and Medicaid Services (CMS), an agency within the U.S. Department of Health and Human Services. CMS issues regulations and guidelines for Medicaid that states are required to follow.

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](#) (provisions related to hospital payment rates are found in [Minnesota Statutes, chapter 256](#) and provisions related to nursing facility payment rates are found in [Minnesota Statutes, chapter 256R](#)).

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 and MNsure

County human services agencies, and tribal governments choosing to participate, share the responsibility for determining if applicants meet state and federal eligibility standards for MA. Depending on their basis of eligibility, individuals apply for MA by:

- submitting an application online through the MNsure website; or
- filing a paper application at a county or tribal 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 for individuals who have disabilities and 15 days for pregnant women.)

The Minnesota eligibility system, defined in [Minnesota Statutes, section 62V.055](#), subdivision 1, and also referred to as the Minnesota Eligibility Technology System (METS), is used by county human services agencies and tribal governments to determine MA eligibility for families and children, pregnant women, and adults without children. MA eligibility is determined online through this eligibility system and by submitting paper application forms to a county or tribal human services agency. This eligibility system is also used to determine eligibility for MinnesotaCare,¹ and for premium tax credits and cost-sharing reductions available under the Affordable Care Act (ACA) for qualified health plan coverage purchased through MNsure.

County agencies, and tribal governments choosing to participate, are responsible for determining eligibility for MA applicants who are age 65 or older, blind, or have disabilities, or who belong to certain smaller MA eligibility categories. Eligibility for these categories of individuals is determined using the legacy MAXIS eligibility determination system.

¹ MinnesotaCare is administered by DHS as a Basic Health Program under the ACA, to provide subsidized health coverage to eligible Minnesotans. For more information, see the House Research publication [MinnesotaCare](#).

Eligibility Requirements

MA pays for 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 children, parents and caretakers, pregnant women, people age 65 or over, persons who are blind or have disabilities, and most recently, adults without children, who meet the program's income and, if applicable, asset standards.

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

- be a citizen of the United States or a lawfully present noncitizen who meets specified criteria
- 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 any applicable asset limits, or qualify on the basis of a "spenddown" (described later in this publication)
- not reside in a public institution, or in a public or private Institution for Mental Diseases (IMD)

Eligibility for most enrollees is redetermined every 12 months. Persons who qualify for MA through a spenddown have their eligibility redetermined every six months.

Citizenship

To be eligible for MA, an individual must be a citizen of the United States or a lawfully present noncitizen who meets specified criteria. MA eligibility varies by immigration status. For example, asylees and refugees are generally eligible for MA, while lawful permanent residents who are not pregnant women or children under age 21 are not eligible for MA until they have resided in the United States for five or more years. Minnesota has generally chosen to provide MA coverage for all groups of noncitizens for which MA eligibility is mandatory or optional under federal welfare law and for which a federal match is provided.

Undocumented persons, and lawfully present noncitizens not eligible for regular MA coverage with a federal match, are eligible only for MA coverage of emergency services. Emergency MA (EMA) with federal financial participation (FFP) covers MA services necessary to treat an emergency medical condition, including labor and delivery and a limited set of chronic care and long-term care services (certain dialysis services, services to treat cancer, and kidney transplants). Undocumented pregnant women may qualify for Children's Health Insurance Program (CHIP) funded MA coverage for the duration of their pregnancy and a 60-day postpartum period (see page 19).

Residency

To be eligible for MA, an individual must be a resident of Minnesota, as determined under federal law.² Generally, persons age 21 and older are considered residents if they live in Minnesota and intend to reside in the state, or they live in Minnesota and entered the state with a job commitment or to seek employment. Generally, persons younger than age 21 who are not emancipated are considered residents if they live in Minnesota, or reside with a parent or caretaker who is a Minnesota resident. Persons visiting Minnesota, including those visiting for the purpose of obtaining medical care, are not considered residents.

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. With Minnesota's expansion of eligibility to include adults without children, persons in all major groups are now potentially eligible for MA, if they meet income and other program eligibility requirements.

In Minnesota, 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.)
- adults without children, ages 21 through 64
- children eligible for or receiving state or federal adoption assistance payments
- children eligible for federal foster care payments or state foster care or kinship care assistance³
- individuals under age 26 who received foster care services while age 18 or older, and who were enrolled in MA or MinnesotaCare at the time foster care services ended⁴

² 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](#)).

³ Eligibility for children receiving state foster care or kinship care assistance is effective January 1, 2020, or upon federal approval, whichever is later.

⁴ Coverage for these former foster care youth was required by the ACA, effective January 1, 2014. No income limit applies to persons covered under this category.

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 in most groups eligible for MA coverage may be able to qualify by spending down their income (see page 8).

Income Limits

To be eligible for MA, an applicant's income must not exceed program income limits. Different income limits apply to different categories of individuals (see table on page 9). 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 guidelines vary with family size and are adjusted annually for inflation.

Income determination. An income methodology that specifies countable and excluded income is used to determine income for different eligibility groups. As required by the ACA, MAGI-based income⁵ is used as the income methodology for children, infants, parents and caretakers, pregnant women, and adults without children. In the past, the income methodology used for these eligibility groups was that used by the state's Aid to Families with Dependent Children (AFDC) program as of July 16, 1996 (this AFDC methodology still applies to parents and caretakers who qualify for MA through a spenddown). The income methodology used for enrollees who are elderly, blind, or have disabilities is based on that used by the federal SSI program.

The state, as a part of ACA compliance, uses a standard 5 percent of FPG income disregard when determining eligibility for groups for whom MAGI-based income is required to be used as the income methodology. This standard disregard replaced state-specific disregards and has the effect of raising the FPG income limit for MAGI-based income groups by 5 percentage points.

Recent changes in income limits. The income limits for adults without children, parents and caretakers, and children 19 through 20 were increased to 133 percent of FPG on January 1, 2014, as part of the state's implementation of the ACA's option to expand eligibility for these groups.⁶

⁵ Modified adjusted gross income (MAGI) is defined as adjusted gross income increased by: (1) foreign earned income exclusion; (2) tax-exempt interest; and (3) an amount equal to the value of Social Security benefits not subject to tax (I.R.C. § 36B). MAGI-based income excludes from MAGI certain scholarships, awards, or fellowship grants used for educational purposes and certain types of income received by American Indians and Alaska natives, and counts lump sums as income only in the month received.

⁶ Adults without children with incomes up to 75 percent of FPG had been covered in Minnesota since March 1, 2011, under the ACA's Medicaid early expansion option. The income limit for parents and caretakers, and children ages 19 through 20, was 100 percent of FPG at the time of the January 1, 2014, increase.

Also on January 1, 2014, the MA income limit for children ages two through 18 was increased from 150 percent to 275 percent of FPG. This change was accompanied by a reduction in the MinnesotaCare income limit from 275 percent to 200 percent of FPG for children and other eligibility groups, and the establishment of an income floor for MinnesotaCare coverage at 133 percent of FPG. The increase in the MA income limit for children, and the accompanying reduction in the MinnesotaCare income limit for that group, means that most children who would have been eligible for MinnesotaCare under that program's old income limit are now eligible for MA. Since MinnesotaCare law provides that persons eligible for MA are not eligible for MinnesotaCare, most children now enroll in MA rather than MinnesotaCare.

Transitional MA⁷

Individuals who lose MA eligibility (under the 133 percent of FPG income limit) due to increased earned income or the loss of an earned income disregard,⁸ or due to increased child⁹ or spousal support, may be able to retain MA coverage for a transitional period, if: (1) the individual's income did not exceed 133 percent of FPG for at least three of the past six months; and (2) the household contains a dependent child and a caretaker. Individuals who lose eligibility due to earned income or loss of an earned income disregard remain eligible for an initial period of six months and can continue to receive MA coverage for up to six additional months if their income does not exceed 185 percent of FPG. Individuals who lose eligibility due to increased child or spousal support remain eligible for four months.

Asset Limits

MA has two main asset limits. One applies to persons who are elderly, blind, or who have a disability.¹⁰ The other applies to parents and caretakers who qualify for MA through a spenddown (the spenddown is described in a section that follows). Children under age 21, pregnant women, parents and caretakers who do not qualify through a spenddown, and adults without children are exempt from any asset limit. In addition, different asset limits apply to some of the smaller MA eligibility groups (see table on page 9).

Age 65 or older, blind, or disabled. Persons who are age 65 or older, blind, or who have a disability 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

⁷ See [Minnesota Statutes, section 256B.0635](#). Ongoing funding for transitional MA was provided by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), H.R. 2, Pub. L. No. 114-10, which became law on April 16, 2015. Prior to this, funding was periodically reauthorized by the U.S. Congress.

⁸ The loss of an earned income disregard is no longer applied in practice as an eligibility criterion, due to the use of a standard income disregard (see previous section on Income Determination).

⁹ Loss of eligibility due to increased child support is no longer relevant since child support is not counted as income under the MAGI-based income methodology.

¹⁰ 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.

household, with \$200 added for each additional dependent. Certain assets are excluded when determining MA eligibility for these individuals, including the following:

- the homestead
- household goods and personal effects
- a burial plot for each family member
- life insurance policies and assets for burial expenses, up to the limits established for the SSI program¹¹
- 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 program¹²
- certain assets owned by American Indians related to the relationship between tribes and the federal government, or with unique Indian significance

Parents and caretakers on a spenddown. An asset limit of \$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, applies to parents and caretakers who qualify for MA through a spenddown (see page 8 for a discussion of the spenddown).¹³

Certain items are excluded when determining MA eligibility for these individuals, including the following:

- the homestead
- household goods and personal effects
- a burial plot for each family member
- 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
- 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

¹¹ The SSI program allows recipients to set aside, or designate, up to \$1,500 in assets to cover certain burial expenses.

¹² 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.

¹³ This asset limit applied to all parents and caretakers through December 31, 2013, but was eliminated effective January 1, 2014, for parents and caretakers not on a spenddown, as part of ACA compliance.

- certain assets owned by American Indians related to the relationship between tribes and the federal government, or with unique Indian significance

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 would qualify for coverage under MA, except for excess income, can qualify for MA through a “spenddown.” However, no spenddown option is available for persons eligible as adults without children.

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	133% of FPG
Age 65 or older, blind, or disabled	81% of FPG

The spenddown standard for persons who are age 65 or older, blind, or who have a disability, was increased from 80 percent to 81 percent of FPG effective June 1, 2019, and is scheduled to increase to 100 percent of FPG effective July 1, 2022.

MA Eligibility – Income and Asset Limits – Benefits

Eligibility Category	Income Limit	Asset Limit	Benefits
Children under age two ¹⁴	≤ 283% of FPG	None	All MA services
Children two through 18 years of age	≤ 275% of FPG	None	All MA services
Children 19 through 20 years of age	≤ 133% of FPG	None	All MA services
Pregnant women	≤ 278% of FPG	None	All MA services
Parents or relative caretakers of dependent children on MA	≤ 133% of FPG	None, unless on spenddown	All MA services
Age 65 or older, blind, or have a disability	≤ 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
Adults without children	≤ 133% of FPG	None	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
Specified Low-income 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) ¹⁵	≥ 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 disabled working individuals	≤ 200% of FPG	Must not exceed twice the SSI asset limit	Medicare Part A premium only

¹⁴ Children with incomes greater than 275 percent and less than or equal to 283 percent of FPG are funded through the federal Children’s Health Insurance Program (CHIP) with an enhanced federal match. As part of the conversion from the existing net income standard to an equivalent standard based on MAGI income methodology, the income limit for children under age two was increased from 280 percent to 283 percent of FPG and the income limit for pregnant women was increased from 275 percent to 278 percent of FPG.

¹⁵ Ongoing funding for coverage of qualifying individuals was provided by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), H.R. 2, Pub. L. No. 114-10, signed into law on April 16, 2015. Prior to this, funding was renewed periodically by the U.S. Congress.

Eligibility Category	Income Limit	Asset Limit	Benefits
Disabled children eligible for services under the TEFRA children's home care option ¹⁶	≤ 100% of FPG ¹⁷	None	All MA services
Employed persons with disabilities	No income limit	\$20,000	All MA services

House Research Department

Institutional Residence

Individuals living in public institutions, such as secure correctional facilities, are generally not eligible for MA, except that since January 1, 2014, the MA program has paid for covered services provided to inmates while they are inpatients in a hospital or other medical institution.

Individuals living in Institutions for Mental Diseases (IMDs) are generally not eligible, unless they are under age 21 and are receiving inpatient psychiatric services in certain settings, 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.

Minnesota recently received federal approval for MA to pay for substance use disorder services provided to short-term residents of facilities classified as IMDs, for the period July 1, 2019, through June 30, 2024.¹⁸

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.

The ACA authorizes states to provide persons newly eligible under the optional MA expansion (adults without children in the case of Minnesota) with benchmark or benchmark-equivalent benefits¹⁹—an alternative benefit set that can be different from the regular MA benefit set.

¹⁶ Authorized by section 134 of the federal Tax Equity Fiscal Responsibility Act (TEFRA) of 1982.

¹⁷ 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. As noted in the table, children can qualify for MA at higher income levels, but the income of the parent or caretaker would also be counted.

¹⁸ Center for Medicare and Medicaid Services, approval letter for Minnesota's section 1115 demonstration project – Minnesota's Substance Use Disorder System Reform (Project No. 11-W-00320/5), dated June 28, 2019.

¹⁹ Benchmark or benchmark-equivalent coverage must be equal to one of three specified benchmark plans, be actuarially equivalent plans, or be coverage that is approved by Secretary of Health and Human Services. One of the options for secretary-approved coverage is a state's regular Medicaid benefit set.

Minnesota has chosen to provide adults without children with the regular MA benefit set (described below) that is provided to persons in most other MA eligibility categories.

Federally Mandated Services for 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
- Pregnancy-related services (through 60 days postpartum)

Optional Services for 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
- Chiropractor services
- Clinic services
- Community emergency medical technician services
- Community paramedic services
- Dental services²⁰
- Doula services
- Other diagnostic, screening, and preventive services
- Emergency hospital services

²⁰ Coverage of dental services for adults who are not pregnant is limited to specified services (see [Minn. Stat. § 256B.0625](#), subd. 9 (2014)).

- 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 for children and adults
- Nurse anesthetist services
- Certified geriatric, adult, OB/GYN, and neonatal nurse practitioner services
- Occupational therapy services
- Personal care assistant services
- Pharmacy services²¹
- Physical therapy services
- Podiatry services
- Post-arrest community-based service coordination²²
- 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

Cost-sharing

Certain MA enrollees are subject to the following cost-sharing:

- \$3 per nonpreventive visit (does not apply to mental health services)
- \$3.50 for nonemergency visits to a hospital emergency room

²¹ MA does not cover prescription drugs covered under the Medicare Part D prescription drug benefit for individuals enrolled in both MA and Medicare (referred to as “dual eligibles”). These individuals 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.

²² Federal approval for this service has been received, and DHS plans to offer this service around the beginning of 2020.

- \$3 per brand-name prescription and \$1 per generic prescription, subject to a \$12 per-month limit. Antipsychotic drugs are exempt from copayments when used for the treatment of mental illness.
- A monthly family deductible of \$3.20 (adjusted annually by the increase in the medical care component of the CPI-U)

Children and pregnant women are exempt from copayments and deductibles; other exemptions apply. Total monthly cost-sharing is limited to 5 percent of family income. American Indians and Alaska Natives are exempt from cost-sharing if they have ever received a service from the Indian Health Service, a tribal health program or an urban Indian program, or through a referral from one of these programs.

Health care providers are responsible for collecting the copayment or deductible from enrollees; MA reimbursement to a provider is reduced by the amount of the copayment or deductible. Providers cannot deny services to enrollees who are unable to pay the copayment or deductible.

The family deductible is waived for enrollees of managed care and county-based purchasing plans. The commissioner may waive the family deductible for individuals and allow long-term care and waiver services providers to assume responsibility for payment.

Some Services 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 and require the level of care provided in a nursing home.

Minnesota also has a solely state-funded program, the **Alternative Care (AC)** program, which provides community-based care for elderly individuals who are at risk of nursing home placement and 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 or related conditions 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 need the level of care provided in a hospital.

The **Community Access Disability Inclusion (CADI)** waiver provides community-based care to disabled individuals under age 65 who need the level of care provided in a nursing home.

The **Brain Injury (BI)** waiver provides community-based care to persons under age 65 diagnosed with traumatic or acquired brain injury that need the level of care provided in a nursing home that provides specialized services for persons with brain injury or a neurobehavioral hospital.

For each of the federally approved waiver programs, the costs of caring for individuals in the community cannot exceed (in the aggregate) the cost of institutional care.

MA Managed Care

MA enrollees receive services under a fee-for-service system (described in the next section) or through a managed care system. Minnesota's managed care programs operate under federal waivers that allow states to implement innovative methods of health care delivery, require enrollment in managed care plans, and limit enrollee provider choice to those providers under contract with a managed care plan.

Under the managed care system, MA enrollees who are families and children or adults without children receive services under the Prepaid Medical Assistance Program (PMAP) from managed care plans or through county-based purchasing initiatives. Enrollees who are age 65 or older receive services from managed care and county-based purchasing plans through Minnesota Senior Care Plus or through Minnesota Senior Health Options (MSHO). Enrollees who have disabilities have the option of receiving services through the Special Needs BasicCare (SNBC) program, a statewide program for persons with disabilities.

County-based purchasing provides an alternative method of health care service delivery under PMAP (and also under the Minnesota Senior Care Plus, MSHO, and SNBC programs described below). County boards that elect to implement county-based purchasing are responsible for providing all services required by PMAP or the applicable program to enrollees, either through their own provider networks or by contracting with managed care plans. DHS payments to counties cannot exceed payment rates to managed care plans. As of August 2019, three county-based purchasing initiatives involving 25 counties were operational.

Programs for Families and Children

Under PMAP, managed care and county-based purchasing plans contract with DHS to provide services to MA enrollees who are families and children or adults without children. 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 managed care or county-based purchasing 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 or county-based purchasing initiatives to provide services in all 87 counties.

As of August 2019, 736,909 MA enrollees received services through PMAP from managed care or county-based purchasing plans.

Competitive Bidding

DHS has traditionally contracted with all managed care and county-based purchasing plans that met program standards and agreed to payment terms for serving families and children (and most recently adults without children) under MA and MinnesotaCare. In recent years, DHS has selected plans to serve these population groups using competitive bidding. Under competitive bidding, plans submit proposals that are scored on price and technical qualifications. Based on these scores, DHS has normally chosen two or three plans to serve each county (with county-based purchasing plans sometimes serving as the sole plan under MA in certain counties). Under competitive bidding, not all plans submitting proposals are selected to serve MA and MinnesotaCare enrollees, and there may be changes in the plans selected to serve each county over different cycles of competitive bidding.

Competitive bidding was first used in 2011 to select plans to serve MA and MinnesotaCare enrollees in the seven-county metropolitan area beginning in calendar year 2012. In 2013, competitive bidding was used to select plans to serve enrollees in 27 counties located outside of the seven-county metropolitan area beginning in calendar year 2014. In 2015, competitive bidding was used in 2015 to select plans to serve MA and MinnesotaCare enrollees in all Minnesota counties, as part of a statewide procurement, beginning in calendar year 2016.

DHS had issued a request for proposals to use competitive bidding to select plans to serve MA and MinnesotaCare enrollees in the 80 Greater Minnesota counties, beginning in calendar year 2020. DHS cancelled the request for proposal process in September 2019, due in large part to a district court order that delayed managed care contracting in eight counties.²³

Programs for the Elderly

Minnesota Senior Care Plus provides MA services to enrollees age 65 or older. Minnesota Senior Care Plus covers the same services as PMAP, except that prescription drugs for MA enrollees also eligible for Medicare were covered by Medicare Part D (see footnote 21 on page 12). 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.

Enrollees in Minnesota Senior Care Plus must enroll in a separate Medicare plan to obtain their prescription drug coverage under Medicare Part D. However, enrollees also have the option of receiving managed care services through MSHO, rather than Minnesota Senior Care Plus. MSHO

²³ District Court, Second Judicial District, *South Country Health Alliance v. Minnesota Department of Human Services*, Court File No. 62-CV-19-5828, - Limited Temporary Injunction and Order for Disclosure, August 30, 2019.

includes all Medicare and MA prescription drug coverage under one plan. MSHO provides a combined Medicare and MA benefit, is available statewide, and operates under federal Medicare Advantage Special Needs Plan (SNP) authority.²⁴ 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 MA enrollees age 65 or older are enrolled in MSHO rather than Minnesota Senior Care Plus, due in part to the integrated Medicare and MA prescription drug coverage. As of August 2019, MSHO enrollment was 9,987, compared to enrollment in Minnesota Senior Care Plus of 16,812.

Programs for Persons with Disabilities

Special Needs BasicCare (SNBC) is a managed care program for persons with disabilities between the ages of 18 and 64. Some SNBC plans integrate MA with Medicare services, for persons who are dually eligible. The program served 54,499 individuals as of August 2019.

Managed Care Enrollment

Generally, MA recipients who are in families with children are required to enroll in PMAP. 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.

Since January 1, 2012, persons with disabilities have been enrolled in special needs plans, unless they choose to opt out of managed care enrollment and remain in fee-for-service.

As of August 2019, 848,207 MA enrollees received services through PMAP, Minnesota Senior Care Plus, MSHO, or SNBC.

Managed Care Payment Rates

Managed care and county-based purchasing plans receive a capitated payment rate for each enrollee (a capitated payment is fixed and does not vary with the actual services provided to the enrollee). The PMAP capitation rate is risk-adjusted using the Chronic Disability Payment System (CDPS) to reflect the overall health status of a plan's enrollees. Five percent of each plan's capitation rate is withheld annually and returned pending the plan's completion of performance targets related to various process and quality measures. Payment rates are the same for both managed care and county-based purchasing plans.

²⁴ 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.

The SNBC capitation rate is also risk adjusted using the CDPS system. MSHO and Minnesota Senior Care Plus rates are adjusted for age, sex, institutional status, Medicare status (for Minnesota Senior Care Plus), and geographical area.²⁵

DHS does not regulate managed care 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 managed care plan or county boards.

IHP demonstration project. Providers participating in the Integrated Health Partnership (IHP) demonstration project may have their capitated payments adjusted in an annual reconciliation process, to reflect the financial terms of the demonstration project. The IHP demonstration project was authorized by the legislature in 2010 (see [Minn. Stat. § 256B.0755](#)). Under the demonstration project, DHS contracts with groups of health care providers (referred to as integrated health partnerships) to provide or arrange for covered health care services under a value-based payment model that takes into account the cost and quality of health care services provided. All participating provider groups receive population-based payments to coordinate the care provided to enrollees. In addition, larger, more integrated provider groups are reimbursed under a risk-gain payment arrangement under which current spending for a defined set of services for attributed enrollees is compared to a spending target for these services that takes into account past expenditures for the set of services. The provider group shares savings (resulting from spending less than the target amount) and losses (resulting from spending more than the target amount) with the state. These shared savings and losses are calculated and applied to provider groups annually in the form of a reconciliation payment. As of August 1, 2019, over 447,279 MA and MinnesotaCare enrollees in fee-for-service or managed care were served by 25 integrated health partnerships.

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 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 selected provider types are described below.

²⁵ Rates for elderly recipients enrolled in 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.

IHP demonstration project. Providers participating in the IHP demonstration project (see description in previous section) may have their fee-for-service payments adjusted in an annual reconciliation process, to reflect sharing in any savings and losses relative to the target spending amount established under the demonstration project.

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 a specified percentile of all customary charges statewide for a procedure during a base year. The legislature has at times changed the specified percentile and base for different provider types and different procedures. Providers in all geographic regions of 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, physical therapist, occupational therapist, speech therapist, audiologist, community/public health clinic, family planning clinic, optician, dentist, and psychologist.

Other MA services are reimbursed at the lesser of: (1) the submitted charge; or (2) the Medicare maximum allowable rate or a rate established by DHS. Services reimbursed in this manner include those for costs relating to a laboratory, hospice, home health agency, medical supplies and equipment, prosthetics, and orthotics.

The legislature has modified payment rates for noninstitutional health care providers and health care services a number of times in recent years.

Drug Reimbursement

Under the MA fee-for-service program, pharmacies are reimbursed for most drugs at the lower of: (1) the ingredient costs of the drug plus a professional dispensing fee; or (2) the pharmacy's usual and customary price charged to the public. The ingredient cost for most drugs is based on the National Average Drug Acquisition Cost (NADAC).²⁶ For drugs for which a NADAC is not reported, the ingredient cost is estimated as the wholesale acquisition cost (WAC) plus 2 percent.²⁷ The professional dispensing fee in most cases is \$10.48 per prescription.

²⁶ The federal rule on outpatient drug reimbursement issued February 1, 2016 ([81 FR 5170](#)) requires Medicaid drug reimbursement to pharmacies to be based on a pharmacy's actual acquisition cost, as opposed to the estimated acquisition cost. NADAC is one of the methods of determining actual acquisition cost allowed by the rule. NADAC costs are calculated based on monthly national surveys of retail community pharmacy acquisition costs for covered outpatient drugs.

²⁷ WAC is the manufacturer's list price charged to wholesalers and other direct purchasers, not including discounts, rebates, and price reductions.

Other reimbursement limits apply to drugs dispensed by providers participating in the federal 340B Drug Pricing Program,²⁸ multiple-source drugs (drugs for which at least one generic exists), and certain specialty pharmacy products.

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 intended to represent the average cost to hospitals 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.) Payment rates based on DRGs are adjusted by various factors, including disproportionate share hospital (DSH) payments, which provide additional payments to hospitals with higher than average rates of MA utilization. MA uses the All Patient Refined DRGs (APR-DRGs) as its DRG system.

Hospital payment rates are not automatically adjusted for inflation, but under Minnesota law are required to be rebased (recalculated using more current cost data) every two years. Rates were most recently rebased to July 1, 2019.

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.

Minnesota also receives a federal payment through the Children's Health Insurance Program (CHIP) for the cost of MA services provided to:

- 1) children under age two with household incomes greater than 275 percent but not exceeding 283 percent of FPG;

²⁸ The federal 340B program allows federally qualified health centers, certain hospitals, and other eligible organizations to purchase drugs from manufacturers at significantly reduced prices.

- 2) uninsured pregnant women who are undocumented noncitizens with incomes up to 278 percent of FPG, through the period of pregnancy, including labor and delivery and 60 days postpartum; and
- 3) children under age 21 with household incomes greater than 133 percent but below 275 percent of FPG.

The CHIP payment is the difference between the state's enhanced CHIP federal matching rate and the state's MA federal matching rate of 50 percent.²⁹

As part of implementing the optional expansion of eligibility for adults without children and other groups under the ACA, Minnesota receives an enhanced federal match for the cost of services provided to enrollees who are newly eligible.³⁰ In Minnesota, the newly eligible group comprises adults without children; Minnesota receives the regular federal Medicaid match for parents and caretakers, persons with disabilities, and other persons in groups not considered to be newly eligible. The enhanced federal match is, 93 percent in 2019, and 90 percent from 2020 on. The enhanced federal match was 100 percent of MA costs for 2014 through 2016, 95 percent of MA costs in 2017, and 94 percent of MA costs in 2018.

Nonfederal Share

The state, with some exceptions, has been responsible for the nonfederal share of MA costs since January 1991.³¹

²⁹ Minnesota's regular enhanced CHIP federal matching rate is 65 percent. Minnesota's enhanced CHIP federal matching rate was 88 percent through federal fiscal year 2019, reflecting an increase under the ACA. A federal continuing resolution enacted on January 22, 2018, funds the CHIP program through FFY 2027. The continuing resolution provides an 11.5 percentage-point increase for FFY 2020 (resulting in a federal matching rate for Minnesota of 76.5 percent for that year). Minnesota's federal match will return to its regular matching rate of 65 percent in FFY 2021.

³⁰ Under the ACA, persons are newly eligible if they would not have been eligible under the MA state plan or a waiver as of December 1, 2009.

³¹ 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 that exceed 90 days of persons with disabilities under age 65, 10 percent of the cost of placements that exceed 90 days in ICFs/DD with seven or more beds, and 20 percent of the costs of placements that exceed 90 days in nursing facilities that are institutions for mental diseases (IMDs).

MA Expenditures – State Fiscal Year 2018

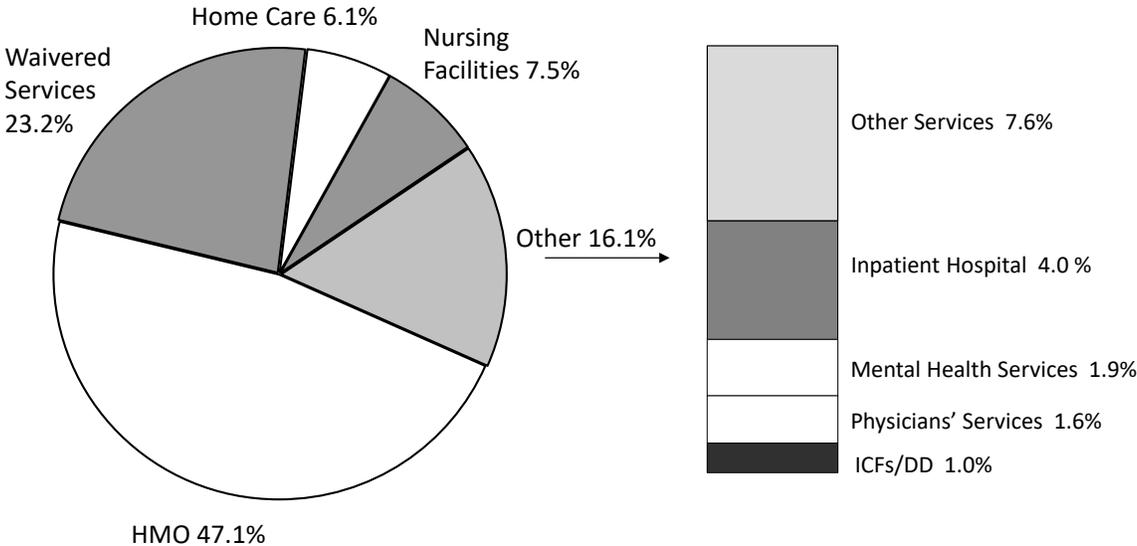
In fiscal year 2018, total MA expenditures for services were \$12.554 billion. This total was distributed between the levels of government as follows:

Actual Expenditures – SFY 2018	
Federal	\$7.213 billion
Nonfederal	\$5.341 billion

The following chart shows the percentage of MA spending in fiscal year 2018 on the major service categories.

- HMO services was the largest single expenditure category (representing 47 percent of MA spending).
- Community-based long-term care (waivered services and home care services) accounted for just under 30 percent of MA spending.
- Long-term institutional care (care provided in nursing homes and ICFs/DD) accounted for 7.5 percent of MA spending.

MA Expenditures by Service – SFY 2018



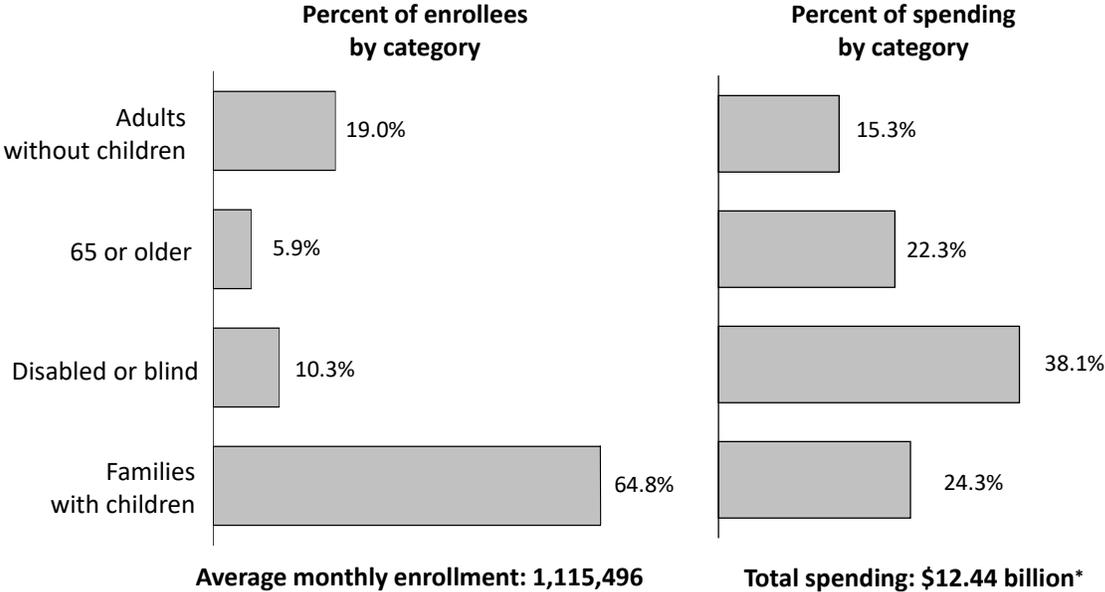
Note: The waived services category includes waiver payments to HMOs.
Source: Department of Human Services, November 2018 Forecast, Background Tables

Recipient Profile

During fiscal year 2018, an average of 1,115,496 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 graph 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 64.8 percent of eligibles. However, this group accounted for only 24.3 percent of MA spending.
- The elderly, and the disabled or blind, accounted for 60.4 percent of MA spending, although only 16.2 percent of eligibles are in these two groups.

Minnesota Medical Assistance Eligibles – SFY 2018



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

Source: Department of Human Services

**MA Income Limit – Federal Poverty Guidelines
for 7/1/19 through 6/30/20 – 12-month Standard**

Household Size	81%	100%	120%*	133%	135%*	200%*	275%	278%	283%
1	\$10,128	\$12,492	\$15,228	\$16,611	\$17,112	\$25,224	\$34,347	N/A	\$35,346
2	13,716	16,920	20,532	22,490	23,088	34,068	46,502	47,009	47,855
3	17,304	21,348	25,836	28,368	29,064	42,912	58,657	59,297	60,363
4	20,892	25,776	31,140	34,247	35,040	51,756	70,812	71,585	72,872
5	24,480	30,204	36,444	40,126	41,016	60,600	82,967	83,872	85,381
6	28,068	34,632	41,748	46,004	46,992	69,444	95,122	96,160	97,889
7	31,656	39,060	47,052	51,883	52,968	78,288	107,277	108,447	110,398
8	35,244	43,488	52,356	57,761	58,944	87,132	119,432	120,735	122,906
Each Additional Person	3,588	4,428	5,304	5,878	5,976	8,844	12,155	12,287	12,508

* Includes a \$20 disregard

Source: Department of Human Services, Insurance Affordability Programs (IAPs) – Income and Asset Guidelines

Glossary of Acronyms

AC: Alternative care (program)

ACA: Affordable Care Act

APR-DRG: All Patient Refined diagnosis-related group

BI: Brain injury (waiver)

CAC: Community alternative care (waiver)

CADI: Community access for disability inclusion (waiver)

CDPS: Chronic Disability Payment System

CHIP: Children’s Health Insurance Program

CMS: Center for Medicare and Medicaid Services

DD: Developmental disabilities (waiver)

DHS: Department of Human Services (Minnesota)

DRG: Diagnosis-related group

EMA: Emergency Medical Assistance

EW: Elderly waiver

FFP: Federal financial participation

FMAP: Federal medical assistance percentage

FPG: Federal poverty guidelines

ICF/DD: Intermediate care facility for persons with developmental disabilities

IHP: Integrated Health Partnership

IMD: Institution for mental diseases

LTCP: Long-term care partnership

MAGI: Modified adjusted gross income

METS: Minnesota Eligibility Technology System

MSA: Minnesota Supplemental Aid

MSHO: Minnesota Senior Health Options

NADAC: National Average Drug Acquisition Cost

PMAP: Prepaid Medical Assistance Program

SNBC: Special Needs BasicCare (program)

SNP: Special needs plan

SSI: Supplemental Security Income

WAC: Wholesale acquisition cost



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