

## 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 describes how the program works, including eligibility, covered services, funding, and other aspects of the program.

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## Administration

The MA program is Minnesota’s version of the federal Medicaid program. MA is administered by county and Tribal agencies, under the supervision of the Department of Human Services. Minnesota has established its own eligibility, covered service, and operating and administrative standards for MA, subject to the general requirements of federal Medicaid law and regulations. County agencies, participating Tribal governments, and MNSure share responsibility for determining applicant and enrollee eligibility for MA.

## Federal Government

Medicaid was established by the U.S. Congress in 1965 as Title XIX of the Social Security Act. 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.

All Medicaid programs must stay within the scope of these federal regulations and guidelines, but state programs can and do vary widely, due in part 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. Minnesota's MA law 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 the operation of the MA program at the state level and for supervising administration of the program by county and Tribal agencies. 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.

Eligibility determinations for most individuals must be completed within 45 days of receiving an application. The time limit is 60 days for individuals who have disabilities and 15 days for pregnant women.

**Eligibility systems.** 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,<sup>1</sup> 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.

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<sup>1</sup> 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

Generally, MA is available to children, parents and caretakers, pregnant women, people age 65 or over, persons who are blind or have disabilities, and 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)

**Retroactive coverage.** 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. (Minn. Stat. § 256B.056, subd. 7)

**Presumptive eligibility.** Some individuals may be determined to be temporarily eligible for MA through a presumptive eligibility process, under which specified providers<sup>2</sup> determine eligibility based on preliminary information, with ongoing eligibility then determined by county agencies within a specified time period.

**Redetermination of eligibility.** Eligibility for most enrollees is redetermined every 12 months. Persons who qualify for MA through a spenddown have their eligibility redetermined every six months. (Minn. Stat. § 256B.056, subd. 7 and 7a)

**Continuous eligibility for children.** MA enrollees are required to report income and other changes that may affect their eligibility; eligibility is then redetermined based on this change in circumstances. The 2023 Legislature allowed children to remain eligible for MA for a specified time period, even if income or other factors related to eligibility change (this is referred to as "continuous eligibility"). Effective January 1, 2024, or upon federal approval and the implementation of required administrative and systems changes, whichever is later, children under age 19 will remain eligible for MA for a period of 12 months. Effective January 1, 2025, or upon federal approval, whichever is later, children age 19 or older but under age 21 will remain eligible for period of 12 months, and children under age six will remain eligible through the

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<sup>2</sup> Presumptive eligibility determinations under MA are limited to hospitals participating in the Hospital Presumptive Eligibility Program (Minn. Stat. § 256B.057, subd. 12) and presumptive eligibility providers participating in the Medical Assistance for Women with Breast or Cervical Cancer program. (Minn. Stat. § 256B.0637) The commissioner of human services is required to present recommendations and draft legislation related to presumptive eligibility for MA, home and community-based services, and other services for persons with disabilities and older adults, to the legislature by January 1, 2025. (Laws 2023, ch. 61, art. 1, § 81)

month in which the child turns age six. (Laws 2023, ch. 70, art. 16, § 11; codified as Minn. Stat. § 256B.056, subd. 7)

## Changes Related to COVID-19

Under the authority provided in the Governor’s Executive Order 20-12, DHS temporarily suspended renewal, income review, and related reporting and eligibility verification requirements for MA enrollees, effective March 18, 2020. This continuation of MA eligibility was a federal requirement that states had to comply with in order to receive the enhanced federal Medicaid match during the COVID-19 pandemic. These changes were originally to remain in effect until the last day of the month in which the federal public health emergency declared by the Secretary of Health and Human Services ends.<sup>3</sup> However, the federal Consolidated Appropriations Act eliminated the link between Medicaid continuous coverage and the federal public health emergency, and ended the continuous coverage requirement on March 31, 2023. The federal law instead gave states a 14-month period to complete renewals for Medicaid enrollees. This period is referred to as the “unwinding period” and for Minnesota runs from April 1, 2023, to May 31, 2024. The federal law also continued the enhanced federal Medicaid match through December 31, 2023, but at lower levels according to a phase-down schedule that began April 1, 2023.<sup>4</sup>

**Provisions governing the transition from continuous coverage.** The 2023 Legislature enacted a number of provisions to govern the transition during the unwinding period away from the pandemic-related Medicaid continuous coverage requirement. ([Laws 2023, ch. 22](#)) These provisions include:

- extending an existing prohibition on collecting unpaid MA-EPD (MA for employed persons with disabilities) premiums, through the month prior to an enrollee’s first renewal following the resumption of MA eligibility renewals;
- suspending periodic data matching for up to 12 months following the resumption of MA and MinnesotaCare renewals;
- allowing MA enrollees who are age 65 or over, blind, or who have a disability, and other MA-related eligibility groups subject to an asset test, additional time to spend down excess assets, until the enrollee’s second annual renewal following the resumption of eligibility renewals;
- allowing DHS to temporarily adjust MA eligibility verification requirements as needed to comply with federal guidance and ensure timely renewals;

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<sup>3</sup> The Secretary of Health and Human Services declared a federal public health emergency related to the COVID-19 pandemic on January 27, 2020. The secretary renewed the public health emergency for several 90-day periods, most recently on February 11, 2023. The public health emergency was not subsequently renewed and therefore ended on May 11, 2023.

<sup>4</sup> The federal Medicaid match increase is 6.2 percentage points for the first quarter of calendar year 2023, and is reduced to 5.0, 2.5, and 1.5 percentage points respectively for each succeeding quarter of calendar year 2023.

- allowing DHS additional time to take final administrative action on fair hearing requests, and requiring the commissioner to suspend certain procedural terminations of MA enrollees as required by the federal Centers for Medicare and Medicaid Services; and
- waiving MinnesotaCare premiums for the period of May 1, 2023, through June 30, 2024.

## Citizenship and Immigration Status

To be eligible for MA, an individual must be a citizen of the United States or a lawfully present noncitizen who meets specified criteria. (Minn. Stat. § 256B.06, subd. 4, (a) to (d)) 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 law and for which a federal match is provided.

**Undocumented persons; emergency MA.** 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. (Minn. Stat. § 256B.06, subd. 4, (e) to (h), (k)) 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 12-month postpartum period (see page 12).

## Residency

To be eligible for MA, an individual must be a resident of Minnesota, as determined under federal law.<sup>5</sup> (Minn. Stat. § 256B.056, subd. 1) 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. 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.

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<sup>5</sup> Federal law generally 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).

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 assistance
- individuals under age 26 who received foster care services while age 18 or older, and who were enrolled in MA or MinnesotaCare or another state's Medicaid program at the time foster care services ended

Certain disabled children who would normally not be eligible for MA because of parental income are also covered under Minnesota's MA program.

**COVID-19 and uninsured individuals.** MA coverage for the testing, diagnosis, and treatment of COVID-19 for uninsured individuals, without regard to income, asset, or age requirements, ended May 11, 2023, with the end of the federal public health emergency.

**Dual eligibles.** MA also provides benefits to certain individuals who are also enrolled in Medicare (these individuals are sometimes referred to as "dual eligibles"). Medicare enrollees who meet the standard MA income and asset limits may qualify for MA covered services and MA payment of Medicare premiums, coinsurance, and deductibles. In this case, MA is a secondary payor to Medicare and functions as a "wrap-around" policy. Medicare enrollees with higher income and asset limits may qualify for MA payment of various types of Medicare cost-sharing under what are referred to as Medicare Savings Programs (refer to the table "MA Eligibility – Income and Asset Limits – Benefits"). (Minn. Stat. §§ 256B.055, 256B.057)

Individuals in most groups that are eligible for MA coverage, who have excess income, may be able to qualify by spending down their income (see page 9).

## 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 10). (Minn. Stat. § 256B.056, 256B.057, subd. 1) 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 income<sup>6</sup> is used as the income methodology for children, infants, most parents and caretakers, pregnant women, and adults without children. (Minn. Stat. § 256B.056, subd. 1a, (b)) The income methodology used for enrollees who are elderly, blind, or have disabilities is based on that used by the federal SSI program. (Minn. Stat. § 256B.056, subd. 1a, (a))

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.

## Transitional MA

Individuals who lose MA eligibility (under the 133 percent of FPG income limit) due to increased earned income or due to increased spousal support, may be able to retain MA coverage for a transitional period,<sup>7</sup> 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 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 and other requirements are met. Individuals who lose eligibility due to increased spousal support remain eligible for four months. (Minn. Stat. § 256B.0635)

## Asset Limits

MA has two main asset limits. One applies to persons who are elderly, blind, or who have a disability.<sup>8</sup> 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. No asset limit will apply to persons eligible for MA as employed persons with disabilities (MA-EPD), effective January 1, 2024, or upon federal

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<sup>6</sup> Modified adjusted gross income (MAGI) is defined as adjusted gross income increased by: (1) the 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.

<sup>7</sup> See Minnesota Statutes, section 256B.0635.

<sup>8</sup> 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.

approval, whichever is later. In addition, different asset limits apply to some of the smaller MA eligibility groups (see table on page 10).

**Age 65 or older, blind, or disabled.** Persons who are age 65 or older, blind, or who have a disability need to meet an asset limit of \$3,000 for an individual and \$6,000 for two persons in a household, with \$200 added for each additional dependent. (Minn. Stat. § 256B.056, subd. 3) Certain assets are excluded when determining MA eligibility for these individuals, including the following:

- the homestead
- household goods and personal effects
- burial space items, such as a burial plot
- certain life insurance policies and assets used to fund burial expenses, up to the limits established for the SSI program<sup>9</sup>
- 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<sup>10</sup>
- 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 next section). (Minn. Stat. § 256B.056, subd. 3c)

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

<sup>9</sup> The SSI program allows recipients to set aside, or designate, up to \$1,500 in assets to cover certain burial expenses.

<sup>10</sup> 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.

- individual retirement accounts and funds
- assets owned by children
- 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.” (Minn. Stat. § 256B.056, subd. 5 and 5c) However, no spenddown option is available for persons eligible as adults without children.

Under a spenddown, an individual reduces their income by incurring medical bills in amounts that are equal to or greater than the amount by which the individual's 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 the 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 | 100% of FPG        |

### MA Eligibility – Income and Asset Limits – Benefits

| Eligibility Category                                       | Income Limit  | Asset Limit   | Benefits  |
|--|---------------|---|---|
| Children under age two <sup>11</sup>                       | ≤ 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 <sup>12</sup>                               | ≤ 278% of FPG | None  | All MA services   |
| Parents or relative caretakers of dependent children on MA | ≤ 133% of FPG | None, unless on spenddown (then \$10,000 for households of one and \$20,000 for households of two or more)                    | 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 (Medicare enrollees may also qualify for MA payment of various Medicare cost-sharing. See Medicare Savings Programs below.) |
| Adults without children                                    | ≤ 133% of FPG | None  | All MA services   |
| <b>Medicare Savings Programs</b>                           |               |   |   |
| (a) Qualified Medicare Beneficiaries (QMBs)                | ≤ 100% of FPG | \$10,000 for households of one and \$18,000 for households of two or more <sup>13</sup>                                       | Premiums, coinsurance, and deductibles for Medicare Parts A and B   |
| (b) Specified Low-income Medicare Beneficiaries (SLMBs)    | ≤ 120% of FPG | \$10,000 for households of one and \$18,000 for households of two or more   | Medicare Part B premium only  |
| (c) Qualifying individuals (QI)                            | < 135% of FPG | \$10,000 for households of one and \$18,000 for   | Medicare Part B premium only  |

<sup>11</sup> 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.

<sup>12</sup> Pregnant women are eligible for coverage 12 months postpartum.

<sup>13</sup> The asset limit will be the Medicare Part D extra help low-income subsidy (LIS) asset limit, once that asset limit exceeds the dollar amounts specified in the table.

| Eligibility Category  | Income Limit                | Asset Limit                               | Benefits                     |
|---|-----------------------------|---|------------------------------|
|   |                             | households of two or more                 |                              |
| (d) Qualified disabled working individuals  | ≤ 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 <sup>14</sup> | ≤ 100% of FPG <sup>15</sup> | None                                      | All MA services              |
| Employed persons with disabilities  | No income limit             | \$20,000 <sup>16</sup>                    | All MA services              |

House Research Department

## Institutional Residence

**Correctional facilities.** Individuals living in public institutions, such as secure correctional facilities, are generally not eligible for MA coverage, except that the MA program pays for covered services provided to inmates while they are inpatients in a hospital or other medical institution. (Minn. Stat. § 256B.055, subd. 14)

**IMDs.** Federal rules generally prohibit federal Medicaid funding for people receiving behavioral health care services in Institutions for Mental Diseases (IMDs), which are residential facilities with 17 or more beds that primarily provide diagnosis and treatment for people with mental illness or substance use disorder. Federal MA matching funds are available for services provided to IMD residents who are under age 21 and are receiving inpatient psychiatric services in certain settings, are age 65 or older, or who otherwise qualify for an exception. (Minn. Stat. § 256B.055, subd. 13)

Minnesota has received CMS approval to receive through a demonstration project (“1115 Demonstration”) federal matching funds for MA-covered services, including opioid use disorder and substance use disorder (OUD/SUD) benefits and residential services, provided to MA enrollees in IMDs participating in the demonstration project. These MA enrollees have been eligible for federally funded MA since July 22, 2020.<sup>17</sup> Residential treatment programs and

<sup>14</sup> Authorized by section 134 of the federal Tax Equity Fiscal Responsibility Act (TEFRA) of 1982.

<sup>15</sup> 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.

<sup>16</sup> No asset limit will apply effective January 1, 2024, or upon federal approval, whichever is later. (Laws 2023, chapter 61, article 3, § 4, amendment to Minn. Stat. § 256B.057, subd. 9)

<sup>17</sup> See DHS Bulletin 21-21-11, DHS Announces New Federal Medical Assistance Funding for 1115 Substance Use Disorder (SUD) System Reform Demonstration, August 19, 2021. For required participation by providers, see DHS

withdrawal management programs licensed by DHS and enrolled in MA and MinnesotaCare, and out-of-state residential substance use disorder treatment programs enrolled in MA and MinnesotaCare, will be required to participate in the 1115 Demonstration by January 1, 2024; for other providers, participation is optional.

## Benefits

The MA program provides enrollees with all federally mandated services and most services designated by the federal government as optional for states to provide. Minnesota has also received federal approval to provide home and community-based waiver services that are not part of the regular federal mandated or optional services. Most MA covered services are specified in section 256B.0625.

The same covered services are available to MA enrollees under both fee-for-service and managed care (see discussion of these delivery systems below). Enrollees under both fee-for-service and managed care are subject to nearly identical cost-sharing requirements.

## Federally Mandated Services for All MA Recipients

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

- Child and teen checkup – also referred to as early periodic screening, diagnosis, and treatment (EPSDT) – services for children under 21 (these services include all medically necessary services coverable under the federal Medicaid program, regardless of whether the services are specifically covered under a state’s Medicaid plan)
- 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
- Nursing facility services
- Outpatient hospital services
- Physician services
- Pregnancy-related services (through 12 months postpartum)
- Rural health clinic services

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Bulletin 21-51-01, 1115 Substance Use Disorder System Reform Demonstration 2021 Legislative Changes, September 2, 2021.

## 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 services<sup>18</sup>
- Other diagnostic, screening, and preventive services
- Doula services
- Emergency hospital services
- Enhanced asthma care services
- Hearing aids
- Home and community-based waiver services
- Hospice care
- Housing stabilization services
- 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

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<sup>18</sup> Beginning January 1, 2024, or upon federal approval, whichever is later, MA will cover medically necessary dental services for adults; prior to this date, coverage of dental services for adults who are not pregnant is limited to specified services (see Minn. Stat. § 256B.0625, subd. 9 and Laws 2023, chapter 70, article 1, section 11).

- Pharmacy services<sup>19</sup>
- Physical therapy services
- Podiatry services
- Post-arrest community-based service coordination
- Private duty nursing services
- Prosthetics and orthotics
- Public health nursing services
- Recuperative care services<sup>20</sup>
- Rehabilitation services, including day treatment for mental illness
- Speech therapy services
- Vision care services and eyeglasses

## Cost-sharing

The 2023 Legislature eliminated all cost-sharing for MA enrollees, effective January 1, 2024. (Laws 2023, ch. 70, art. 16, §§ 12 and 13; codified as Minn. Stat. § 256B.0631, subs. 1 and 1a) Prior to that date, certain MA enrollees are subject to the following cost-sharing (see Minn. Stat. § 256B.0631):

- \$3 per nonpreventive visit (does not apply to mental health services)
- \$3.50 for nonemergency visits to a hospital emergency room
- \$3 per brand-name prescription, \$1 per generic prescription, and \$1 per prescription for a brand-name multisource drug on the preferred drug list, 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 \$3.80 for calendar year 2023 (adjusted annually by the increase in the medical care component of the CPI-U)

MA applies the same cost-sharing requirements under both fee-for-service and managed care, except that managed care and county-based purchasing plans are not required to charge a family deductible.

Under fee-for-service, health care providers are responsible for collecting the copayment or deductible from enrollees, and MA reimbursement to providers is reduced by the amount of

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<sup>19</sup> 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.

<sup>20</sup> Recuperative care is a care model that prevents hospitalization or provides postacute medical care and support services for recipients who are homeless or meet related criteria (Minn. Stat. § 256B.0701). Coverage for this service is effective January 1, 2024.

the copayment or deductible. Under both fee-for-service and managed care, providers cannot deny services to enrollees who are unable to pay the copayment or deductible.

**Exemptions from cost-sharing.** Children and pregnant women are exempt from copayments and deductibles; other groups are also exempt. 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.

No cost-sharing is required for the diagnosis, testing, and treatment of COVID-19. This is a federal requirement that states were required to comply with in order to receive the enhanced federal Medicaid match during the federal COVID-19 public health emergency. States must now comply with this requirement in order to receive the temporary enhanced federal Medicaid match for the continuous coverage unwinding period from April 1, 2023, through December 31, 2023. In addition, similar requirements apply to states under the American Rescue Plan Act of 2021, through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 public health emergency (i.e., September 30, 2024).

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)** funds home and community-based services for persons age 65 or older who are MA-eligible, require the level of care provided in a nursing home, and choose to live in the community.

Minnesota also has a solely state-funded program, the **Alternative Care (AC)** program, that provides home and community-based services for persons age 65 or older, who require the level of care provided in a nursing home, choose to live in the community, and are not yet financially 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. MA managed care services can be provided by health maintenance organization (HMO) health plans or by county-based purchasing plans. (Minn. Stat. §§ 256B.69, 256B.692) HMOs and county-based purchasing plans must generally provide enrollees with the same preventive, acute, and basic care services that must be provided under MA fee-for-service; the main exception is that a number of long-term care and other services are provided under fee-for-service.<sup>21</sup> 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 HMO health plans or through county-based purchasing plans. Enrollees who are age 65 or older receive services from HMO health plans or 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.** 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 other health plans. DHS payments to counties cannot exceed payment rates to HMO health plans. As of June 2023, three county-based purchasing initiatives involving 33 counties were operational.

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<sup>21</sup> These services include, but are not limited to: abortion, federally qualified health centers, the Indian Health Service, nursing facility services beyond 180 days, state-operated dental clinics, and waived services other than elderly waiver services.

## 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, intermediate care facility services for persons with developmental disabilities, and services from certain provider types with federally prescribed payment arrangements such as federally qualified health centers, Indian health services, and facilities operated by a Tribe or Tribal organization.

Enrollees 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 contracts with managed care plans and county-based purchasing plans to provide services in all 87 counties.

As of June 2023, 1,097,979 MA enrollees received services through PMAP from managed care or county-based purchasing plans.

## Competitive Procurement

DHS uses a competitive procurement process to select managed care and county-based purchasing plans to serve MA and MinnesotaCare enrollees. Under this process, plans submit proposals that are scored on technical qualifications; price bids by plans have also been considered in some years.<sup>22</sup> Based on these scores, DHS most recently has chosen two or more plans to serve each county (the one exception being Itasca County, which is served by one county-based purchasing plan). Under competitive procurement, 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 procurement.

Competitive procurement 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. There have since been a number of rounds of competitive procurement.

In recent years, DHS issued a request for proposals (RFP) to use competitive procurement to select plans to serve MA and MinnesotaCare enrollees in the 80 greater Minnesota counties, beginning in calendar year 2020. DHS canceled the RFP process in September 2019, due in large part to a district court order that delayed managed care contracting in eight counties.<sup>23</sup> In January 2021, DHS issued an RFP to select plans to serve MA families and children and MinnesotaCare enrollees in the seven-county metropolitan area, beginning in calendar year

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<sup>22</sup> The submittal of price bids by plans was last required by DHS during the 2016 statewide competitive procurement process. DHS has the option to reinstate the use of price bids in future requests for proposals.

<sup>23</sup> District Court, Second Judicial District, *South Country Health Alliance v. Minnesota Department of Human Services*, Court File No. 62-CV-19-5818, - Limited Temporary Injunction and Order for Disclosure, August 30, 2019.

2022. In October 2021, DHS issued an RFP to serve persons age 65 and over and SNBC enrollees statewide, beginning in calendar year 2023, and in January 2022, issued an RFP to serve MA families and children and MinnesotaCare enrollees in greater Minnesota, beginning in calendar year 2023.<sup>24</sup>

## Programs for the Elderly

Minnesota Senior Care Plus (MSC+) provides MA services to enrollees age 65 or older. MSC+ covers the same services as PMAP, except that prescription drugs for MA enrollees also eligible for Medicare are covered by Medicare Part D (see footnote 19 on page 15). Enrollees in MSC+ must enroll in a separate Medicare plan to obtain their prescription drug coverage under Medicare Part D. In addition to covering all basic Minnesota Senior Care services, MSC+ 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.

Persons age 65 or older eligible for both MA and Medicare also have the option of receiving managed care services through MSHO, rather than MSC+. MSHO 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.<sup>25</sup> Enrollment in MSHO is voluntary. As is the case with MSC+, 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 MSC+, due in part to the integrated Medicare and MA prescription drug coverage. As of June 2023, MSHO enrollment was 46,285, compared to enrollment in Minnesota Senior Care Plus of 28,470.

## 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 67,907 individuals as of June 2023.

## Managed Care Enrollment

Generally, MA recipients who are parents, children, or adults without children are required to enroll in PMAP. As noted above, recipients who are age 65 or older are required to enroll in MSC+ but a majority have chosen to participate instead in the voluntary MSHO program.

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<sup>24</sup> In 2022, county-based purchasing plans challenged the DHS procurement process. On September 20, 2022, the district court for the Second Judicial District ruled against the county-based purchasing plans, allowing the procurement process for calendar year 2023 contracts to be completed (see *South Country Health Alliance, et al. vs. Minnesota Department of Human Services, et al.*, Court File No. 62-CV-22-907).

<sup>25</sup> 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.

Persons with disabilities are required to enroll in special needs plans, unless they choose to opt out of managed care enrollment and remain in fee-for-service.

As of June 2023, 1,240,646 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 monthly capitated payment for each enrollee (a capitated payment is fixed and does not vary with the actual services provided to the enrollee). 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.

The PMAP capitation rate is risk-adjusted using the Chronic Illness and Disability Payment System (CDPS+Rx) to reflect the overall health status of a plan's enrollees.

DHS generally does not regulate managed care and county-based purchasing payment rates to health care providers under contract to serve MA enrollees. Managed care and county-based purchasing plans may establish their own provider payment rates for most service categories. These payment rates may sometimes be based on the MA fee-for-service rates or set at a percentage of those rates, but this is at the discretion of the plan and is not a requirement.

**IHP demonstration project.** Providers participating in the Integrated Health Partnership (IHP) demonstration project may have their payments from managed care plans 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 this arrangement, 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 in the aggregate for services to both managed care and fee-for-service enrollees and applied to provider groups annually in the form of a reconciliation payment.

As of July 2023, 531,148 MA and MinnesotaCare enrollees in fee-for-service or managed care were served by 28 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 for covered services, except when the recipient is incurring medical bills in order to meet the MA spenddown (discussed earlier in the eligibility section).

DHS uses different methods to reimburse different types of providers; reimbursement methods for selected provider types are described below.

**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 (calculated in the aggregate for services to both managed care and fee-for-service enrollees) relative to the target spending amount established under the demonstration project.

**Implementation plan for direct payment system.** The 2023 Legislature directed the commissioner to develop an implementation plan for a direct payment system and present this plan to the legislature by January 15, 2026. The direct payment system would deliver services to eligible individuals through fee-for-service, county-based purchasing plans, and county-owned health maintenance organizations. Eligible individuals are persons eligible for MA as families and children and adults without children. ([Laws 2023, ch. 70](#), art. 16, § 9; codified as Minn. Stat. § 256.9631)

## 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. (Minn. Stat. § 256B.76, subd. 1) 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, 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 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.

## Dental Reimbursement

Prior to January 1, 2022, most dental services under fee-for-service were reimbursed at a base rate (tied to a percentile of 1989 charges). This base rate was increased by any applicable provider or service-specific add-on payments, and by a payment increase of 37.5 or 35 percent for providers classified as critical access dental providers.

Beginning January 1, 2022, the base rate under fee-for-service was increased by 98 percent, with the cost of this increase partially offset by eliminating most provider or service-specific add-on payments, and by reducing the critical access dental provider increase to 20 percent (these changes in the aggregate resulted in an overall increase in dental reimbursement). Managed care and county-based purchasing plans are required to pay dental providers under MA (and also under MinnesotaCare) at levels at least equal to the fee-for-service rate and must also increase reimbursement to critical access dental providers by at least the amount of the critical access dental provider increase.

## 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 lesser of the National Average Drug Acquisition Cost (NADAC) or the state maximum allowable cost (SMAC).<sup>26</sup> For drugs for which a NADAC or SMAC is not reported, the ingredient cost is estimated as the wholesale acquisition cost (WAC) minus 2 percent.<sup>27</sup> The professional dispensing fee in most cases is \$10.77 per prescription.

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

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<sup>26</sup> 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. SMAC is the state payment schedule used for generic drugs.

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

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

## 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 with costs that exceed a specified threshold; these stays are referred to as cost 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 under Minnesota law are required to be rebased (recalculated using more current cost data and adjusted for inflation) every two years.

## 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 for covered services is 51.49 percent for federal fiscal year 2024 (October 1, 2023, through September 30, 2024).

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;
- 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 12 months 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 of 66.04 percent (for federal fiscal year 2024) and the state's MA federal matching rate of 51.49 percent.

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 of 90 percent for the cost of services provided to enrollees who are adults without children. Minnesota receives the regular federal Medicaid match for parents and caretakers, persons with disabilities, and other eligibility categories.

The federal Families First Coronavirus Response Act (Pub. L. No. 116-127) provided Minnesota and other states with an increase of 6.2 percentage points in the federal Medicaid match, beginning January 1, 2020, through the last day of the calendar quarter in which the public health emergency declared by the Secretary of Health and Human Services ends. As a condition of receiving this higher federal match, states had to comply with certain maintenance of effort requirements.<sup>29</sup> The Families First Coronavirus Response Act also provided Minnesota with a 4.34 percentage point increase in its enhanced CHIP federal matching rate through the last day of the calendar quarter in which the federal public health emergency ends.

The federal Consolidated Appropriations Act continued the enhanced federal Medicaid and CHIP match through December 31, 2023, but at lower levels according to a phase-down schedule. The federal Medicaid match continues at 6.2 percentage points through the first quarter of calendar year 2023, but then is reduced to 5.0, 2.5, and 1.5 percentage points respectively for each succeeding quarter. The enhanced CHIP match is reduced proportionately as part of the phase-down, from 4.34 through the first calendar quarter of 2023, to 3.5, 1.75, and 1.05 percentage points respectively for each succeeding quarter.

## Nonfederal Share

The state is responsible in most cases for the nonfederal share of MA costs. Counties are responsible for the nonfederal share for specified services.<sup>30</sup> The MA program also includes provider surcharges, intergovernmental transfers, and other financing mechanisms under which health care providers or governmental units make certain payments to DHS. These payments are then used by DHS to pay for the nonfederal share of MA expenditures tied to increases in provider payment rates, and in some cases to provide revenue to the general fund.

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<sup>29</sup> These requirements included, but were not limited to: maintaining Medicaid eligibility standards, methodologies, and procedures that are not more restrictive than those in effect on January 1, 2020; maintaining eligibility for persons enrolled in Medicaid on March 18, 2020; and providing coverage without cost-sharing for testing services and treatment for COVID-19.

<sup>30</sup> Counties are responsible for the nonfederal share of MA costs for selected services, as follows: 50 percent of the nonfederal share for the cost of placement of severely emotionally disturbed children in regional treatment centers, 20 percent for the cost of nursing facility placements that exceed 90 days of persons with disabilities under age 65, 10 percent of the cost of placements that exceed 90 days in ICF/DDs with seven or more beds, and 20 percent of the cost of placements that exceed 90 days in nursing facilities that are institutions for mental diseases (IMDs).

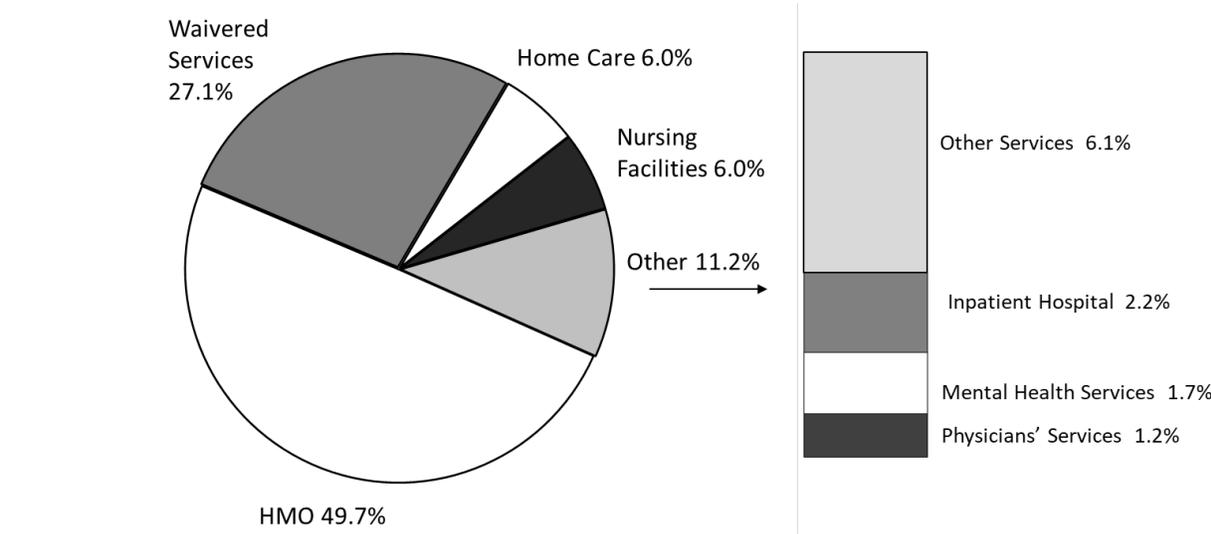
## MA Expenditures – State Fiscal Year 2022

In fiscal year 2022, total MA expenditures for services were \$16.488 billion. This total was distributed between the levels of government as follows:

| Actual Expenditures – SFY 2022 |                  |
|--------------------------------|------------------|
| Federal                        | \$10.843 billion |
| Nonfederal                     | \$5.645 billion  |

The following chart shows the percentage of MA spending in fiscal year 2022 on the major service categories. The chart shows that about one-half of MA spending (49.7 percent) is for services provided through HMOs, and over one-quarter of MA spending (27.1 percent) is for home and community-based waiver services.

### MA Expenditures by Service – SFY 2022



Note: The waived services category includes waiver payments to HMOs.  
Source: Department of Human Services, Background Data Tables for February 2023 Forecast

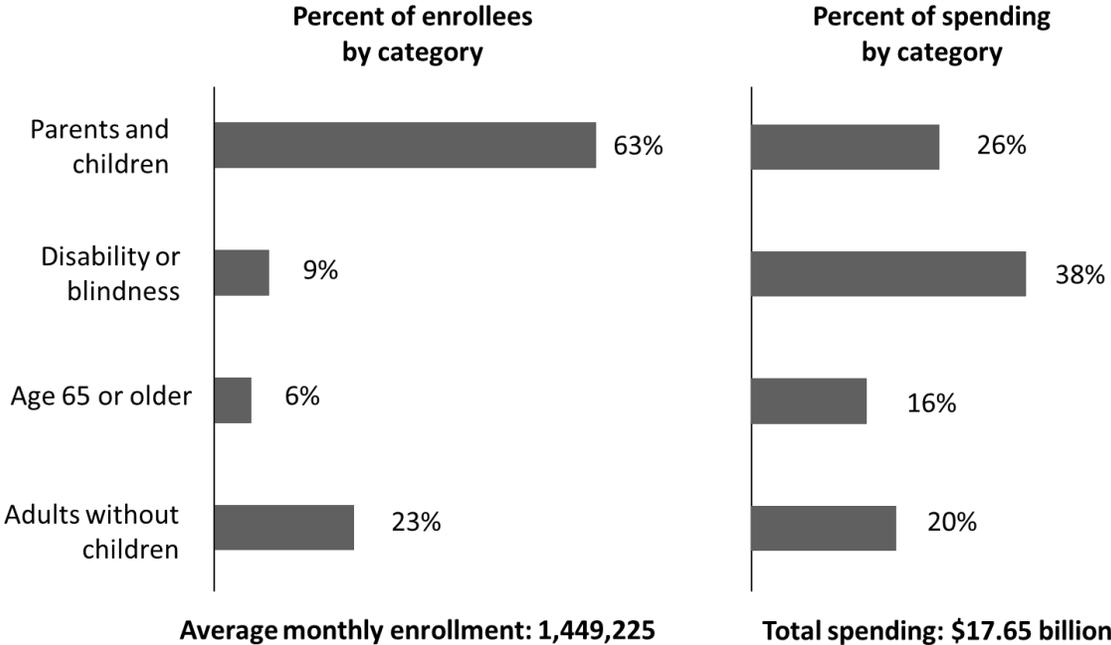
## Recipient Profile

During fiscal year 2022, an average of 1,449,225 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.

- Parents and children make up the largest eligibility group, constituting 63 percent of eligibles. However, this group accounted for only 26 percent of MA spending.

- Persons age 65 or older, and persons eligible on the basis of disability or blindness, accounted for 54 percent of MA spending, although only 15 percent of eligibles are in these two groups.

**Minnesota Medical Assistance Eligibles – SFY 2022**



Source: Department of Human Services

**MA Income Limit – Federal Poverty Guidelines  
for 7/1/23 through 6/30/24 – 12-month Standard**

| Household Size         | 100%     | 120%*    | 133%     | 135%*    | 200%*    | 275%     | 278%     | 283%     |
|------------------------|----------|----------|----------|----------|----------|----------|----------|----------|
| 1                      | \$14,580 | \$17,736 | \$19,391 | \$19,932 | \$29,400 | \$40,095 | N/A      | \$41,261 |
| 2                      | 19,728   | 23,904   | 26,227   | 26,880   | 39,684   | 54,230   | \$54,821 | 55,807   |
| 3                      | 24,876   | 30,072   | 33,063   | 33,828   | 49,968   | 68,365   | 69,110   | 70,353   |
| 4                      | 30,024   | 36,240   | 39,900   | 40,776   | 60,252   | 82,500   | 83,400   | 84,900   |
| 5                      | 35,172   | 42,408   | 46,736   | 47,724   | 70,536   | 96,635   | 97,689   | 99,446   |
| 6                      | 40,320   | 48,576   | 53,572   | 54,672   | 80,820   | 110,770  | 111,978  | 113,992  |
| 7                      | 45,468   | 54,744   | 60,408   | 61,620   | 91,104   | 124,905  | 126,267  | 128,538  |
| 8                      | 50,616   | 60,912   | 67,244   | 68,568   | 101,388  | 139,040  | 140,556  | 143,084  |
| Each Additional Person | 5,148    | 6,168    | 6,838    | 6,948    | 10,284   | 14,135   | 14,289   | 14,546   |

\* Includes a \$20 disregard

## Glossary of Acronyms

|   |   |
|---|---|
| <b>AC:</b> Alternative care (program)                                       | <b>FMAP:</b> Federal medical assistance percentage                                    |
| <b>ACA:</b> Affordable Care Act   | <b>FPG:</b> Federal poverty guidelines  |
| <b>APR-DRG:</b> All Patient Refined diagnosis-related group                 | <b>ICF/DD:</b> Intermediate care facility for persons with developmental disabilities |
| <b>BI:</b> Brain injury (waiver)  | <b>IHP:</b> Integrated Health Partnership   |
| <b>CAC:</b> Community alternative care (waiver)                             | <b>IMD:</b> Institution for mental diseases   |
| <b>CADI:</b> Community access for disability inclusion (waiver)             | <b>LTCP:</b> Long-term care partnership   |
| <b>CDPS+Rx:</b> Chronic Disability Payment System                           | <b>MA-EPD:</b> MA for employed persons with disabilities                              |
| <b>CHIP:</b> Children’s Health Insurance Program                            | <b>MAGI:</b> Modified adjusted gross income   |
| <b>CMS:</b> Centers for Medicare and Medicaid Services                      | <b>METS:</b> Minnesota Eligibility Technology System                                  |
| <b>DD:</b> Developmental disabilities (waiver)                              | <b>MSA:</b> Minnesota Supplemental Aid  |
| <b>DHS:</b> Department of Human Services (Minnesota)                        | <b>MSC+:</b> Minnesota Senior Care Plus   |
| <b>DRG:</b> Diagnosis-related group   | <b>MSHO:</b> Minnesota Senior Health Options  |
| <b>DSH:</b> Disproportionate share hospital (payments)                      | <b>NADAC:</b> National Average Drug Acquisition Cost                                  |
| <b>EMA:</b> Emergency Medical Assistance                                    | <b>ODU/SUD:</b> Opioid use disorder and substance use disorder (benefits)             |
| <b>EPSDT:</b> Early periodic screening, diagnosis, and treatment (services) | <b>PMAP:</b> Prepaid Medical Assistance Program                                       |
| <b>EW:</b> Elderly waiver   | <b>SMAC:</b> State maximum allowable cost   |
| <b>FFP:</b> Federal financial participation                                 | <b>SNBC:</b> Special Needs BasicCare (program)  |
|   | <b>SNP:</b> Special needs plan  |
|   | <b>SSI:</b> Supplemental Security Income  |
|   | <b>WAC:</b> Wholesale acquisition cost  |



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