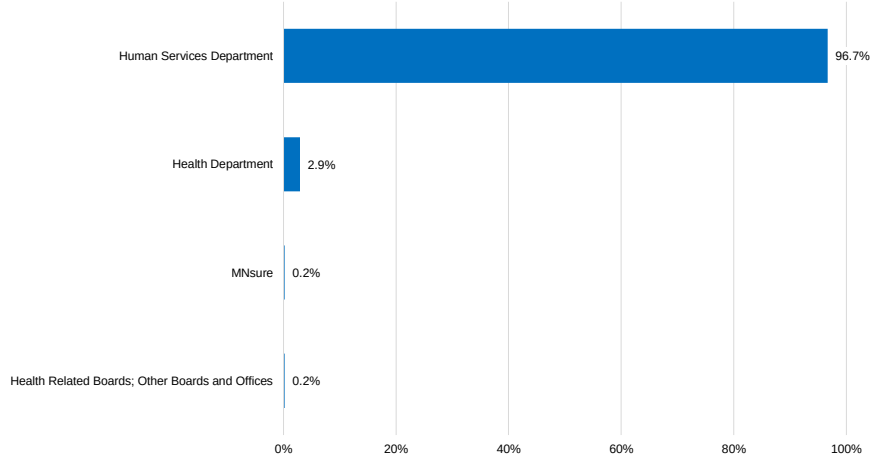
Health & Human Services

Overview of Committee Jurisdiction

House Research Department

January 2019

Health and Human Services All Funds Expenditures
Base FY 2020-21 = $39.165 Billion



Source: House Research and House Fiscal Analysis. Data from 2017 End of Session Consolidated Fund Balance Statement.

Health Care and Human Services Programs

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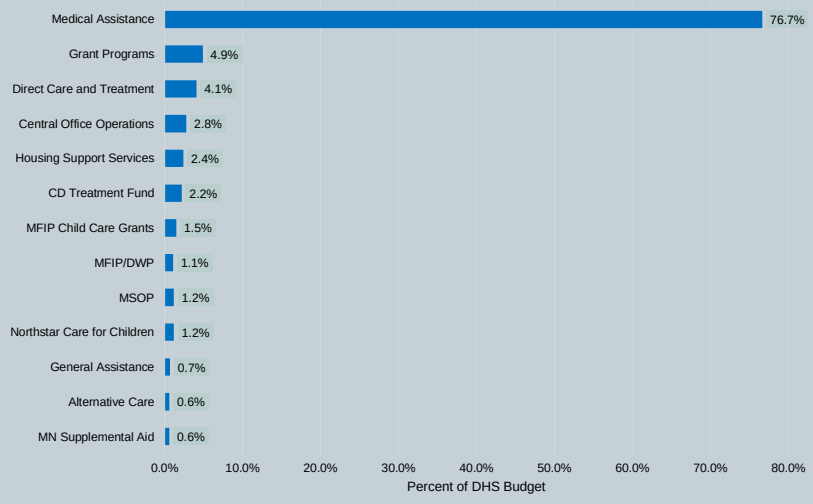
- Focus on health care, economic assistance, and social service programs.
- In general, programs are state-supervised and county-administered.
  - The **Department of Human Services (DHS)** is the primary executive branch agency that oversees human services programs. DHS supervises program administration, ensures compliance with federal requirements, makes rules, and provides training, program evaluation, and technical assistance to counties.
  - Counties administer programs, accepting applications, determining client eligibility, contracting with local service providers, and referring clients to services.
- Congress sets broad standards and requirements for human services programs and appropriates funds.
- The Minnesota Legislature sets human services policy for the state. This policy is often influenced by federal requirements that are prerequisites to receiving federal funding.

Department of Human Services Budget Program Base FY 2020-21
DHS State General Fund Expenditures: $14.73 Billion



Source: House Research and House Fiscal Analysis. Data from November 2017 Forecast.

DHS Program Areas

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- Health Care
- Long-Term Care
- Chemical and Mental Health
- Income Assistance and Housing Programs
- Protection of Children and Vulnerable Adults
- Program Integrity and Operations

Health Care
Overview of Subsidized Coverage

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In Minnesota, persons with low to middle incomes can obtain subsidized health coverage through three main programs or systems—MA, MinnesotaCare/Basic Health Program, and the MNsure insurance exchange.

- **MA**, the state's Medicaid program, is administered by the state within broad federal guidelines.
- **MinnesotaCare** was established by the state in 1992, as a program to serve low- to moderate-income persons. Since 2015, the program has operated as a Basic Health Program under the Affordable Care Act (ACA).
- **MNsure** is the state's health insurance exchange established under the ACA. It is a system to link persons to coverage and determine eligibility for MA, MinnesotaCare, or premium tax credits and cost-sharing reductions.

Health Care
Overview of Subsidized Coverage

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The three programs or systems provide a rough continuum of coverage for many Minnesotans with low to middle incomes (up to 400% FPG).

- Adults without children/parents and caretakers:
  - MA (0% to 133% FPG);
  - MinnesotaCare (over 133% to 200% FPG); and
  - MNsure tax credits (over 200% to 400% FPG).
- Covered services and enrollee costs will vary across the continuum.

Health Care

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Medical Assistance (MA) Overview

- MA is a jointly funded, federal-state program that pays for health care services provided to eligible low-income individuals.
- MA is the state's Medicaid program. The federal government established Medicaid in 1965. Medicaid programs vary across states—each state adopts its own operating and administrative standards, but must remain within the parameters of federal Medicaid law.

Health Care

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MA Administration

- County agencies administer MA, under the supervision of DHS, and also determine eligibility for persons who are elderly, blind, or have disabilities.
- The Minnesota eligibility technology system (METS) is used by DHS and the counties to determine eligibility for families and children, and adults without children.

Health Care

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MA Administration

- DHS uses two systems to deliver services to MA enrollees.
- Under the fee-for-service system, DHS reimburses providers using fee schedules established by the agency.
- DHS also contracts with managed care and county-based purchasing plans, and provides these plans with a monthly capitation payment for each enrollee.

Health Care

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MA Eligibility - Overview

- Belong to an eligible group
- Meet income and any applicable asset limits
- Be a US citizen, or a legal noncitizen who meets certain criteria
- MA provides up to three months of retroactive coverage from the time of application, if the person would have been eligible in those months

Health Care

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MA Eligibility – Eligible Groups

- MA coverage is available for: children, parents and caretakers, pregnant women, elderly, persons with disabilities, and adults without children.
- Adults without children with incomes up to 133% of FPG have been covered since January 1, 2014.
- This group is covered under the ACA expansion option.
- Extending coverage to this group essentially allowed all major groups of individuals to qualify for MA if eligibility requirements are met.

Health Care

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MA Eligibility - Income Limits

- MA income limits vary by eligibility group and are set as a percentage of the federal poverty guidelines (FPG)
  - Children under age 2: 283% FPG ($58,807 household of three)
  - Children 2 through 18: 275% FPG ($57,145 household of three)
  - Parents and caretakers, children 19 through 20: 133% FPG ($27,637 household of three)
  - Pregnant women: 278% FPG ($47,758 household of two)
  - Aged, blind, disabled: 100% FPG ($12,144 household of one)
  - Adults without children: 133% FPG ($16,146 household of one)

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MA Eligibility - Income Methodology

- Currently, in determining income eligibility, the MA program excludes or disregards various types of income (net income standard).
- Since January 1, 2014, the ACA has required states to use MAGI for parents, children, pregnant women, and adults without children (a state's existing income method will continue to apply to the elderly, disabled, and certain other groups).
- The ACA also requires states to use a standard 5% of FPG income disregard for groups subject to MAGI; this replaced existing state income disregards.

Health Care

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MA Eligibility - Spenddown

- Individuals with income above the program income limit can qualify by "spending down"—by incurring medical bills in amounts equal to or greater than the amount of income in excess of the following spenddown limits:
  - 133% FPG for families and children
  - 80% FPG for aged, blind, and disabled (81% effective June 1, 2019)
- No spendddown option for adults without children

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MA Eligibility - Asset Standards

- Some enrollees must meet asset standards:
  - Parents and caretakers on a spenddown: $10,000 for one and $20,000 for two or more in assets that are not excluded
  - Elderly, blind, disabled: $3,000 for one/$6000 for two or more in unexcluded assets
  - No asset limit for pregnant women, children, parents and caretakers not on a spenddown, and adults without children (ACA compliance)

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MA - Covered Services

- MA covers all federally-mandated and most optional health care services.
- The MA benefit set tends to be comprehensive, compared to private sector coverage (e.g. MA usually covers a wider range of long-term care services).
- The ACA requires states to provide persons covered as newly eligible under a Medicaid expansion with benchmark or benchmark equivalent benefits. One of the benefit options is a state's regular Medicaid benefit set; this is what Minnesota has chosen for its newly eligible enrollees.

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MA - Enrollee Cost-sharing

- MA does not charge enrollee premiums.
- Enrollees are subject to a family deductible (does not apply to managed care enrollees) and various copayments.
- Cost-sharing under federal law must be "nominal" for most enrollees and total monthly cost-sharing cannot exceed 5% of income for persons with incomes at or below 100% of FPG.
- Children and pregnant women are exempt from cost-sharing.

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MA - Financing

- MA is financed jointly by the state and federal government. Federal government provides a 50% match towards the cost of MA services; state general fund pays remaining 50% (there is a county-share for specified services).
- The federal Children's Health Insurance Program (CHIP) provides an enhanced match of 88% (through FFY 2019) towards the cost of certain services.
- For newly eligible persons under the ACA Medicaid expansion (in MN, these are adults without children), 94% federal match for 2018, phasing down to 90% for 2020 and future years.

Health Care

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MA – Managed Care

- A majority of MA enrollees receive covered services through HMOs and county-based purchasing plans.
  - MA managed care enrollment July 2018: 892,137
  - MA enrollees (May 2018): 1,101,523
- Families and children, adults without children, and the elderly are required to enroll in managed care.
- Persons with disabilities may opt-out and remain in the fee-for-service system.

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MA – Managed Care (cont'd.)

- Each plan must provide or arrange for most MA covered services, including up to 180 days of nursing facility services, and elderly waiver services.
- Each plan determines its own provider network and sets its own provider payment rates.

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MA – Managed Care (cont'd.)

- Since 2012, competitive bidding has been used in the metro-area counties to set rates for families and children and adults without children. 2016 enrollment reflects the results of the first statewide competitive bidding for this group.
- Rates for persons who are elderly or have disabilities are set through negotiation on an aggregate (not plan-specific) basis, based upon claims experience, trends in utilization, and other factors.
- Rates vary with enrollee characteristics. The payment is fixed and does not vary with the amount of services provided to an enrollee.
- DHS withholds a portion of payment rates, pending completion of performance targets.

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Integrated Health Partnership Demonstration

- The IHP demonstration is a health care provider direct contracting program – DHS contracts with health care provider organizations (called integrated health partnerships) to provide services to MA and MinnesotaCare enrollees. The program operates in both the fee-for-service and managed care systems.
- The program uses a value-based payment model under which all IHPs receive population-based payments for care coordination. The larger, more integrated IHPs are paid under a risk/gain-sharing arrangement, under which the IHP shares in savings and losses relative to their total costs for a defined set of services, for enrollee who are attributed to the IHP.
- Payment is dependent on the IHP meeting specified quality measures – continued receipt of population-based payments, and a portion of any shared savings payment, is contingent on an IHP's score on quality measures.
- As of 2018, 24 IHPs provided services to 450,000 state program enrollees (429,699 in MA and the remainder in MinnesotaCare).
- DHS estimates total savings for the period 2013 through 2017 to be about $277 million (of which about $92 million was returned to IHPs as shared savings).

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Health Care

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MA Spending and Enrollment

- MA spending FY 2017
  - Total: $10.888 billion
  - State: $4.400 billion
  - Federal: $6.328 billion
  - County: $160 million
- MA enrollment FY 2017
  - 1,082,654 average monthly enrollees

Health Care

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MinnesotaCare - Overview

- MinnesotaCare is a jointly-funded, federal-state program that provides subsidized health coverage mainly to parents and caretakers and adults without children.
- Established by the legislature in 1992 as part of broader health care access legislation.
- Has operated as a basic health program under the ACA beginning January 1, 2015.

Health Care

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MinnesotaCare – Basic Health Program

- DHS received federal approval for its basic health program proposal in December 2014, for coverage to begin January 1, 2015.
- Optional program under the ACA that allows states to cover persons with incomes greater than 133% but not exceeding 200% of FPG.
- The program serves as a transition between MA coverage and subsidized coverage through MNsure, the state's health insurance exchange.

Health Care

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MinnesotaCare - Administration

- Program is administered by the state through the DHS central office.
- DHS contracts with managed care and county-based purchasing plans to provide services to enrollees.
- The Minnesota Eligibility Technology System (METS)—the system developed under MNsure—is used to determine enrollee eligibility.

Health Care

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MinnesotaCare - Eligibility

- Meet income limits
- No asset limit
- Meet requirements related to lack of access to health insurance, and not be MA eligible
- Be a Minnesota resident
- Be a citizen or legal noncitizen

Health Care

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MinnesotaCare – Income Limits

- Eligibility is limited to persons with incomes greater than 133% but not exceeding 200% of FPG (the income limit for the basic health program under the ACA).
- Exceptions to income floor for certain groups and legal noncitizens.
- Those 133% FPG and under – MA coverage.
- Those with incomes greater than 200% FPG – may receive subsidized coverage through MNsure.

Health Care

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MinnesotaCare - Asset Limit

- Since January 1, 2014, there has been no asset limit for MinnesotaCare (ACA compliance for a basic health program).

Health Care

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MinnesotaCare - Requirements Related to Lack of Insurance (Insurance Barriers)

- Since January 1, 2014, persons must not have minimum essential coverage (the level of coverage needed to avoid a financial penalty under the ACA).
- Since January 1, 2014, persons must not have access to subsidized coverage that is affordable (not more than 9.86% income for 2019) and provides minimum value (coverage at least 60% of medical expenses on average).

Health Care

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MinnesotaCare – Not MA Eligible

- Since January 1, 2014, persons eligible for MA have not been eligible for MinnesotaCare (prior to this date, enrollees could choose either program if they were eligible).
- This has had the effect of shifting most children and pregnant women from MinnesotaCare to MA since the MA income limits for these groups are higher.

Health Care

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MinnesotaCare - Covered Services

- The program has several benefit sets. Pregnant women and children have access to a broader range of services—nearly all MA benefits—than adults who are not pregnant.
- Parents and adults without children are eligible for most MA services.
- This benefits meet the ACA requirement that a basic health program provide at least the essential health benefits.

Health Care

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MinnesotaCare - Premiums

- MinnesotaCare enrollees age 21 and older pay premiums based on a sliding scale; children are exempt.
- Persons with incomes below 35% of FPG pay no premiums. American Indians and Alaska natives are exempt.
- Effective August 1, 2015, premiums were increased for enrollees with incomes between 150% and 200% of FPG.

Health Care

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MinnesotaCare - Cost-sharing

- Various copayment and coinsurance requirements apply; pregnant women and children and American Indians and Alaska natives are exempt.
- Cost-sharing was increased effective January 1, 2016. DHS is required to adjust copayments, coinsurance, and deductibles to maintain the actuarial value at 94 percent.

Health Care

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MinnesotaCare - Financing

- The state share is funded by a 2% tax on the gross revenues of health care providers (to sunset beginning in 2020) and a 1% tax on nonprofit health plan premiums; money from these taxes is deposited into the Health Care Access Fund.
- As a basic health program, the state receives from the federal government 95% of the value of premium tax credits and cost-sharing reductions that would otherwise have been provided through MNsure.
- Federal funding is deposited into the state's basic health program trust fund.

Health Care

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MinnesotaCare - Spending and Enrollment FY 2017

- Total: $397.2 million
- State: $11.6 million
- Federal: $349.6 million
- Enrollee premiums and drug rebates: $36.1 million
- Average monthly enrollees FY 2017: 89,081

Health Care

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MNsure Health Insurance Exchange

- The ACA required states, or the federal government if states do not act, to establish health insurance exchanges for the individual and small group markets, by January 1, 2014.
- Minnesota established a state-run exchange (MNsure) in Laws 2013, chapter 9. MNsure laws are codified in Minnesota Statutes, chapter 62V.
- The exchange facilitates the selection and purchase of health coverage by individuals and small employers, and determines eligibility for premium tax credits and cost-sharing reductions.
- The exchange is a common entry point for individuals to apply for health coverage from the private sector and from Medicaid and other public health care programs.

Health Care

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MNsure Subsidies

- Federal government provides premium tax credits and the Affordable Care Act requires insurers to provide cost-sharing reductions for persons with low to moderate incomes who purchase coverage through MNsure, the state's health insurance exchange established under the ACA.
- These tax credits and subsidies have been available through MNsure for coverage since January 1, 2014.
- The Centers for Medicare and Medicaid Services (CMS) has not reimbursed health insurers for the cost of cost-sharing reduction since October 2017.

Health Care

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MNsure Subsidies – Eligibility

- Meet general requirements for exchange coverage (citizen or legal noncitizen, not incarcerated).
- Income must be greater than 200% but not exceed 400% FPG (250% for cost-sharing reductions).
- Not covered by Medicaid, Medicare, MinnesotaCare, employer coverage (unless coverage is unaffordable or provides less than 60% actuarial value), or other specified coverage.

Health Care

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MNsure Subsidies - Covered Services

- Exchange plans must cover essential health benefits as defined by the ACA.
- The ACA requires essential health benefits to be similar to a typical employer health plan. The ACA requires the following categories to be covered: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness and chronic disease management, and pediatric services (including oral and vision care).

Health Care

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MNsure Subsidized Coverage - Premiums and Premium Tax Credits

- Enrollee is responsible for premiums of the policy chosen through the exchange, but may be eligible for premium tax credits.
- Premium tax credits: limit premium payments to a specified percentage of income, based on the cost of the second lowest cost silver plan. In Minnesota, premium tax credits limit enrollee premium costs for 2019 to 6.54% of income (for persons with income just over 200% FPG) to 9.86% of income (at 400% FPG).

Health Care

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MNsure Subsidized Coverage - Cost-sharing

- Health insurers are required to provide cost-sharing subsidies to persons with incomes not exceeding 250% FPG, purchasing plans at the silver level only—these increase the plan's actuarial value from 70% to 73% (sometimes achieved by reducing a plan's annual out-of-pocket limit).
- Insurers had been reimbursed by the federal government for the cost of providing cost-sharing reductions.
- The federal government's decision on October 12, 2017, to terminate cost-sharing reduction payments is expected to lead insurers to raise premiums.

Health Care

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MNsure Subsidized Coverage – Financing

- Federal government pays all of the cost of premium tax credits.
- MNsure enrollees are projected to receive $372.2 million in premium tax credits in 2017. (MNsure website)
- Average monthly tax credit by household: $475/month (as of 11/12/18)

Health Care

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Two programs were established in 2017 to contain the cost of individual market premiums: the premium subsidy program and the premium security plan (reinsurance)

Premium Subsidy Program:

1. Enacted in January 2017 and reduced an enrollee's individual market premium cost by 25% for calendar year 2017 only.
2. MMB administered the program and made payments directly to insurers, not enrollees.
3. The program provided $137 million in subsidies for approximately 118,000 Minnesota residents.
4. The program operated in calendar year 2017 only.

Health Care

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Minnesota Premium Security Plan (Reinsurance):

1. Enacted in April 2017, and Governor Dayton signed the federal waiver needed for implementation in October 2017.
2. Administered by the Minnesota Comprehensive Health Association (MCHA) and began operation in January 2018.
3. If an enrollee with coverage in the individual market has claims costs that exceed the attachment point (of $50,000), MCHA pays 80% of the enrollee's claims, up to a $250,000 cap. Payment is made to the insurer.
4. Plan is funded mainly with federal funds and state money from the general fund and health care access fund.

DHS Program Areas

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- Health Care
- Long-Term Care
- Chemical and Mental Health
- Income Assistance and Housing Programs
- Protection of Children and Vulnerable Adults
- Program Integrity and Operations

Long-Term Care

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- Long-term care services are available to the elderly and disabled through:
  - MA;
  - state programs; and
  - programs administered by the Board on Aging.

Long-Term Care

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- Long-term care services provided under MA include:
  - Nursing facility services
  - Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD)
  - Home health care
  - Personal Care Assistance (PCA) services
  - Home and Community-Based Waiver Services (HCBS)

Long-Term Care

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- Long-term care programs provided by the state include:
  - Long-Term Care Consultation Services
  - Alternative Care (AC) Program
  - Family Support Grants
  - Consumer Support Grants
  - Semi-Independent Living Services (SILS)
  - Essential Community Support Services

MA Enrollees and Expenditures

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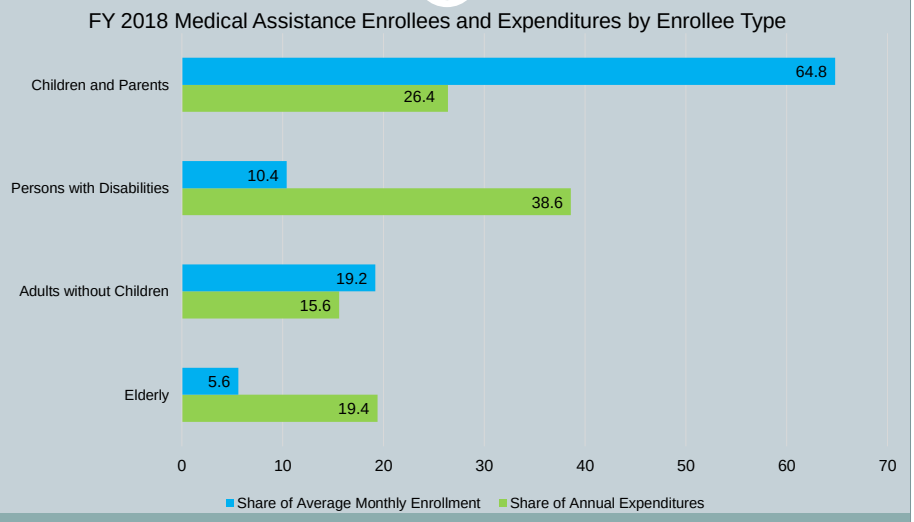

Source: House Research. Data provided by DHS.

Long-Term Care

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- Programs administered by the Board on Aging include:
  - Senior LinkAge Line and related information services
  - MinnesotaHelp
  - Senior Nutrition Services
  - Caregiver Grants
  - Dementia Grants
  - Minnesota Senior Corps
  - Ombudsman for Long-Term Care

DHS Program Areas

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Chemical and Mental Health

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Substance Use Disorder Treatment

- "Rule 25" **Assessment**
  - Interview with a counselor to assess a person's substance use and SUD treatment needs and placement, conducted by the county or tribal agency.*
- **Treatment**
  - Detoxification/withdrawal management
  - Residential and nonresidential programs
  - Halfway houses
  - Extended care
- **Recovery** community organizations, peer-based recovery support services, and service coordination.

Substance Use Disorder Treatment

- Counties and tribes are responsible for:
  - Assessing the treatment needs of a resident ("Rule 25");
  - Determining financial eligibility for publicly-funded treatment;
  - Pre-authorization of and placement in appropriate SUD treatment services; and
  - Paying for 22.95% (non-MA recipients) or 30% (MA recipients) of the cost of services.
- Publicly-funded SUD treatment is provided via either managed care or under fee-for-service, through the **Consolidated Chemical Dependency Treatment Fund (CCDTF)**.
  - In order to be eligible for CCDTF funding, the recipient must meet clinical requirements, have no insurance to cover the full cost of treatment, and either be on a public health care program or meet CCDTF income and household guidelines.

Mental Health

- Counties are responsible for developing mental health systems for children and adults.
- The programs and services must comply with the statutory requirements of the Children's Mental Health Act and the Adult Mental Health Act.
- Funding comes from federal, state, and county sources.
- Public health care programs and private insurance pay for some mental health services.

Chemical and Mental Health

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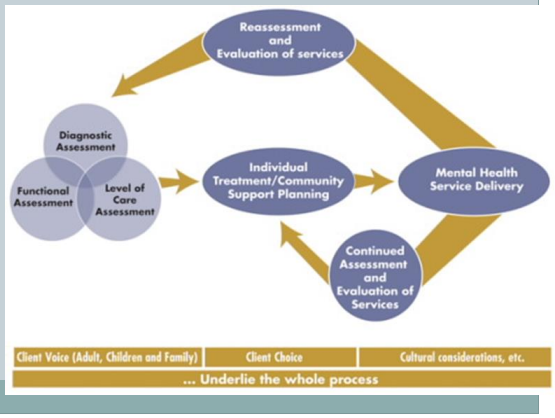
Mental Health

- Six components of mental health service delivery
  1) Diagnostic Assessment
  2) Functional Assessment
  3) Level of Care Assessment
  4) Individual Treatment Plan
  5) Service Delivery
  6) Reassessment



Chemical and Mental Health

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Types of Mental Health Services

- **Emergency services**
  - crisis phone numbers
  - mobile crisis services
  - crisis intervention teams
- **Residential services**
  - Short-term inpatient hospital treatment
  - Intensive Residential Treatment Services (IRTS)
  - Certified Community Behavioral Health Clinics
  - Behavioral health home services
- **Nonresidential services**
  - Adult day treatment
  - Assertive community treatment (ACT)
  - Adult rehabilitative mental health services (ARMHS)
  - Certified peer specialists
  - Targeted case management
  - Medication management
  - Adult mental health urgent care and drop-in centers
  - First episode psychosis coordinated specialty care (can be residential)

Chemical and Mental Health

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Chemical and Mental Health

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Direct Care and Treatment

State-operated health care services for individuals with complex needs related to mental illness, substance use disorder, developmental disabilities, traumatic brain injury, and those committed as mentally ill and dangerous.

Chemical and Mental Health

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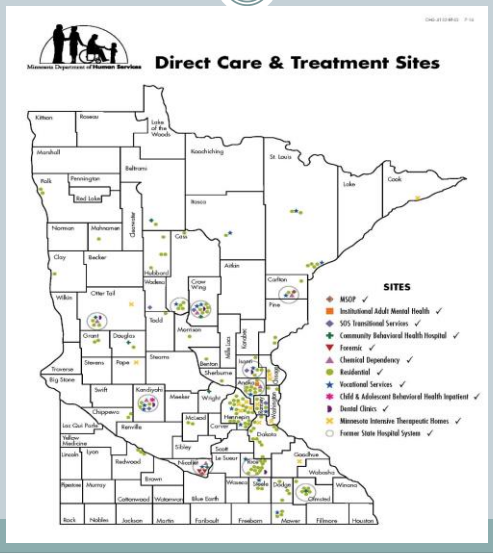

Chemical and Mental Health

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Direct Care and Treatment

- **Adult mental health**
  - Inpatient treatment at community behavioral health hospitals and Anoka Metro Regional Treatment Center
  - Minnesota Specialty Health System
- **Persons committed as mentally ill and dangerous** – Minnesota Security Hospital at St. Peter
- **Child and Adolescent Behavioral Health Services** (CABHS)
  - Outpatient and residential services in Willmar
  - Minnesota Intensive Therapeutic Homes
- **Community Addiction Recovery Enterprise** (C.A.R.E.)
- **Community support services**
- **Rehabilitation services**
- **Forensic services**
  - Minnesota Sex Offender Program
  - Minnesota Security Hospital
  - Forensic Nursing Home
  - Transition Services
  - Competency Restoration Program
- **Community Dental Clinics**

Chemical and Mental Health

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Minnesota Sex Offender Program (MSOP)

- Court-ordered treatment program for individuals civilly committed by the court as sexually dangerous persons or as having a sexual psychopathic personality.
- As of June 30, 2018, 736 individuals were receiving treatment in secure facilities (Moose Lake and St. Peter).
- Federal lawsuit (*Karsjens v. Piper*).
  - District court ruled in 2015 that MSOP is unconstitutional.
  - In January 2017, the 8th Circuit Court of Appeals reversed the district court's decision and held that MSOP is constitutional.
  - Class of sex offenders appealed to U.S. Supreme Court, which chose not to hear the case in October 2017. District court dismissed all remaining claims in August 2018.

DHS Program Areas

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MFIP

- MFIP is a jointly funded, federal-state program designed to provide income assistance to eligible low-income families. Assistance includes:
  - Cash and food assistance
  - Employment and training services
  - Related support services and transitional services

MFIP Administration

- MFIP is a state-supervised, county-administered program.
- County agencies accept applications and make eligibility determinations.

MFIP Eligibility Requirements

- To be eligible for MFIP, a family must:
  - have income and assets below the program's limit;
  - have a minor child;
  - be residents of Minnesota;
  - be U.S. citizens, qualified non-citizens, or non-citizens otherwise lawfully residing in the U.S.;
  - assign rights to child support to the state;
  - participate in work activities;
  - comply with program requirements;
  - have received less than 60 months of assistance; and
  - satisfy any other eligibility requirements of the program.

MFIP Income Standards

- MFIP applicants must meet an initial income test that excludes certain items from income.
- In general, a family is eligible for MFIP if their income, after all applicable deductions are made, is below the MFIP income standard for a family of like size ($984 per month for a family of three).

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MFIP Asset Standards

- To be eligible for MFIP, the equity value of personal property must not exceed $10,000 for applicants and participants.
- Personal property is limited to:
  - Cash
  - Bank accounts
  - Liquid stocks and bonds that can be readily accessed without a financial penalty
  - Non-excluded vehicles (one vehicle per assistance unit member age 16 or older is excluded)

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MFIP Benefits

- Cash assistance - A family of three on MFIP with no income from work receives a standard benefit of $984 each month (made up of $532 cash and $452 food).
- Cash assistance - Families on MFIP with earned income continue to receive an MFIP grant, albeit less than or equal to the amount they received if they were not working. To encourage work, the first $65 of earned income plus one-half of remaining earned income is disregarded when considering the family's grant amount.
- As earnings approach the program's exit level (about 130% of the federal poverty guidelines for a family of three) the family's grant is reduced to zero.

Income Assistance and Housing Programs

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MFIP Funding and Enrollment

- Total cost: $293.1 million in FY 2018
  - State: $90.7 million
  - Federal: $202.4 million
- Monthly average cases: 31,737
- Monthly average payment/case: $769.61

Income Assistance and Housing Programs

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General Assistance (GA)

- GA is a state program that provides cash assistance to low-income single adults and childless couples who fall into specified statutory categories and who meet the GA eligibility requirements, including income and asset requirements. Eligibility is primarily defined in terms of disability and unemployability.
- GA is a state-supervised, county administered program.
  - County agencies accept applications and make eligibility determinations.

GA Eligibility

- In addition to having financial need, a GA applicant must also:
  - be a resident of Minnesota;
  - be ineligible for aid from any cash assistance program that uses federal funds (i.e., MFIP or SSI);
  - be a citizen of the United States; and
  - meet other eligibility requirements.

GA Eligibility (cont'd.)

- A GA applicant must be unable to work because the person:
  - has a professionally certified illness, injury, or incapacity expected to continue for more than 45 days;
  - has a diagnosed developmental disability or mental illness;
  - is of advanced age;
  - is needed in the home to care for a person whose age or medical condition requires continuous care;
  - is placed in a licensed or certified facility for care or treatment under a plan approved by the local human services agency; or
  - resides in a shelter facility for battered women that has a contract with the Department of Corrections.

GA Eligibility (cont'd.)

- A GA applicant must be unable to work because the person:
  - has an application pending for or is appealing a termination of Social Security disability payments;
  - is assessed as not employable;
  - is under age 18 in certain specified circumstances and with consent of the local agency;
  - is eligible for displaced homemaker services and is enrolled as a full-time student;
  - is involved with protective or court-ordered services that prevent working at least four hours per day;
  - is over the age of 18 whose primary language is not English and who is attending high school at least half time; or
  - has a condition that qualifies as a specific learning disability.

GA Income Standards

- To receive GA, an individual's net income must be less than $203 each month for an individual, and $260 each month for a couple.
- Income is calculated in two steps:
  - First, the earned income disregard is subtracted from the applicant's gross monthly earned income, to get the applicant's net earned income amount.
  - Second, all unearned income that is not otherwise excluded is added to the applicant's net earned income amount, in order to arrive at the applicant's net income.

77

GA Asset Standards

- To be eligible for GA, the equity value of personal property must not exceed $10,000.
- Personal property is limited to:
  - Cash
  - Bank accounts
  - Liquid stocks and bonds that can be readily accessed without a financial penalty
  - Non-excluded vehicles (one vehicle per assistance unit member age 16 or older is excluded)

78

GA Benefits

Monthly GA Standards for Single Persons and Childless Couples	
Eligible units	Monthly Standard
One adult	$203
Emancipated minor	$203
One adult, living with parent(s) who have no minor children	$203
Minor not living with parent, stepparent, or legal custodian (with social service plan approval)	$250
Married couple with no children	$260
One adult, living in a medical facility or in group residential housing	$99

Income Assistance and Housing Programs

79

GA Funding and Enrollment

- Total cost: $48.9 million in FY 2018
- Financing: State general fund
- Monthly average cases: 23,238
- Monthly average payment/person: $175.30

Income Assistance and Housing Programs

80

Supplemental Security Income (SSI)/Minnesota Supplemental Assistance (MSA)

- SSI is a federal program that provides cash assistance to aged, blind, and disabled persons.
  - SSI is administered through local offices of the Social Security Administration, using uniform, nationwide standards.
- MSA is a state program that provides supplemental cash assistance to needy aged, blind, or disabled persons who are SSI recipients, or would qualify for SSI except for excess income.
  - The MSA program was established by the Minnesota legislature in 1974. It is a federally mandated, state supplement to SSI.
  - MSA is administered by the counties, under the supervision of DHS.

Income Assistance and Housing Programs

81

SSI/MSA Eligibility

- To qualify for SSI, an individual must be age 65 or older, or blind or disabled, according to criteria established by the Social Security Administration. The individual must also meet program income and asset limits, and satisfy other eligibility criteria.
- An individual's income, after allowed exclusions, must be below the maximum monthly SSI benefit.

Income Assistance and Housing Programs

82

SSI/MSA Asset Standards

- A single SSI/MSA recipient can have no more than $2,000 in net counted assets after all allowable exclusions. A married couple can have $3,000 in net counted assets.
- Certain assets are excluded from consideration in calculating the value of an applicant's assets, including:
  - the value of the homestead, if it is owned and occupied by the recipient or the recipient's spouse
  - the value of one vehicle per household is totally excluded
  - the value of household goods and personal effects (up to an equity value of $2,000)
- For MSA recipients who are not SSI recipients, the asset limit is different.

Income Assistance and Housing Programs

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SSI/MSA Benefits

- The maximum monthly SSI benefit for CY 2018 was $750 for an individual and $1,125 for a married couple.
- The actual benefit received is the difference between the individual's net income, after applying allowed exclusions, and this maximum monthly benefit amount.
- The amount of an MSA cash grant is computed by subtracting an individual's net countable income from the MSA assistance standard. Any SSI payment is counted towards the individual's net income.
- For CY 2018, the MSA assistance standards are $811 for an individual and $1,216 for a married couple.

Income Assistance and Housing Programs

84

SSI/MSA Funding and Enrollment

- Supplemental Security Income
  - Total cost: $662.0 million in FY 2018
  - Financing: Federal funds
  - Monthly average recipients: 93,933
  - Monthly average payment/recipient: $591.13 in October 2018
- Minnesota Supplemental Aid
  - Total cost: $39.1 million in FY 2018
  - Financing: State general fund
  - Monthly average recipients: 30,885
  - Monthly average payment/recipient: $105.41

Income Assistance and Housing Programs

85

Child Care Assistance Programs (CCAP)

- Child Care assistance programs receive federal, state, and county funds to subsidize the child care expenses of eligible families, including families participating in MFIP, and working families or students who receive no cash assistance.
  - CCAP includes:
    - MFIP child care assistance for families receiving MFIP and participating in authorized employment or education activities
    - Transition year child care assistance for families transitioning off of MFIP
    - Basic Sliding Fee child care assistance for low-income working families

Income Assistance and Housing Programs

86

CCAP Administration

- CCAP programs are administered by counties under the supervision of DHS.
- Parents who are eligible for assistance may choose any type of legal child care, including legal unlicensed child care

Income Assistance and Housing Programs

87

CCAP MFIP Child Care Assistance:

- subsidizes child care costs for families who participate in the statewide MFIP program, including families who forego the cash portion of MFIP;
- provides child care assistance for eligible families for the first 12 months after the family leaves MFIP (known as transition year child care); and
- is fully funded through the state general fund, federal Child Care Development Fund (CCDF), and federal Temporary Assistance to Needy Families (TANF).

Income Assistance and Housing Programs

88

CCAP Basic Sliding Fee (BSF) Child Care:

- provides a child care subsidy to working families who are not receiving cash assistance through MFIP;
- is funded through the state general fund, federal CCDF funds, federal TANF funds, and county contributions; and
- assistance is limited by available funding.
- Some counties have waiting lists.

Income Assistance and Housing Programs

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CCAP Eligibility

- In order to be eligible for child care assistance, a family must:
  - have an income at or below 47% of state median income ($45,192 for a family of four in FY 2018) at program entry and up to 67% of state median income ($64,423 for a family of four) at program exit, and children under age 13 (under age 15 for special needs children);
  - participate in an authorized work, training, or education activity;
  - cooperate with child support enforcement; and
  - pay a copayment based on family size and income.

Income Assistance and Housing Programs

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CCAP Benefits

- Benefit amounts under the child care assistance programs depend on the caretaker's activities, the selection of a child care provider, where the child care is provided, and the amount of the family copayment.
- Maximum benefits under the child care assistance programs cannot exceed 120 hours of subsidized care in a two-week period for each eligible child.
- Maximum child care reimbursement rates are set in statute.

Income Assistance and Housing Programs

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CCAP Funding and Enrollment

- MFIP/Transition Year Child Care
  - Total Cost: $165.2 million in FY 2018
    - Federal Funds: $71.9
    - State Funds: $93.3
  - Average Monthly Enrollment: 7,830 families
  - Average Monthly Payment/Family: $1,757.97
- BSF Child Care
  - Total Cost: $101.5 million in FY 2018
    - Federal Funds: $53.8
    - State/local funds: $44.7
  - Average Monthly Enrollment: 6,970 families
  - Average Monthly Payment/Family: $1,213.15

Income Assistance and Housing Programs

92

Food Support and WIC

- The Supplemental Nutrition Assistance Program (SNAP) is a federally funded program operated by the U.S. Department of Agriculture (USDA) that provides food assistance to low-income individuals.
- Women, Infants & Children Nutrition Program (WIC) is a federally funded program administered through MDH and the counties, and provides food support to low-income pregnant women and children under age 5.

Housing Support Services

- Housing support services provide payments on behalf of eligible persons to pay for room and board and related housing services.
- Housing support is administered by the counties under the supervision of the Department of Human Services.

Housing Support

- In order to be eligible for housing support payments, an individual must have county approval for residence in a housing support setting and must:
  - be aged, blind, or over 18 years of age and disabled, and meet specified income and asset standards;
  - belong to a category of individuals potentially eligible for GA and meet specified income and asset standards; or
  - receive licensed residential crisis stabilization services and receive MA.

Income Assistance and Housing Programs

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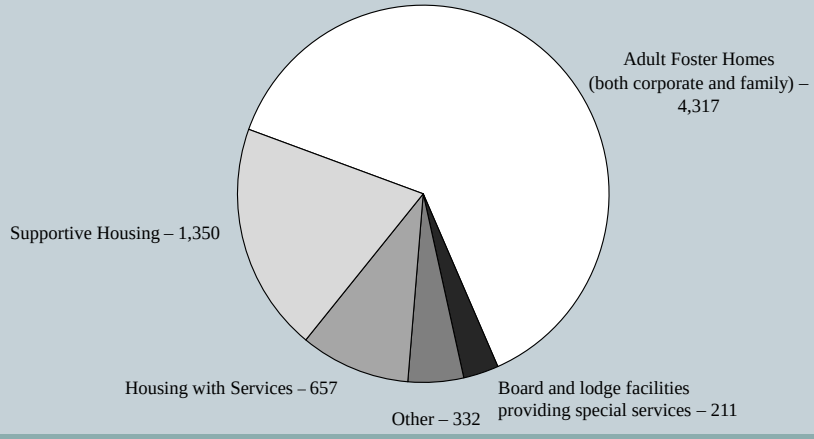
Housing Support Eligibility – FY 2018



Income Assistance and Housing Programs

96

Housing Support Income Standards

- An individual who is aged, blind, or over 18 years of age and disabled according to the criteria used by the Social Security program, is eligible for housing support if he or she has income below the housing support monthly rate specified in the county's agreement with the housing support provider, after making applicable deductions.
- A person who belongs to a category of individuals potentially eligible for GA is eligible for housing support if he or she:
  - has countable income under the GA program, minus the MA personal needs allowance, that is less than the monthly rate specified in the county agency's agreement with the housing support provider; and
  - meets the GA asset standard.

Income Assistance and Housing Programs

97

Housing Support Benefit

- Nearly all housing support recipients qualify for the housing support basic room and board rate of $904 per month.
  - Recipients in certain housing support settings may also qualify for a supplemental payment that is in addition to this base rate.

Income Assistance and Housing Programs

98

Housing Support Funding and Enrollment

- Total funding: $161.3 million in FY 2018 (state general fund)
- Monthly average recipients: 20,502
- Average monthly payment/person: $655.60

Income Assistance and Housing Programs

99

Child Support Enforcement

- Federal law requires each state to establish a child support enforcement program and sets broad standards and requirements.
- The federal government provides TANF and child support enforcement funding to states with child support systems that meet federal requirements.
- The Minnesota Legislature has established child support policy within the parameters established by the federal government.
- DHS is responsible for oversight of the child support system, which counties administer.
- In fiscal year 2017, the federal government matched 68% of county and state funding.
- In fiscal year 2017, Minnesota collected and disbursed child support totaling approximately $580.6 million.
- In fiscal year 2017, for every $1 spent, DHS collected $3.30 in support for Minnesota's children.

DHS Program Areas

100

- Health Care
- Long-Term Care
- Chemical and Mental Health
- Income Assistance and Housing Programs
- Protection of Children and Vulnerable Adults
- Program Integrity and Operations

Protection of Children and Vulnerable Adults

101

Child Welfare Services

- Federal law requires each state to provide intervention and services to protect children from abuse and neglect.
- The legislature establishes the policy to implement federal law and provide services to families so their children are safe.
  - Maltreatment of Minors Act—includes definition of child abuse and neglect, mandated reports, responsibility for investigations and assessments. Minn. Stat. § 626.556.
- Funding for services comes from federal, county, and state sources.
- Counties are responsible for providing child welfare services when a child is alleged to have been abused or neglected in the home.
  - Investigations and family assessments
  - Protective services
  - Foster care
  - Adoption

Protection of Children and Vulnerable Adults

102

Child Welfare Services – Maltreatment of Minors Act

- Law enforcement is required to investigate reports that allege violation of a criminal law.
- When a caregiver outside of the child's home is alleged to have abused or neglected a child, then the following entities are responsible for investigating the allegation:
  - In schools—MDE
  - Foster care, family child care, legally unlicensed child care, unlicensed personal care provider organizations—county social service agency
  - Facilities licensed by DHS, except foster care and family child care, and juvenile correctional facilities—DHS
  - Facilities licensed by MDH—MDH

Protection of Children and Vulnerable Adults

103

Child Welfare Services

- If a child is not safe in a home, or a parent has not cooperated with a service plan, a county may file a **Child in Need of Protection or Services (CHIPS)** case.
  - The child is placed in foster care, and a case plan is developed to attempt to reunify the family within 6-12 months.
  - Review hearings every 3 months
- If the home remains unsafe after the child is in foster care for 11 months, the county will file a permanency petition.
  - Termination of parental rights (TPR) or guardianship to the commissioner of human services (adoption with parental consent).

Protection of Children and Vulnerable Adults

104

Child Welfare Services - Permanency

- Permanency: reunification, adoption, transfer of permanent legal and physical custody to a relative (TPLPC, or “kinship”).
- **Northstar Care for Children** provides monthly assistance payments for children in foster care, and children who are adopted or whose custody is transferred to a relative. Adoption and kinship payments are at the same rate as foster care assistance payments.*
  - Kinship or adoption assistance eligibility determination is started by county or tribal staff, with a final determination made by DHS.
  - Payments based on age, and supplemental payments are based on the child’s assessed special needs

Protection of Children and Vulnerable Adults

105

Services for Vulnerable Adults

- Individuals who are age 18 and older who are: impaired physically, mentally, or emotionally and unable to protect themselves from maltreatment; residents or inpatients of a facility; receive certain outpatient services; or receive certain home care services.
- Reports of suspected maltreatment must be made to the common entry point which must be available 24 hours a day to accept reports.
- Counties, law enforcement, DHS, and MDH assess and investigate allegations of abuse, neglect, and financial exploitation.
- Counties provide protective services when needed.

DHS Program Areas

106

- Health Care
- Long-Term Care
- Chemical and Mental Health
- Income Assistance and Housing Programs
- Protection of Children and Vulnerable Adults
- Program Integrity and Operations

Program Integrity and Operations

107

Provider Fraud Prevention

- The DHS Office of Inspector General (OIG) oversees fraud prevention and recovery efforts for all DHS-administered public programs.
- DHS has implemented procedures and initiatives to reduce provider fraud and improper payments, including:
  - Educating providers
  - Recommending system edits to prevent improper claim payment
  - Conducting provider screening visits
  - Operating a surveillance and integrity review section (SIRS) to investigate MA provider and recipient fraud.
  - 2015 law requiring personal care assistant agencies to develop and implement policies and procedures to verify service.
- DHS contracts with outside entities to conduct post-payment provider audits to identify and recover overpayments and identify underpayments.

Program Integrity and Operations

108

Recipient Fraud Prevention

- Minnesota Restricted Recipient Program – recipients placed in program after reviews show abuse or misuse of medical services. Recipients are restricted to one PCP, clinic, hospital, and pharmacy for 24 or 36 months, reducing costs by $5,000-$6,000 per year.
- The state and counties work together to prevent public assistance fraud.
  - Minnesota funds a county-administered program called the integrity reinvestment project, which pays for preventing and investigating fraud in the state's cash assistance, child care, health care, and food programs.
  - Fraud prevention programs prevent and reduce improper payments by resolving eligibility questions for caseworkers.

Fraud Prevention Investigations

- In 2017, fraud investigators:
  - Completed 8,869 recipient fraud investigations (case closed/benefits reduced in 4,501 of those cases), identifying $7,487,221 in overpayments.
  - Opened 582 provider investigations, identifying $12,742,946 in overpayments.
  - Reviewed 3,580 MinnesotaCare eligibility cases, identifying $25,588 in overpayments.
  - Opened 67 childcare provider investigations, identifying $219,205 in overpayments.

DHS Program Regulation

- Licensing
  - Residential and nonresidential programs for children and adults.
  - Approximately 20,000 programs and providers held DHS licenses in 2017.
  - Certain licensing functions are delegated to counties.
  - Some private agencies have been authorized to perform licensing functions related to child placement and child foster care.
  - DHS directly licenses and monitors all other programs.
- Investigations
  - Allegations of maltreatment of a child or a vulnerable adult served by a licensed program or provider.
  - Allegations of licensing violations.
  - In 2017, DHS received 8,399 maltreatment reports and licensing complaints.
  - 244 reports with maltreatment substantiated.
- Background studies

Program Integrity and Operations

111

Background Studies

- DHS conducts background studies on all individuals who provide direct contact services to children or vulnerable adults, to determine whether the individual has committed an act that would disqualify him or her from providing those services.
  - "Direct contact" means providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to clients in health and human services programs.
- Also required for certain others, such as guardians and conservators, people who provide foster care, people seeking adoption, and people over 13 living in the household where a licensed program is provided.

Program Integrity and Operations

112

Background Studies

- NetStudy 2.0 is the health and human services background study system, fully implemented in 2017.
  - Requires **fingerprint** and **photograph**
  - Records Searched:
    - Bureau of Criminal Apprehension
    - Minnesota Court Information System
    - National crime information database
    - FBI records (in limited circumstances)
    - Records of substantiated maltreatment
    - Professional licensing records
    - Predatory offender registries
  - Electronic updates of study subjects' criminal records; electronic employer notifications
- Disqualifying conduct and crimes listed in Minn. Stat. section 245C.15.
- 352,119 background studies conducted in 2017, 7,036 disqualifications (2%)

Regulation of Health Occupations

113

Health-Related Professional Regulation

- Minnesota statutes provide that no occupation may be regulated by the state unless its regulation is required for the safety and well-being of Minnesotans.
- Health-related occupations are regulated by either MDH or one of the 17 health-related licensing boards. The state regulates at least 56 health-related occupations.
- Some health-related licensing boards regulate a single occupation, while others regulate a range of related occupations.

Regulation of Health Occupations

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Health Licensing Boards

- Board of Behavioral Health and Therapy
- Board of Chiropractic Examiners
- Board of Dentistry
- Board of Dietetics and Nutrition Practice
- Emergency Medical Services Regulatory Board
- Board of Marriage and Family Therapy
- Board of Medical Practice
  - Physicians and surgeons
  - Acupuncturists
  - Athletic trainers
  - Genetic counselors
  - Naturopathic doctors
  - Traditional midwives
  - Respiratory therapists
  - Physician assistants
- Board of Nursing
- Board of Examiners for Nursing Home Administrators
- Board of Occupational Therapy
- Board of Optometry
- Board of Pharmacy
- Board of Physical Therapy
- Board of Podiatric Medicine
- Board of Psychology
- Board of Social Work
- Board of Veterinary Medicine

Regulation of Health Occupations

115

MDH Regulated Occupations

Allied Health Professionals	Environmental Health Professionals	Unlicensed Complimentary & Alternative Health Care Practitioners
Speech-language pathologists	Lead workers	Culturally traditional healing practices
Audiologists	Asbestos workers	Aroma therapy
Body art technicians	Environmental health specialists/sanitarians	Meditation
Mortuary science practitioners	Food managers	Massage therapy
Doulas	Water supply system operators	Mind-body healing practices
Nursing assistants	Wells and borings contractors	Acupressure
Hearing instrument dispensers	Pool operators	

Health Department

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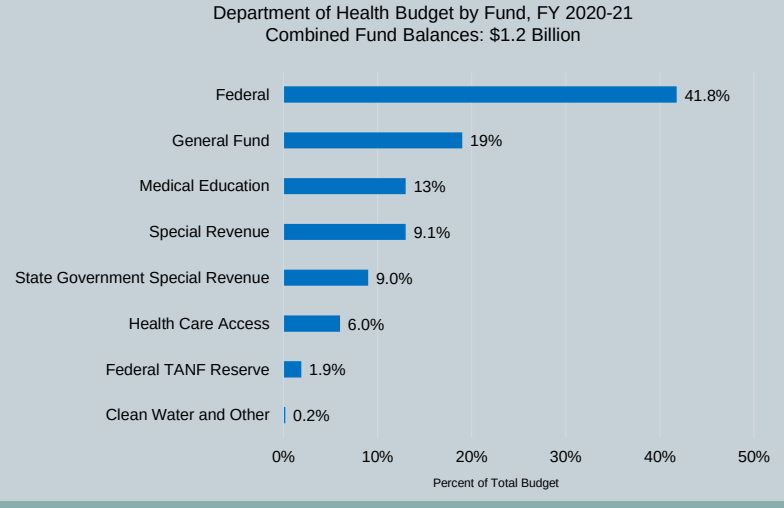

Source: 2017 End of Session Consolidated Fund Balance Statement

Health Department Programs and Activities

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- Public Health
- Health Care Regulation
- Health Care Reform

Health Department Activities and Programs

118

- Public Health Activities: activities to protect and promote the health of people and communities by preventing people from becoming sick or injured, promoting wellness, tracking disease outbreaks, educating people about health risks, and compiling health statistics.
- Health Care Regulation
- Health Care Reform

Public Health

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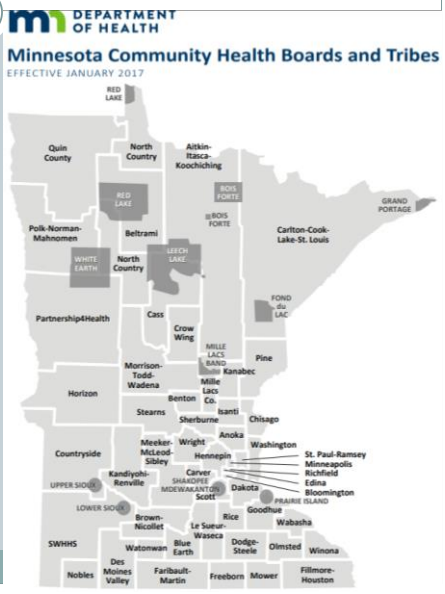
- Public health = partnership between MDH, community health boards, tribal governments, and other organizations



Public Health

120

Health Protection

- Environmental Health Programs
  - Indoor Air Quality
  - Drinking Water
  - Food Safety
  - Wells
- Infectious Disease Epidemiology, Prevention, and Control
  - Foodborne illnesses
  - Immunizations
  - Emerging infectious diseases
  - STDs, HIV, TB
- Public Health Laboratory

Health Improvement

- Community and Family Health
  - Maternal and child health
  - Children and youth with special health needs
  - Family home visiting
- Health Promotion and Chronic Disease Prevention
  - Cancer
  - Heart disease, stroke, diabetes, and asthma
  - Injury and violence prevention
- Office of Statewide Health Improvement Initiatives
- Center for Health Disparities

Public Health

121

Health Protection

- Environmental Health Programs
  - Safe Indoor Environments
    - Clean Indoor Air Act
    - Lead, Asbestos, and Radon
  - Drinking Water
    - Drinking water protection programs
    - Well management
  - Food Safety
  - Radiation Equipment Safety

Public Health

122

Health Protection

- Infectious Disease Epidemiology, Prevention, and Control
  - Foodborne illness outbreaks
  - Immunizations
  - STDs, HIV, and TB
  - Emerging infectious diseases
- Public Health Response Contingency Account

Public Health

123

Health Protection

- Public Health Laboratory
  - Analysis of environmental samples
  - Testing human samples for infectious disease agents
  - Newborn screening program:
    - Tests newborn infants for more than 50 disorders of metabolism, hormones, the immune system, blood, breathing, digestion, hearing, and the heart
    - Three tests: blood spot screening, hearing screening, pulse oximetry screening
    - State law governs the retention, destruction, and use of blood spots and test results; different rules apply depending on when the samples were collected

Public Health

124

Health Improvement

- Community & Family Health
  - Maternal and Child Health
  - Family Home Visiting
  - WIC and Commodity Supplemental Food Program
  - Children and Youth with Special Health Needs

Public Health

125

Health Improvement

- Health Promotion and Chronic Disease Prevention
  - Center for Health Promotion
  - Cancer program
  - Heart disease, stroke, diabetes, and asthma programs
  - Injury and violence prevention activities
- Office of Statewide Health Improvement Initiatives
- Center for Health Equity

Public Health

126

Vital Records System

- MDH operates Office of Vital Records under supervision of State Registrar
- Statewide system of vital records, including records on births, deaths, and marriages
- Requirements exist for who must file vital records, when they must be filed, and amendments to vital records

Health Department Programs and Activities

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- Public Health
- Health Care Regulation
- Health Reform

Health Care Regulation

128

Regulation of Health/Public Health Occupations

Allied Health Professionals	Environmental Health Professionals	Unlicensed Complimentary & Alternative Health Care Practitioners
Speech-language pathologists	Lead workers	Culturally traditional healing practices
Audiologists	Asbestos workers	Aroma therapy
Body art technicians	Environmental health specialists/sanitarians	Meditation
Mortuary science practitioners	Food managers	Massage therapy
Doulas	Water supply system operators	Mind-body healing practices
Nursing assistants	Wells and borings contractors	Acupressure
Hearing instrument dispensers	Pool operators	

Health Care Regulation

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Regulation of Health Facilities and Providers

- Licenses and inspects health facilities such as hospitals, nursing homes, supervised living facilities, housing with services establishments, and hospices.
- Licenses home care providers and conducts periodic surveys of these providers.
- Administers the essential community provider designation program.

Health Care Regulation

130

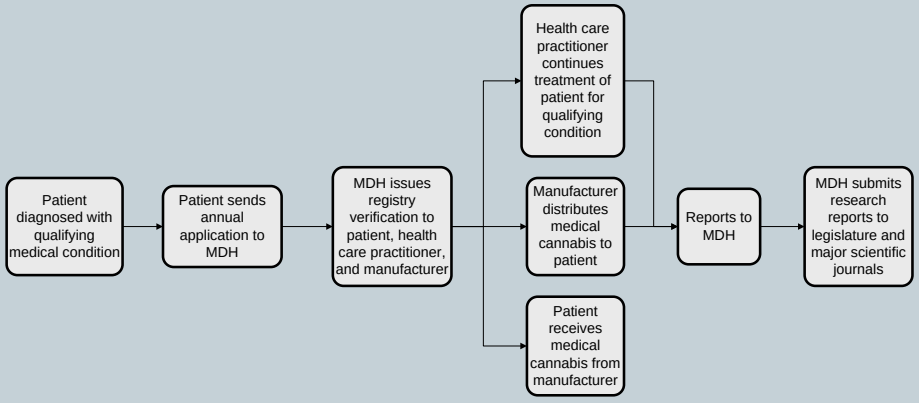
Regulation of Health Carriers

- Licenses health maintenance organizations (HMOs) and regulates their fully insured health plans
- Regulates county-based purchasing organizations
- Ensures provider network adequacy of HMO networks and the networks of health carriers regulated by the Department of Commerce

Health Care Regulation

131

Medical Cannabis Program: General Design



Health Care Regulation

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Medical Cannabis Program: Patient Access

Qualifying medical conditions

- Cancer*
- Glaucoma
- HIV/AIDS
- Tourette's
- ALS
- Seizures
- Severe and persistent muscle spasms
- Crohn's disease
- Terminal illness with life expectancy of under one year*
- Intractable pain
- Post-traumatic stress disorder
- Autism spectrum disorder
- Obstructive sleep apnea

Health Department Programs and Activities

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- Public Health
- Health Care Regulation
- Health Care Reform

Health Care Reform

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Health care reform activities: initiatives and programs to improve the patient experience of care (including quality and satisfaction); improve population health; and reduce health care costs.

- Health care workforce development programs
- Initiatives to improve access and efficiency using technology
- Initiatives to ensure value in health care spending

Health Care Reform

135

Health Care Workforce Development Programs

- Loan Forgiveness Program
- Clinical or Residency Training Grant Programs
- Medical Education and Research Costs (MERC)
- International Medical Graduates Assistance Program

Health Care Reform

136

Initiatives to Improve Access and Efficiency Using Technology

- Electronic health records: all hospitals and almost all providers must have interoperable electronic health records as of January 1, 2015
- Electronic prescription drug program: electronic prescription drug program must be used for all prescriptions, and drug prior authorization requests must be submitted electronically
- Health information exchange: system for transmitting health information between providers and provider organizations

Health Care Regulation and Reform

137

Initiatives to Ensure Value in Health Care Spending

- Health Care Homes: clinics certified by MDH and provide coordination of primary care and other services, care coordinators, and care plans for patients with complex or chronic conditions. MA provides payment to these clinics for care coordination.
- Statewide Quality Reporting and Measurement System (SQRMS): standardized set of quality measures for health care providers.

Health Care Reform

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Initiatives to Ensure Value in Health Care Spending

- All-Payer Claims Database (MN APCD): database of health care claims data on Minnesota residents
  - Data is submitted by health plan companies, third-party administrators, and pharmacy benefits managers that cover Minnesota residents and paid claims over a certain amount in the previous calendar year. MDH also obtains Medicare and MA claims data.
  - Enrollment data, encounter data, and pricing data are submitted.
  - Allowable uses of the data are specified in statute.

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