MN HOUSE RESEARCH

Medical Assistance

Public Assistance Programs: A Series

October 2025

Public Assistance Programs is a series of publications that describe state and federal programs that provide assistance in the form of healthcare, income, food, housing, and child care. Each work in the series describes an individual program. Please see the list on the last page for other works in this series.

Overview

Medical Assistance (MA) is a means-tested, federal-state program that pays for preventive, acute, and basic health care services and long-term services and supports (LTSS) provided to low-income individuals. During state fiscal year 2024, an average of 1.3 million Minnesotans, or about 23 percent of the state's population, were eligible for MA services each month. Parents and children made up the largest eligibility group, constituting 63 percent of eligibles.

MA is both Minnesota's Medicaid program and its state Children's Health Insurance Program (CHIP) and is jointly funded by the federal and state governments. The federal government reimburses Minnesota for a portion of the state's MA costs. In state fiscal year 2024, total MA expenditures for health care services and LTSS were $18.513 billion. The federal government covered about 58 percent of the expenditures, or $10.8 billion, and the state covered the remaining $7.6 billion.

MA must operate within federal Medicaid and CHIP laws and regulations, but states have some flexibility to design their programs within the basic federal framework. This publication describes various aspects of Minnesota's MA program, including eligibility, covered services, provider payment, and funding.[1]

[1] The content of this publication does not reflect federal enactment of Public Law 119-21, referred to as the One Big Beautiful Bill Act.

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Administration

Federal Government

Medicaid was established by the U.S. Congress in 1965 as Title XIX of the Social Security Act, and CHIP was established in 1997 as Title XXI of the Social Security Act. Medicaid and CHIP are administered at the federal level by the Centers for Medicare and Medicaid Services (CMS), an agency within the U.S. Department of Health and Human Services.

States' Medicaid and CHIP programs must comply with federal law as well as regulations and guidance issued by CMS. However, federal law authorizes waiver and demonstration authorities that allow states to operate their programs outside the parameters of federal law, and federal law sometimes includes options and flexibilities for states.[2] As a result, Medicaid and CHIP programs can and do vary widely across the states.

State and Local Governments

MA was established by the state 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.

The Department of Human Services (DHS) is responsible for the operation of the MA program at the state level and for supervising administration of the program by county and participating Tribal

[2] For example, states can choose whether to administer CHIP as part of the state's Medicaid program or as a separate program. Minnesota administers CHIP as part of the state's Medical Assistance program.

agencies. DHS has adopted administrative rules and policies that govern many aspects of the MA program. County human services agencies, and Tribal human services agencies choosing to participate, share the responsibility for determining if applicants meet state and federal eligibility standards for MA.

Eligibility Requirements

The general parameters for Medicaid and CHIP eligibility are set out in federal law and regulations. States are allowed to set eligibility criteria for their programs within those parameters. To be eligible for MA, an individual must:

- be a member of a group for which MA coverage is required or permitted under federal or state law;
- meet program income limits and any applicable asset limits, or qualify on the basis of a spenddown (for more details, see the textbox, "Eligibility on the Basis of a Spenddown");
- be a U.S. citizen or a lawfully present noncitizen who meets specified criteria; and
- be a resident of Minnesota.

Table 1 shows selected MA eligibility groups and corresponding income and asset limits for each group. More detailed information about each of the eligibility requirements follows the table.

Table 1: Selected MA Eligibility Groups and Corresponding Income and Asset Limits

Eligibility Group	Income Limit	Asset Limit
Children under age 2	≤ 283% of FPG	None
Children 2 through 18 years of age	≤ 275% of FPG	None
Children 19 through 20 years of age	≤ 133% of FPG	None
Pregnant women[3]	≤ 278% of FPG	None
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)
Adults without children	≤ 133% of FPG	None
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)

[3] Pregnant women are eligible for coverage through 12 months postpartum.

Eligibility Group	Income Limit	Asset Limit
Disabled children eligible for services under the TEFRA children's home care option[4]	≤ 100% of FPG[5]	None
Employed persons with disabilities (MA-EPD)	No income limit	None
Medicare Savings Programs		
Qualified Medicare Beneficiaries (QMBs)	≤ 100% of FPG	$10,000 for households of one and $18,000 for households of two or more[6]
Specified Low-income Medicare Beneficiaries (SLMBs)	≤ 120% of FPG	$10,000 for households of one and $18,000 for households of two or more[5]
Qualifying individuals (QI)	< 135% of FPG	$10,000 for households of one and $18,000 for households of two or more[5]
Qualified working disabled (QWD) individuals	≤ 200% of FPG	Must not exceed twice the SSI asset limit

Source: House Research Department analysis of federal and state law

Notes: Income disregards are not included in the income limits (e.g., the 5 percent income disregard for certain eligibility categories is not reflected in the income limits). The appendix has a table that shows the corresponding dollar amounts for the income limits by family size for state fiscal year 2026.

Eligibility Groups

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. Groups eligible for MA coverage include the following:

- children[7]
- parents or caretakers of dependent children
- pregnant women
- adults ages 21 through 64 who do not have children

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

[5] 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.

[6] 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.

[7] For Medicaid and CHIP, a "child" is under the age of 21. That is how child is used in this publication unless otherwise specified.

- individuals age 65 or older, including those who may also be enrolled in Medicare (see the following section for more information about "dual eligibles")
- individuals with a disability or who are blind, as determined by the Social Security Administration or the State Medical Review Team (this category includes most persons eligible for either the Minnesota Supplemental Aid (MSA) or Supplemental Security Income (SSI) programs)
- children eligible for or receiving state or federal adoption assistance payments (regardless of income)
- children eligible for federal foster care payments or state foster care or kinship care assistance (regardless of income)
- 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 (regardless of income)
- certain disabled children under age 19 who would normally not be eligible for MA because of parental income (referred to as the TEFRA option for children with disabilities)

Dual Eligibles

Individuals who are enrolled in both Medicaid and Medicare are often referred to as "dual eligibles." Medicare enrollees who meet a state's standard Medicaid income and asset limits may qualify for Medicaid covered services and Medicaid payment of Medicare premiums, coinsurance, and deductibles. In this case, Medicaid is a secondary payor to Medicare and functions as a wrap-around policy.

Medicare enrollees who do not meet a state's standard Medicaid income and asset limits may be eligible to enroll in a Medicare Savings Program. Federal law requires that states offer Medicare Savings Programs to Medicare enrollees with higher income and asset limits than would otherwise qualify them for Medicaid. Individuals enrolled in Medicare Savings Programs qualify for Medicaid payment of various types of Medicare cost-sharing. See Table 1 for details about the eligibility requirements for Minnesota's Medicare Savings Programs.[8]

Income Limits

An MA applicant's income must not exceed program income limits.[9] As shown in Table 1, different income limits apply to different eligibility groups. For example, the MA income limit for most children is higher than the MA income limit for parents or relative caretakers. This means that not all members of a family may be covered under MA. However, individuals in most MA eligibility categories who have excess income may be able to qualify for MA by spending down their income (for more details, see the textbox, "Eligibility on the Basis of a Spenddown").

[8] Minn. Stat. §§ 256B.055, 256B.057.

[9] Minn. Stat. § 256B.056, 256B.057, subd. 1.

MA income limits are based on the federal poverty guidelines (FPG), which vary with family size and are adjusted annually for inflation. The appendix has a table that shows the guidelines by family size for various MA income limits for state fiscal year 2026.

Income Determination

An income methodology that specifies countable and excluded income is used to determine income for different eligibility groups. Federal law requires that modified adjusted gross income (MAGI)[10] is used as the income methodology for children, most parents and relative caretakers, pregnant women, and adults without children. Federal law also requires a standard 5 percent of FPG income disregard when determining eligibility for groups for whom MAGI-based income is required. This standard disregard has the effect of raising the FPG income limit for MAGI-based income groups by five percentage points.

Federal law requires that the income methodology used for individuals who are age 65 and older, blind, or have disabilities is based on that used by the federal SSI program.

Asset Limits

MA has two main asset limits. One applies to individuals who are age 65 or older, blind, or who have a disability. The other applies to parents and relative caretakers who qualify for MA through a spenddown.

Age 65 or older, blind, or disabled. In general, individuals 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 individuals in a household, with $200 added for each additional dependent.[11] 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[12]
- capital and operating assets of a business necessary for the person to earn an income

[10] 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 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.

[11] Minn. Stat. § 256B.056, subd. 3. The Minnesota Long-Term Care Partnership (LTCP) program allows individuals who have qualified long-term care insurance policies to qualify for MA payment of long-term care services while retaining assets above the regular MA asset limit equal in value to the amount paid for care by the policy. For more information, see the Commerce Department LTCP webpage (https://mn.gov/commerce/insurance/other/long-term-care/partnership.jsp).

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

- 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[13]
- certain assets owned by American Indians related to the relationship between Tribes and the federal government, or with unique Indian significance

Parents and relative caretakers on a spenddown. Parents and relative caretakers who qualify for MA through a spenddown are subject to 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 individuals.[14] Certain assets are excluded for determining MA eligibility, including the following:

- the homestead
- household goods and personal effects
- a burial plot for each family member
- life insurance policies and assets for burial expenses, up to the limits established for the SSI program
- capital and operating assets of a business up to $200,000
- funds received for damaged, destroyed, or stolen property are excluded for three months if held in escrow
- a motor vehicle for each person who is employed or seeking employment
- court-ordered settlements of up to $10,000
- individual retirement accounts and funds
- assets owned by children
- 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 individuals residing in nursing homes whose spouses reside in the community.[15]

Children, pregnant women, parents and relative caretakers who do not qualify through a spenddown, and adults without children are exempt from any asset limit. Individuals eligible for MA as employed individuals with disabilities (MA-EPD) are also exempt from asset limits.

[13] 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.

[14] Minn. Stat. § 256B.056, subd. 3c.

[15] These provisions are found in Minnesota Statutes, sections 256B.0575 to 256B.0595. For more information, see the House Research Department publication *Medical Assistance Treatment of Assets and Income*, September 2025.

Eligibility on the Basis of a Spenddown

Most individuals who would qualify for coverage under MA, except for excess income, can qualify for MA through a "spenddown."[16] However, no spenddown option is available for individuals eligible as adults without children.

Under a spenddown, an individual reduces their income by incurring medical bills (paid or unpaid) 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. Unpaid medical bills incurred before the time of application for MA can be used to meet the spenddown requirement. The MA spenddown standard for parents and caretakers is 133 percent of FPG, and the standard for individuals who are age 65 years or older, blind, or disabled is 100 percent of FPG.

Once an individual reaches the spenddown standard, MA covers the individual's expenses over the spenddown amount. 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 to become eligible for MA for the remainder of that month.

Citizenship and Immigration Status

To be eligible for MA, an individual must be a U.S. citizen or a lawfully present noncitizen who meets specified criteria.[17] Federal law identifies who is considered a lawfully present noncitizen and sets the criteria by which lawfully present noncitizens are eligible for Medicaid. For example, asylees and refugees are generally eligible for MA, while certain groups of lawful permanent residents, who are not pregnant women or children, are not eligible for MA until they have resided in the United States for five or more years. Federal law also gives states the option to cover some noncitizens with federal financial participation. Minnesota has generally chosen to provide MA coverage for all groups of noncitizens for which MA eligibility is optional under federal law and for which a federal match is provided.[18] For example, MA covers undocumented pregnant women for the duration of their pregnancy and a 12-month postpartum period.

Residency

An individual must be a resident of Minnesota to be eligible for MA.[19] Generally, individuals age 21 and older are considered residents if they live in Minnesota and intend to reside in the state, or if they live in Minnesota and entered the state with a job commitment or to seek employment.

[16] Minn. Stat. § 256B.056, subds. 5 and 5c.

[17] Minn. Stat. § 256B.06, subd. 4, (a) to (d). Undocumented noncitizens and lawfully present noncitizens not eligible for regular MA coverage with a federal match are eligible for MA coverage of emergency services. For information about emergency medical assistance (EMA), see the House Research Department publication *Emergency Medical Assistance*, October 2025.

[18] For more details about MA citizenship policy, see DHS, Minnesota Health Care Programs Eligibility Policy Manual, section 2.1.2.2.2 MA Immigration Status.

[19] 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). The requirement is codified at Minnesota Statutes, section 256B.056, subdivision 1.

Children who are not emancipated are considered residents if they live in Minnesota or reside with a parent or relative caretaker who is a Minnesota resident. Individuals visiting Minnesota, including those visiting for the purpose of obtaining medical care, are not considered residents.

Eligibility Process and Policies

County agencies and participating Tribal agencies determine individuals' eligibility 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 agency.

County and Tribal agencies use the Minnesota eligibility system, also referred to as the Minnesota Eligibility Technology System (METS),[20] to determine MA eligibility for parents or relative caretakers and children, pregnant women, and adults without children. The METS application is available online through MNsure or by submitting paper application forms to a county or Tribal agency.

For MA applicants who are age 65 or older, blind, or have disabilities, or who belong to certain smaller MA eligibility categories, county and Tribal agencies use the legacy MAXIS eligibility determination system.

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 Policies

There are a number of MA policies that determine the parameters of an individual's eligibility for MA.

Retroactive coverage. MA can retroactively pay for the cost of 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.[21]

Presumptive eligibility. Some individuals may be determined temporarily eligible for MA through a presumptive eligibility process, under which specified providers determine eligibility based on

[20] Minn. Stat. § 62V.055, subd. 1. The METS system is also used to determine eligibility for MinnesotaCare, and for premium tax credits and cost-sharing reductions available for private health plan coverage purchased through MNsure.

[21] Minn. Stat. § 256B.056, subd. 7.

preliminary information, with ongoing eligibility then determined by county or Tribal agencies within a specified time period.[22]

Redetermination of eligibility. Eligibility for most enrollees is redetermined every 12 months. Individuals who qualify for MA through a spenddown have their eligibility redetermined every six months.[23]

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. However, under MA children remain eligible for a specified time period, even if income or other factors related to eligibility change (this is referred to as "continuous eligibility"). As of January 1, 2025, children age 19 or older but under age 21 remain eligible for a period of 12 months, and children under age six remain eligible through the month in which the child turns age six.[24]

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.[25]

Institutions for Mental Diseases (IMDs). Federal law generally prohibits federal Medicaid funding for people receiving behavioral health care services in 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: (1) are under age 21 and are receiving inpatient psychiatric services in certain settings; (2) are age 65 or older; or (3) otherwise qualify for an exception.[26]

Additionally, CMS has approved a demonstration project in Minnesota that allows the state to receive 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.[27] Residential treatment programs and 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, have

[22] 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).

[23] Minn. Stat. § 256B.056, subds. 7 and 7a.

[24] Minn. Stat. § 256B.056, subd. 7.

[25] Minn. Stat. § 256B.055, subd. 14.

[26] 42 U.S.C. § 1396d.

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

been required to participate in the demonstration project since January 1, 2024; for other providers, participation is optional.

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, 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.[28]

Covered Services

Federal law requires that states' programs cover preventive, acute, and basic health care services, as well as long-term services and supports (LTSS). Minnesota's MA program provides enrollees with all federally mandated services and most services designated by the federal government as optional for states to provide.[29] 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.

The same covered services are available to MA enrollees under both fee-for-service and managed care (see discussion of these delivery systems in the following section).

Federally Mandated Services for MA Recipients

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

- Child and teen checkup—also referred to as early periodic screening, diagnosis, and treatment (EPSDT)—services for children (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

[28] Minn. Stat. § 256B.0635.

[29] Most MA covered services are specified in Minnesota Statutes, section 256B.0625.

- Outpatient hospital services
- Physician services
- Pregnancy-related services (through 12 months postpartum)
- Rural health clinic services

Optional Services for MA Recipients

Federal law identifies some services as "optional" for Medicaid and CHIP enrollees. This means that states are not required to cover the service, but if they do, the states receive federal matching funds for providing the services. The following list identifies the services designated "optional" by the federal government that are available by state law to 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[30]
- Clinic services
- Community emergency medical technician services
- Community paramedic services
- Dental services[31]
- 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[32]
- Some Individual Education Plan (IEP) services provided by a school district to disabled students

[30] Beginning January 1, 2026, or upon federal approval, whichever is later, MA coverage for chiropractic services is only available to children and is limited to one annual evaluation and 24 visits per year unless prior authorization for more visits is obtained.

[31] Since January 1, 2024, MA has covered medically necessary dental services for adults. Prior to January 1, 2024, coverage of dental services for adults who were not pregnant was limited to specified services (see Minn. Stat. § 256B.0625, subd. 9, and Laws 2023, ch. 70, art. 1, § 11).

[32] On August 1, 2025, DHS sent a letter to CMS to request assistance with terminating housing stabilization services, stating "This action is necessary to safeguard Medicaid enrollees and protect the fiscal integrity of Minnesota's Medicaid program." As of the date of this publication, a response from CMS is not publicly available and housing stabilization services continue to be MA-covered services.

- Some services for residents of Institutions for Mental Diseases (IMDs)
- Inpatient psychiatric facility services for individuals under age 22
- Intermediate care facility services, including services provided in an intermediate care facility for individuals with developmental disabilities (ICF/DD)
- Long-term ambulatory electrocardiogram monitoring services[33]
- Medical equipment and supplies
- Medical transportation services
- Mental health services
- Nurse anesthetist services
- Certified geriatric, adult, OB/GYN, and neonatal nurse practitioner services
- Occupational therapy services[34]
- Personal care assistant services[35]
- Pharmacy services[36]
- Physical therapy services[37]
- Podiatry services
- Post-arrest community-based service coordination
- Private duty nursing services
- Prosthetics and orthotics
- Public health nursing services
- Recuperative care services[38]
- Rehabilitation services, including day treatment for mental illness
- Speech therapy services
- Traditional health care practices received through specified Indian health facilities[39]

[33] This service is covered beginning January 1, 2026, or upon federal approval, whichever is later.

[34] Beginning January 1, 2026, or upon federal approval, whichever is later, MA coverage for occupational therapy and related services is limited to 24 visits per year unless prior authorization for more visits is obtained.

[35] Individuals who use this program will be transitioned to CFSS, which is another optional service provided under MA. Beginning October 1, 2024, when an individual's reassessment is conducted by the lead agency, an individual who uses PCA services will receive information about how to transition to CFSS. The transition is scheduled to be completed by January 1, 2026.

[36] MA does not cover prescription drugs covered under the Medicare Part D prescription drug benefit for dual eligibles. Instead, dual eligibles are 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.

[37] Beginning January 1, 2026, or upon federal approval, whichever is later, MA coverage for physical therapy and related services is limited to 14 visits per year unless prior authorization for more visits is obtained.

[38] Recuperative care is a care model that prevents hospitalization or provides post-acute medical care and support services for recipients who are homeless or meet related criteria (Minn. Stat. § 256B.0701). Coverage for this service took effect January 1, 2024.

[39] This service is covered beginning January 1, 2027, or upon federal approval, whichever is later.

- Vision care services and eyeglasses

Home and Community-Based Waiver Services

States can seek approval from the federal government to provide services to Medicaid enrollees that are not normally covered and reimbursed under the Medicaid program. These services are referred to as "waiver services." Minnesota has federal approval for the home and community-based waiver service programs listed in Table 2. 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.

Table 2: MA Home and Community-Based Waiver Services

Waiver Program	Description
Elderly Waiver	Provides home and community-based services for individuals 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
Alternative Care (AC) program	Provides home and community-based services for individuals 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
Home and Community-Based Waiver for Persons with Developmental Disabilities (DD)	Provides community-based care to individuals diagnosed with developmental disabilities or related conditions who are at risk of placement in an intermediate care facility for individuals with developmental disabilities (ICF/DD)
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
Community Access Disability Inclusion (CADI) waiver	Provides community-based care to individuals with disabilities who are under age 65 and who need the level of care provided in a nursing home
Brain Injury (BI) waiver	Provides community-based care to individuals under age 65 who are diagnosed with traumatic or acquired brain injury that need the level of care provided in a nursing home that provides specialized services for individuals with brain injury or a neurobehavioral hospital

Source: HRD analysis of state statute and DHS guidance.

Cost-sharing

Since January 1, 2024, MA enrollees have not been subject to any cost-sharing.[40] Prior to January 1, 2024, MA imposed some cost-sharing requirements, within federal parameters, for some nonpreventive visits, nonemergency visits to a hospital emergency room, and some prescription drugs, and certain MA enrollees were subject to a monthly family deductible.[41]

Service Delivery

MA enrollees generally receive services under either a managed care or a fee-for-service system. Under **managed care**, an MA recipient enrolls in a health plan offered by a health maintenance organization (HMO) or a county-based purchasing plan.[42] The MA recipient receives services under the managed care plan, and DHS makes monthly capitated payments to the HMO or county-based purchaser to provide the services (a capitated payment is fixed and does not vary with the actual services provided to the enrollee). Under **fee-for-service (FFS)**, MA recipients, with some exceptions, are free to receive services from any health care provider participating in the MA program. The MA recipient receives a service from a participating provider, and then the provider bills the state and is reimbursed by the state for the service based on payment rates specified in state statutes.

Most MA recipients are required to receive services through managed care, including children, parents or relative caretakers, adults without children, and individuals aged 65 and older. As a result, around three-quarters of MA recipients are served under managed care in a given year.

Managed Care

Most MA recipients are required to enroll in health plans offered by health maintenance organizations (HMOs) or county-based purchasing plans.[43] (Hereafter, plans offered by HMOs and county-based purchasers as part of MA are referred to as "managed care plans.") In general, managed care plans must provide enrollees with the same preventive, acute, and basic care services that are provided under MA

County-based purchasing plans

County-based purchasing provides an alternative method of health care service delivery under MA managed care. County boards that elect to implement county-based purchasing are responsible for providing all services required by MA managed care programs (e.g., PMAP, MSC+, etc.) 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 2025, three county-based purchasing initiatives involving 33 counties were operational.

[40] Minn. Stat. § 256B.0631, subds. 1 and 1a.

[41] See Minn. Stat. § 256B.0631.

[42] As of January 1, 2025, HMOs and county-based purchasers must be organized as nonprofits to participate in MA (Minn. Stat. §§ 256B.035; 256B.69, subd. 2).

[43] As of January 1, 2025, HMOs and county-based purchasers must be organized as nonprofits to participate in MA (Minn. Stat. §§ 256B.035; 256B.69, subd. 2).

FFS, with the exception of specified services that are only provided on an FFS basis.[44]

Managed Care Programs

Under the managed care system, the state has created different programs that are designed for specific MA populations based on their needs. HMOs and county-based purchasers contract with DHS to offer managed care plans that provide services for MA recipients in the different programs.

Generally, MA recipients who are parents or relative caretakers, children, or adults without children are required to enroll in the Prepaid Medical Assistance Program (PMAP). MA recipients who are age 65 or older must enroll in Minnesota Senior Care Plus (MSC+), or opt to participate instead in the voluntary Minnesota Senior Health Options (MSHO) program. Individuals with disabilities are required to enroll in Special Needs BasicCare (SNBC), unless they choose to opt out of managed care and remain in FFS. See Table 3 for more details about these programs.

Table 3: MA Managed Care Programs

Program	Description	Enrollment (August 2025)
PMAP	PMAP provides services to children, parents and relative caretakers, and adults without children. PMAP provides recipients with all MA-covered services, except for some home and community-based waiver services, some nursing facility services, intermediate care facility services for individuals with developmental disabilities, and services from certain provider types with federally prescribed payment arrangements.[45]	862,044
MSC+	MSC+ provides services to individuals 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. Enrollees in MSC+ must enroll in a separate Medicare plan to obtain their prescription drug coverage under Medicare Part D. 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.	19,028

[44] These services include, but are not limited to: abortion; services received from federally qualified health centers, the Indian Health Service, or state-operated dental clinics; nursing facility services beyond 180 days; and waivered services other than elderly waiver services.

[45] Provider types with federal prescribed payment arrangements include: federally qualified health centers; Indian health services; and facilities operated by a Tribe or Tribal organization.

Program	Description	Enrollment (August 2025)
MSHO	Individuals age 65 or older who are eligible for both MA and Medicare have the option, but are not required, to receive 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 and operates under federal Medicare Advantage Special Needs Plan (SNP) authority.[46] As is the case with MSC+, MSHO covers elderly waiver services and 180 days of nursing home services.	45,846
SNBC	SNBC provides services for individuals with disabilities between the ages of 18 and 64. Some SNBC plans integrate MA with Medicare services, for individuals who are dually eligible.	58,712

Source: August 2025 enrollment is from DHS monthly managed care enrollment figures.

Competitive Procurement

DHS uses a competitive procurement process to select managed care plans to serve MA and MinnesotaCare enrollees.[47] Under this process, as currently implemented, HMOs and county-based purchasers submit proposals that are scored on technical qualifications.[48] 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 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 several rounds of competitive procurement. Most recently, in January 2021, DHS issued a request for proposals (RFP) to select plans to serve MA families and children and MinnesotaCare enrollees in the seven-county metropolitan area, beginning in calendar year 2022. In October 2021, DHS issued an RFP to serve persons age 65 and over and SNBC enrollees statewide, beginning in

[46] 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.

[47] MinnesotaCare is a program that provides subsidized health care coverage to low-income individuals who are not eligible for MA. For more information about MinnesotaCare, see the House Research Department publication *MinnesotaCare*, October 2024.

[48] Price bids by plans have also been considered in some years, most recently during the 2016 statewide competitive procurement process. DHS has the option to reinstate the use of price bids in future requests for proposals.

calendar year 2023, and in January 2022, issued an RFP to serve MA parents or relative caretakers and children and MinnesotaCare enrollees in greater Minnesota, beginning in calendar year 2023.[49]

Capitated Payments to Plans

Managed care plans receive a monthly capitated payment for each 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 managed care plans offered by HMOs and county-based purchasers.

Fee-for-Service System

Under the FFS system, an MA recipient receives a service from a participating provider, and then the provider bills the state and is reimbursed by the state for the service. As a condition of participating in the MA program, providers agree to accept MA payment as payment in full. Providers are prohibited from requesting additional payments from MA recipients for covered services, except when the recipient is incurring medical bills to meet an MA spenddown.

Provider Reimbursement

Under Managed Care

DHS generally does not regulate how managed care plans pay health care providers under contract to serve MA enrollees. For most service categories, managed care plans may establish their own provider payment rates. The payment rates may be based on the MA FFS rates or set at a percentage of those rates, but this is at the discretion of the plan and is not a requirement. However, for some service categories, the state does establish rates that managed care plans must pay. For example, the plans are required to pay dental providers under MA (and also under MinnesotaCare) at levels at least equal to the MA FFS rate and must also increase reimbursement to critical access dental providers by at least the amount of the critical access dental provider increase.

Under Fee-for-Service

Under the FFS system, DHS uses different methods to reimburse different types of providers; reimbursement methods for selected provider types are described below.

Reimbursement for Physician 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.[50] 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

[49] Department of Human Services, Managed Care Organizations (MCO) contract information, forms and resources, accessed September 3, 2025.

[50] Minn. Stat. § 256B.76, subd. 1.

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.

Many 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.

Dental Reimbursement

Most dental services under FFS are reimbursed at a base rate (that was increased by 98 percent beginning January 1, 2022).[51] Providers classified as critical access dental providers receive an additional 20 percent on top of the base rate.

Drug Reimbursement[52]

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).[53] 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.[54] The professional dispensing fee in most cases is $11.55 per prescription.[55]

[51] Prior to January 1, 2022, most dental services under FFS 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.

[52] The 2025 Legislature made changes to how drugs must be reimbursed under the MA FFS system. The changes are not reflected in this publication, as the earliest they could go into effect is January 1, 2027.

[53] Medicaid drug reimbursement to pharmacies must be based on a pharmacy's actual acquisition cost, and NADAC is one of the methods of determining actual acquisition cost that is allowed under federal regulations (Title 42, Chapter IV, Subchapter C, Part 447, Subpart I). 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.

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

[55] Minn. Stat. § 256B.0625, subd. 13e.

Other reimbursement limits apply to drugs dispensed by providers participating in the federal 340B Drug Pricing Program,[56] multiple-source drugs (drugs for which at least one generic exists), and certain specialty pharmacy products.

Hospitals

For MA covered inpatient hospital services, hospitals are paid per admission. The payment amount 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.

Under the IHP Demonstration Project

The IHP demonstration project was authorized by the legislature in 2010.[57] 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 considers the cost and quality of health care services provided.[58]

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.

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

[57] Minn. Stat. § 256B.0755.

[58] For more information about the integrated health partnerships program, see the House Research Department publication *Integrated Health Partnerships Program*, January 2024.

As of July 2025, the MA program had 26 integrated health partnerships serving 444,029 MA enrollees in fee-for-service and managed care.[59]

Direct Payment System

The 2023 Legislature directed DHS 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 MA and MinnesotaCare enrollees through fee-for-service, county-based purchasing plans, and county-owned health maintenance organizations.[60] The 2024 Legislature expanded the scope of this provision to require the development of implementation plans for at least two other health care delivery models besides a direct payment system.[61]

Financing

The federal and state governments jointly finance Medicaid and CHIP programs. As such, the federal government reimburses Minnesota for a portion of MA program costs, as described below, with the state having to cover the remaining costs.

Federal Share

The federal share for most Medicaid covered services is determined by the Federal Medical Assistance Percentage (FMAP), which is based on a formula included in Title XIX of the Social Security Act. The formula is based on a state's per capita income—providing higher reimbursement to states with lower per capita incomes—and is recalculated annually. Minnesota's FMAP for covered services is 50.68 percent for federal fiscal year 2026.[62]

The federal share is determined differently for some eligibility groups. As part of implementing the optional expansion of eligibility for adults without children and other groups under the ACA, Minnesota receives a federal match of 90 percent for the cost of services provided to enrollees who are adults without children. Additionally, Minnesota receives an enhanced match (or E-FMAP) through CHIP for the cost of MA services provided to populations that are CHIP-eligible. The CHIP payment is the difference between the state's enhanced CHIP federal matching rate of 65.48 percent (for federal fiscal year 2026) and the state's MA federal matching rate of 50.68 percent. The following populations in Minnesota are eligible for the E-FMAP:

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

[59] DHS email communication, July 15, 2025.

[60] Minn. Stat. § 256.9631.

[61] Laws 2024, ch. 127, art. 54, § 1.

[62] Federal fiscal year 2026 starts October 1, 2025, and ends September 30, 2026.

3) children under age 19 with household incomes greater than 133 percent but below 275 percent of FPG

In addition to paying a share of covered services, the federal government also pays a share of a state's Medicaid administrative activities. The federal match for administrative activities does not vary by state and is generally 50 percent, with increased matches for specified activities, such as fraud control and maintaining information technology systems for claims processing.[63]

Nonfederal Share

The state is responsible in most cases for the nonfederal share of MA costs. The state funds its share through the general fund and the health care access fund (HCAF). Counties are responsible for the nonfederal share for specified services.[64]

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 typically 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.

Expenditures

In state fiscal year 2024, total MA expenditures for services were $18.513 billion.[65] The federal government covered about 58 percent of the expenditures, or $10.8 billion, and the state covered the remaining amount, or about $7.6 billion.[66]

The following chart shows the percentage of MA spending in fiscal year 2024 on major service categories. The chart shows that a little under half of MA spending (46.1 percent) is for managed care services, and nearly one-third of MA spending (31.5 percent) is for home and community-based waiver services.

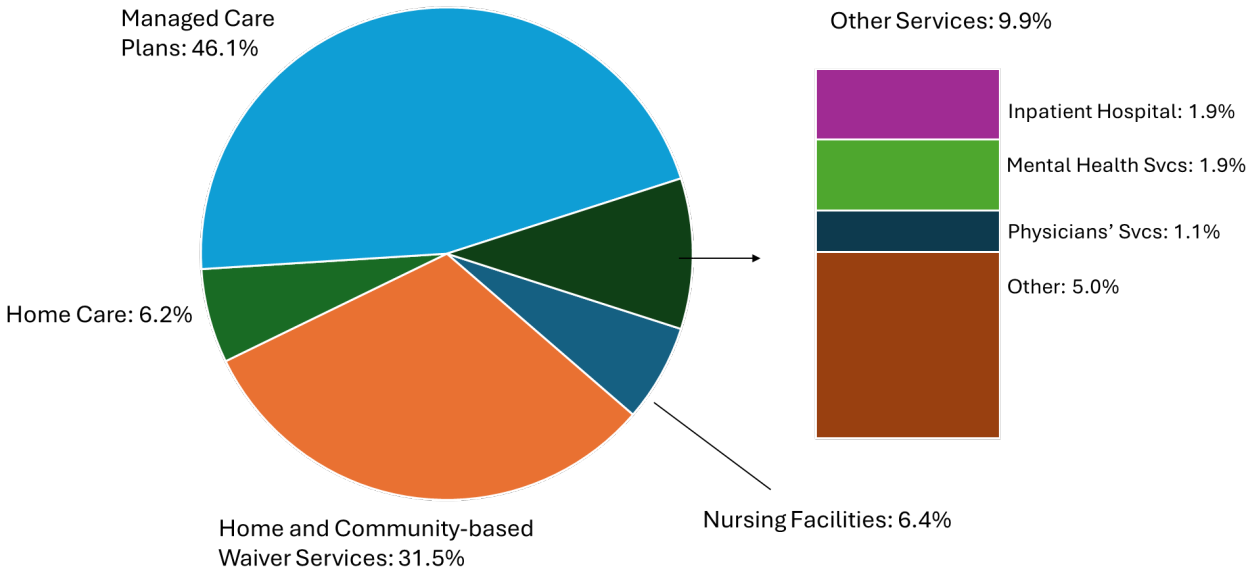
[63] For more information, see Medicaid and CHIP Payment and Access Commissioner (MACPAC), Federal Match Rates for Medicaid Administrative Activities, at https://www.macpac.gov/federal-match-rates-for-medicaid-administrative-activities/.

[64] 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).

[65] The data in this section are from the Department of Human Services, Background Data Tables for the February 2025 Forecast.

[66] This includes $6.6 billion from the state's general fund; $776.1 million from the HCAF; and $186.5 million from counties.

MA Expenditures by Service – SFY 2024



Total MA Expenditures for SFY 2024: $18.513 billion

Source: Department of Human Services, Background Data Tables for February 2025 Forecast

Note: The home and community-based waiver services category includes waiver payments to HMOs.

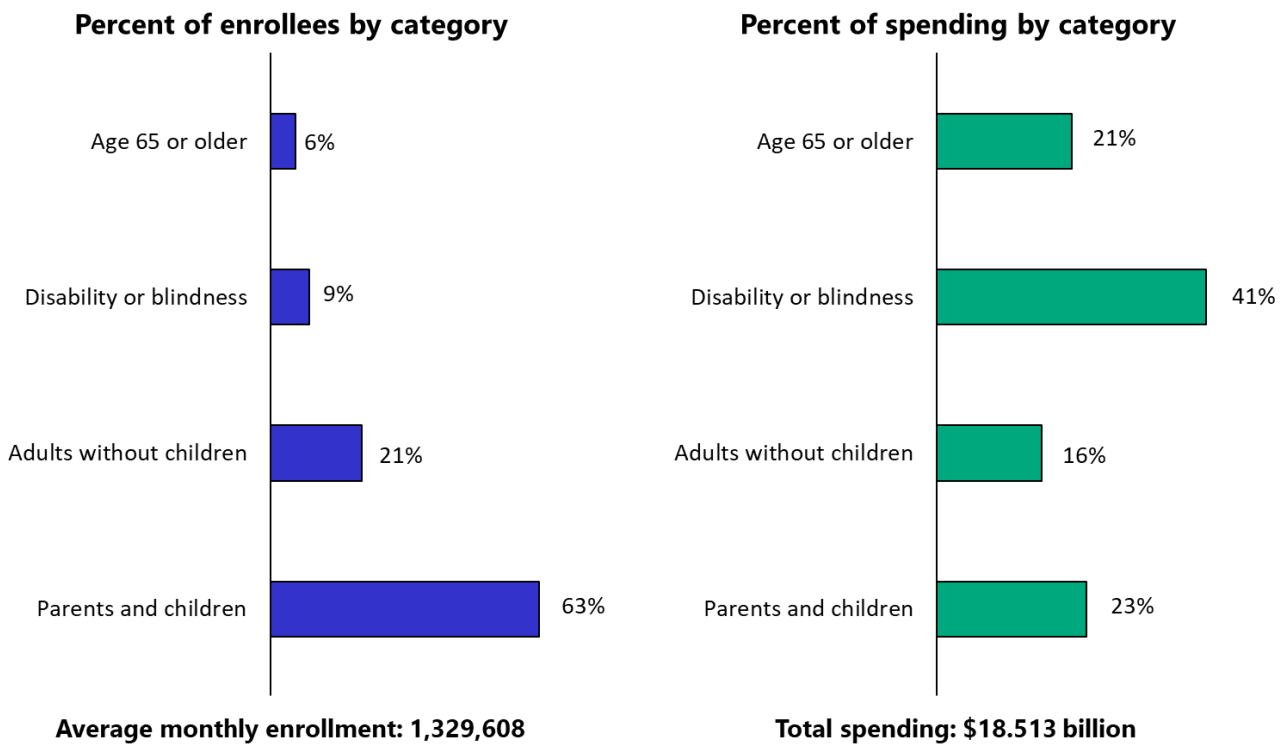
Recipient Profile

During fiscal year 2024, an average of 1.3 million individuals were eligible for MA services each month.[67] 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 made up the largest eligibility group, constituting 63 percent of eligibles. However, this group accounted for only 23 percent of MA spending.
- Individuals age 65 or older, and individuals eligible on the basis of disability or blindness, constituted 15 percent of eligibles, but they accounted for 62 percent of MA spending.

[67] Department of Human Services Data Warehouse, July 2025.

Minnesota Medical Assistance Eligibles – SFY 2024



Source: Department of Human Services Data Warehouse, July 2025

Appendix: Annual MA Income Guidelines for State Fiscal Year 2026

Annual MA Income Guidelines
Effective 7/1/25 through 6/30/26

						Medicare Savings Program		
	Elderly, Blind, Disabled	Parents, Caretakers, Children age 19-20 years, Adults without children	Children age 2-18 years	Pregnant Women	Children under age 2 years	QMB	SLMB	QI	QWD
Hshold Size	**100% FPG**	**133% FPG**	**275% FPG**	**278% FPG**	**283% FPG**	**100% FPG***	**120% FPG***	**135% FPG***	**200% FPG***
1	$15,660	$20,814	$43,037	NA	$44,289	$15,900	$19,020	$21,372	$31,548
2	21,168	28,129	58,162	$58,797	59,845	21,408	25,260	28,800	42,552
3	26,676	35,444	73,287	74,087	75,419	26,916	32,220	36,228	53,556
4	32,184	42,759	88,412	89,377	90,984	32,424	38,820	43,656	64,560
5	37,692	50,074	103,537	104,667	106,549	37,932	45,420	51,084	75,564
6	43,200	57,389	118,662	119,957	122,114	43,440	52,020	58,512	86,568
7	48,708	64,704	133,787	135,247	137,679	48,948	58,620	65,940	97,572
8	54,216	72,019	148,912	150,537	153,244	54,456	65,220	73,368	108,576
Each Additional Person	5,508	7,315	15,125	15,290	15,565	5,508	6,600	7,428	11,004

Source: Modified version of Department of Human Services, Insurance Affordability Programs – Income and Asset Guidelines, accessed September 4, 2025.
Notes: Income disregards are not included in the income limits, except as indicated by an asterisk (*).
*A $20 standard disregard applies, meaning the first $20 of an individual's monthly income is not counted towards the income limit for the program.
"QMB" = Qualified Medicare Beneficiaries; "SLMB" = Service Limited Medicare Beneficiaries; "QI" = Qualifying Individuals; "QWD" = Qualified Working Disabled individuals.

About This Series

Public Assistance Programs is a series of publications that describe state and federal programs that provide assistance in the form of healthcare, income, food, housing, and child care. Each work in the series describes an individual program.

Current works in this series include:

- Overview of Public Assistance Programs
- General Assistance (GA)
- Minnesota Family Investment Program (MFIP)
- Minnesota Supplemental Aid (MSA)
- Supplemental Security Income (SSI)
- Medical Assistance (MA)
- MinnesotaCare
- Subsidized health coverage through MNsure
- Child Care Assistance Program (CCAP)
- Food Support
- Housing Support

Please see the health and human services area of the House Research website for more information about these programs and related topics.

Earlier Versions

Information in the series was originally published as the *Minnesota Family Assistance: A Guide to Public Programs Providing Assistance to Minnesota Families*, which was a comprehensive guide to these programs.

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