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Gateway Policy Explorer: Long-Term Care Series

Minnesota, USA

Long-Term Care In-Kind Benefit Plan Details

1992-2025

Authors
Eden Wetzel
Maya Fransz-Myers
David Knapp

Contributors
Jinkook Lee
Drystan Phillips
Kanghong Shao

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Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

Minnesota, USA

In-Kind Benefits

Plan details 1992-2025 * †

Public long-term care (LTC) benefits in Minnesota are primarily provided by Medicaid, a public health insurance program for low-income individuals. Enrollment in Medicaid is voluntary.

In Minnesota, LTC services are primarily provided as in-kind benefits. LTC benefits vary by program, with separate programs for home-based care, community care, residential care, and some that cover a variety of care. Programs vary in eligibility criteria. Minnesota is a 209(b) state, one of the relatively few states that chooses to use more restrictive eligibility criteria than are used by the Supplemental Security Income (SSI) program for its main eligibility track.

Since 1992, Minnesota's Medicaid LTC system has been subject to two major policy reforms: increases in income limits for aged and disabled Medicaid eligibility in 2001, and the expansion of Medicaid eligibility to cover adults with incomes up to 138% of the federal poverty level (FPL) under the Affordable Care Act in 2014.

Key Dates

First law: 1965

Major changes since 1992: 2001, 2014

Contents

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† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Chapter 1: Policy enacted 1992-2000

Overview

Long-term care (LTC) benefits in Minnesota are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Minnesota is administered at the state level by the Minnesota Department of Human Services (MNDHS) and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Minnesota are mostly provided through state plan benefit programs (Personal Care Assistance - PCA, Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Elderly Program).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. PCA and Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the Elderly Program are also able to receive a variety of LTC benefits if deemed medically eligible, such as adult day health care (ADHC).

Benefit programs vary in dependence requirements. PCA applicants must require some assistance with activities of daily living (ADL), Home Health requires the individual to have a medical necessity for services, and Nursing Facility and Elderly Program beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment prior to admission.

Other changes during this policy period:

- (1992-2000) Minnesota Medicaid implemented several adjustments to the income requirements for eligibility track 1b (209(b) States). See Box 1 for more information (Minn. Stat. § 256B.056, 1992; Minn. Laws Ch. 407 , 1998; MNDHS, 2000).
- (1995) Participants in the Elderly Program must be reassessed at least every 12 months or more often as needed. Prior to 1995, participants are required to be reassessed at least every 6 months (Minn. Stat. § 256B.0915 Subd. 5, 1992; Minn. Stat. §§ 256B.0627, 256B.0915 Subd. 5, 1997).
- (1996) The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 restricted most legal immigrants entering the United States after August 22, 1996 from receiving federally funded Medicaid (and some other public assistance) for at least 5 years after immigration (U.S. Congress, 1996).
- (1997) Minnesota implements eligibility track 2a (Institutional rules for people receiving LTC) for institutionalized individuals and individuals participating in the Elderly Program with monthly income up to 300% of the federal Supplemental Security Income (SSI) benefit rate. Prior to 1997, these individuals were subject to income limits established under eligibility track 1b (209(b) States) (Horvath, 1997; Minn. Stat. § 256B.0915 Subd. 1d., 1997).
- (2000) Minnesota implements PCA Choice, allowing individuals to hire and manage the caregiver of their choice to provide personal care services through the state plan PCA program.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2025b)

Minnesota Law for Medicaid

- Minnesota Rules, Chapter 9505. Health Care Programs (Minn. Rules, 1997)
- Minnesota Statutes, Chapter 144. Department of Health (Minn. Stat., 2024a)
- Minnesota Statutes, Chapter 256B. Medical Assistance for Needy Persons (Minn. Stat., 1992, 1997, 2000, 2001, 2024b)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Minnesota Medicaid spending on beneficiaries in fiscal year 1992 was 54.43%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Minnesota Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Minnesota.

Eligibility for Medicaid in Minnesota for people needing LTC services is primarily attained by satisfying at least 1 of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1b. 209(b) States

  Individuals requiring Medicaid eligibility to access nursing facility care services and the Elderly Program must qualify for Medicaid through this eligibility track (until 1997). Minnesota is 1 of a few states that uses more restrictive methodologies to determine Medicaid eligibility than those of the Supplemental Security Income (SSI) program.
  - ◇ Income requirements: Semiannual income may not exceed 120% of the income standards by family size for the Aid to Families with Dependent Children (AFDC) program. In 1992, this was $420 per month for an individual. An exact dollar amount for couples has not been confirmed. Additional income disregards exist when a person is institutionalized or enrolled in the Elderly Program and has a spouse residing in the community (CMS, 1992; Minn. Stat. § 256B.056, 1992).[1] See Table 2 for historical monthly benefit amounts. Minnesota made several adjustments to this income standard during this policy period. See Box 1 for changes to income limits for this eligibility track from 1992-2000. Individuals who do not meet this income threshold are able to "spend down" their excess income either by incurring medical expenses that decrease income down below the threshold, or by making monthly payments in the amount of their excess income to the state (Minn. Stat. § 256B.056, 1997).[2]
  - ◇ Asset requirements: Resources may not exceed $3,000 for an individual and $6,000 for a couple. An additional $200 for each additional legal dependent is added to the resource limit (Minn. Stat. § 256B.056, 1992). Additional asset disregards exist when a person is institutionalized or enrolled in the Elderly Program and has a spouse residing in the community.[3]
    - ▪ Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[4]
  - ◇ Citizenship/immigration requirements (SSA, 1998): The applicant must be an Minnesota resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals that entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident.[5] See (SSA, 2023) for additional information.
  - ◇ Other requirements
    - ▪ The applicant must be at least age 65, blind, or disabled.[6]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC

- ◇ Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount. In 1997, this was $1,452 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist when a person is institutionalized or participating in the Elderly Program and has a spouse residing in the community.[1] See Table 3 for historical monthly spousal disregards (Horvath, 1997; Minn. Stat. § 256B.0915 Subd. 1d., 1997).
- ◇ Asset requirements: Resources may not exceed $3,000 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). Additional asset disregards exist when a person is institutionalized and has a spouse residing in the community.[3] See Table 3 for historical monthly spousal disregards.
  - Asset transfer: Same requirements as eligibility track 1b.
- ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
- ◇ Other requirements
  - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in a federally approved home and community-based services (HCBS) program (e.g., Elderly Program).

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - ◇ Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income over a 1-month or 6-month period to the medically needy income limit. In 1992, this was $420 per month for an individual. An exact dollar amount for couples has not been confirmed (CMS, 1992; Minn. Stat. § 256B.056, 1992). Valid expenses include medical care and other types of remedial care. Additional income disregards exist when a person is institutionalized or participating in the Elderly Program and has a spouse residing in the community.[1] See Table 3 for historical monthly spousal disregards.
  - ◇ Asset requirements: Same asset requirements as eligibility track 1b.[3]
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
  - ◇ Other requirements
    - The applicant must be at least age 65, blind, or disabled.[6]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. These tracks have been omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Personal Care Assistance (PCA), Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit eligibility* section of this policy period).

Elderly Program

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65 (MNDHS, 2003; CMS, 2023).

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Community Access for Disability Inclusion (CADI)
- Community Alternative Care (CAC)
- Brain Injury Program

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the 4 largest programs are summarized below.

PCA

PCA provides personal care services, which include (Minn. Stat. § 256.0627, 1997; MNDDC, 2002):

- Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with instrumental ADLs (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

From 2000, PCA program beneficiaries have the choice between traditional PCA and PCA Choice. Both options require the beneficiary to select a PCA provider agency, direct their services, and assist in choosing their PCA worker. However, in traditional PCA, the agency is responsible for all employment-related tasks. In PCA Choice, the beneficiary is responsible for some employment-related activities, including recruiting, hiring, training, supervising, scheduling, and arranging for backup workers.

Home Health Services

Home Health provides (Minn. Stat. § 256B.0627, 1992; Minn. Rules Ch. 9505.0295, 1997; Minn. Stat. § 256B.0627, 1997):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care
- Therapy: Respiratory therapy, rehabilitative and other therapeutic services

Prior authorization is required for home health services after the first 40 home health aide or skilled nursing service visits in a calendar year. From 1997, beneficiaries may receive up to 5 face-to-face skilled nursing service visits per year without prior authorization (Minn. Stat. § 256B.0627 Subd. 5.b., 1992; Minn. Stat. § 256B.0627 Subd. 5.a., 1997).

Nursing Facility Care

Nursing Facility Care does not provide home care.

Elderly Program

The Elderly Program provides (HHS p. 481, 1992; MNDHS, 2001a; MNDHS, 2003b):[7]

- Extended personal care: PCA services with no limit on the amount of services provided
- Extended home health: Home health services with no limit on the amount of services provided
- Homemaker services: Home cleaning services and assistance with home management activities, such as IADLs and arranging for household repairs and transportation

To be eligible for extended personal care or home health services, beneficiaries must receive and exhaust the state plan benefit for each month the extended service is authorized.

Community care

Community care benefits vary by LTC health benefit program. The details of the 4 largest programs are summarized below.

PCA, Home Health Services, Nursing Facility Care

These programs do not provide community care.

Elderly Program

The Elderly Program provides Adult Day Health Care (ADHC). Centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (HHS p. 481, 1992; MNDHS, 2003b; MNDHS, 2013; CMS, 2023).[8]

Residential care

Residential care benefits vary by LTC health benefit program. The details of the 4 largest programs are summarized below.

PCA, Home Health Services, Elderly Program

These programs do not provide residential care.

Nursing Facility Care

Minnesota Medicaid covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (CFR, 1992; Minn. Stat. § 256B.0625, 1992; Minn. Stat. § 256B.0625, 2001; MNDHS, 2024c). Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Minnesota's largest home and community-based services (HCBS) program.

Minnesota Medicaid provides additional benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

Elderly Program

The Elderly Program provides the following services in addition to those offered under the state plan, unless otherwise noted (HHS p.481,1992; MNDHS, 2001a; MNDHS, 2003b; MNDHS, 2013;CMS, 2023): [7]

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Adult companion services: Non-medical care, supervision, and socialization provided to the beneficiary in accordance with a therapeutic goal, usually related to reducing social isolation
- Home-delivered meals: Delivers healthy meals to the beneficiary's home
- Specialized equipment and supplies: Additional equipment and supplies that are necessary to address the participant's functional limitations [8]
- Extended Transportation: Transportation to program services or other community services, activities, and resources
- Environmental accessibility adaptations (Home Modification): Physical adaptations made to the home to allow the enrollee to function with greater independence in the home and without which the enrollee would require institutionalization, including the installation of ramps and grab-bars, widening of doorways, or modification of bathroom facilities [8]
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Community transition services: Non-reoccurring expenses for people who are in the process of transitioning from a nursing facility to a community setting (e.g., moving expenses, housing deposits)
- Caregiver services: Instruction provided to a participant or caregiver to teach a variety of skills necessary for independent living, such as the use of specialized or adaptive equipment and assistance with ADLs, as well as counseling to assist with decision-making and problem solving [8]

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Minnesota Department of Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

PCA

Personal care services must be provided by qualified aides under the supervision of a registered nurse (MNDCC, 2002). Certain family members including parents of adult recipients, adult children, and adult siblings may be permitted to provide PCA services if they qualify for a hardship waiver (Minn. Stat. § 256B.0627, 1997).

Home Health Services

Skilled nursing services must be provided by a licensed registered nurse or practical nurse under the supervision of a licensed registered nurse. Home health aide services, such as personal care, assistance with medications, or ambulation, are provided by home health aides, but must be under the supervision of a licensed registered nurse (MNDHS, 2024b).

Nursing Facility Care
Nursing facility services are provided and supervised by registered nurses and other nursing personnel (MNDHS, 2024c).

Elderly Program
The provision of care for program services will vary by authorized service (MNDHS, 2003b).

Benefit eligibility

Qualifying period
Potential users may apply at any time.

Minimum level of dependence
The minimum level of dependence varies by health benefit program. The details of the 4 largest programs are summarized below. Information on how level of care is assessed is detailed in the *Care Needs Assessment* section of this policy period.

PCA
Applicants must receive an assessment that determines personal care services to be medically necessary, and services must be ordered by the beneficiary's physician (MNDDC, 2002). The PCA program defines medically necessary as the individual having a need for assistance based on a disability, diagnosis, or chronic condition. However, there is no explicit criteria that defines medical necessity.

Home Health Services
Home health services must be medically necessary, ordered by the beneficiary's physician, and performed in accordance with a written plan of care (CFR, 1996; MNDHS, 2016a).

Nursing Facility Care, Elderly Program
Applicants must meet a nursing facility level of care (NFLOC) as determined by a preadmission screening (PAS) prior to admission. The screening is conducted by a social worker and a public health nurse (Minn. Rules Ch. 9505.2413, 1997). Available state sources do not detail explicit dependence criteria for these programs during this policy period.

Duration of benefit
Reassessments of eligibility differ by program and service type. Below we detail reassessments for Medicaid, followed by reassessments for the 4 largest programs.

Medicaid
Federal law requires states to renew Medicaid eligibility at least every 12 months.

PCA, Elderly Program
PCA program participants must be reassessed at least every 12 months and Elderly Program participants must be reassessed at least every 6 months (Minn. Stat. §§ 256B.0627, 256B.0915 Subd. 5, 1992).

From 1995, participants in both programs must be reassessed at least every 12 months or more often as needed (Minn. Stat. §§ 256B.0627, 256B.0915 Subd. 5, 1997; MNDCC, 2002; CMS, 2023; MNDHS, 2024e).

Home Health Services
The beneficiary's physician must review the plan of care for home health services at least once every 60 days (Minn. Stat. § 256.0627, 1997; MNDHS, 2024a).

Nursing Facility Services
Functional capacity of residents must be reassessed at least every 12 months. Additionally, quarterly reassessments are conducted by nursing facilities to develop and revise the resident's plan of care. Reassessments are documented on the Resident Assessment Instrument (RAI) (MNDHS, 2001b).

Means testing
In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for the 4 largest programs.

Medicaid

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

PCA, Home Health Services, Nursing Facility Care

There is no age requirement.

Elderly Program

The individual must be at least age 65 (MNDHS, 2003b; CMS, 2023).

Care needs assessment

Definition of dependence

Definitions of dependence vary depending on the health benefit program. The details are summarized below for the 4 largest programs.

PCA

Personal care services must be medically necessary as determined by a level of care assessment and must be physician ordered (MNDDC, 2002). The PCA program defines medically necessary as the individual having a need for assistance based on a disability, diagnosis, or chronic condition. However, there is no explicit criteria that defines medical necessity during this policy period.

Home Health Services

Home health services must be medically necessary, physician ordered, and provided according to a written plan of care. Prior authorization from DHS is required for all Home Health services except for the first 40 home health aide or skilled nursing visits each year. From 1997, this number is reduced to 5 skilled nursing visits per year (Minn. Stat. § 256B.0627, 1992, 1997).

Nursing Facility Care, Elderly Program

Applicants must be evaluated using the Preadmission Screening and meet a nursing facility level of care (NFLOC). However, available state sources for this policy period do not detail explicit criteria defining the threshold of need required to meet an NFLOC.

Evaluation of dependence

Evaluations of dependence vary depending on the health benefit program. The details of the 4 largest programs are summarized below.

PCA

Applicants for PCA must be assessed in-person using the MN Health Status Assessment (HSA) in order to receive services. The HSA assesses the individual's need for assistance to (MNDDC, 2002):

- Perform activities of daily living (ADLs) and instrumental ADLs (IADLs)
- Complete health-related tasks, such as dressing a wound
- Address behavior-related issues

The assessor asks the individual about their need for assistance in these areas, and they observe accomplishment of the tasks, if appropriate. An MNDHS nurse consultant will review the assessment and determine the daily number of minutes the individual needs for the 3 areas listed above. From 1997, nurse consultants no longer perform these duties, and the assessor completes the assessment and determines the amount of services (OLA, 2009). Guidelines detailing the process for determining the recommended daily number of minutes of service needed were not found. It is possible this process was subjective and based on the assessor's professional judgement.

Author's note: Available state records do not provide details on the assessment used to determine eligibility for PCA. However, the 1997 Minnesota Statutes reference the HSA, and it is likely that the form remained relatively the same between periods. We provide information on the HSA from later years above (Minn. Stat. § 256B.0627, 1997).

Home Health Services

Home health services must be medically necessary, ordered by the beneficiary's physician, and performed in accordance with a written plan of care. Physicians must review this plan of care at least once every 60 days (Minn. Stat. § 256B.0627, 1997).

Nursing Facility Care, Elderly Program

Applicants for nursing facility care and the Elderly Program must meet a nursing facility level of care (NFLOC) determined during the Preadmission Screening.

Author's note: Available state records do not provide explicit details on the assessment used to determine NFLOC eligibility during this policy period.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS) (42 CFR 483.100-138; UCSF, 2023). See Box 2 for more information on the PASRR, and Box 3 for the MDS.

Evaluators

Evaluators vary by health benefit program. The details of the 4 largest programs are summarized below.

PCA

Assessments are conducted by public health nurses employed by the county. If an individual is receiving PCA services as a benefit under the Elderly Program, a service coordinator for that program will conduct the assessment (Minn. Stat. § 256.0627, 1997; MNDCC, 2002). Until 1997, MNDHS nurse consultants were required to review PCA assessments and decide how many hours of services should be authorized (OLA, 2009). The beneficiary's physician must provide an order for services that states that services are medically necessary.

Home Health Services

Medical necessity for home health services must be certified by the applicant's attending physician (CFR, 1996; Minn. Stat. § 256.0627, 1997).

Nursing Facility Care

A Preadmission Screening which includes a level of care evaluation is conducted by a social worker and a public health nurse (Minn. Rules Ch. 9505.2413, 1997).

Elderly Program

Level of care evaluations are conducted by service coordinators employed by the state (MNDHS, 2003b).

Benefit limitations

Can you mix LTC benefits?

All Minnesota Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the 4 largest programs.

Medicaid

As required by federal law, Minnesota enforces Estate Recovery. The acceptance of Medicaid in Minnesota creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (Minn. Stat. § 256B.15, 1997).

PCA, Home Health Services

Available Minnesota state documents do not detail policy on copayments or related charges for these programs during this policy period, but they are subject to federal maximum allowable cost standards that are very limited.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. See Table 3 for historical spousal impoverishment standards. In 1992, the PNA was $54 per month (Minnesota Legislature, 1988). See Table 4 for historical monthly PNAs.

Elderly Program

There are no copayments or similar charges imposed upon participants for program services.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 2: Policy enacted 2001-2013

Policy change in 2001

In 2001, Minnesota expanded Medicaid coverage for aged, blind, and disabled beneficiaries by implementing a series of increases to eligibility income limits. Minnesota raised the income limit for eligibility track 1b (209(b) states) to 100% of the federal poverty level (FPL), and increased the income limit for eligibility track 3a (Medically needy aged, blind, or disabled) to 70% of the FPL in 2001 and 75% of the FPL in 2002 (ASPE, 2002; Black & Ireys, 2006; MNDHS, 2022a).

Other policy changes during this period:

- (2001) The Preadmission Screening tool used to determine level of care for long-term care services is renamed the Long-Term Care Consultation (LTCC). The LTCC provides additional services including identifying available services, education about long-term care services, and transitional assistance from nursing facilities into the community (Auerbach & Reinhard, 2005; MNDHS, 2003a).
- (2003) The Personal Care Assistance (PCA) program permits parents of adult recipients, adult children, and adult siblings of beneficiaries to serve as personal care assistants without a hardship waiver (OLA, 2009).
- (2004) The Elderly Program implemented consumer-direction for personal care services, which allows some recipients to hire and manage the caretaker of their choice (MNDHS, 2004).
- (2006) The Deficit Reduction Act of 2005 enacted 2 policy changes affecting financial eligibility criteria for Minnesota Medicaid:
  - The look back period for asset transfers increased from 36 months (60 months for a trust) to 60 months for all assets (Minn. Stat. § 256B.0595, 2024b).
  - A home equity limit that makes individuals with home equity above $500,000 ineligible for long-term care is implemented. Prior to 2006, in determining an applicant's assets, the value of an individual's home was usually exempt. Homes occupied by a spouse or a disabled or minor child are exempt. From 2011, this figure increases annually with inflation (Minn. Stat. § 256B.056 Subd. 2a, 2024b).
- (2010) The Minnesota House of Representatives redesigned the PCA program and recodified the laws governing the services (MN House of Representatives, 2012). The main change to the program reduced access to services by requiring that a recipient need assistance in at least 1 activity of daily living (ADL), or exhibit at least 1 behavioral problem (e.g., physical aggression). Previously, applicants required proof of medical necessity for services determined through an assessment and physician orders, but there was no explicit dependence criteria.
- (2010) Personal care assistants are permitted to perform more complex health-related tasks like tracheostomy suctioning if they are trained to do so, this training is documented in the care plan, and the service is supervised by a registered nurse (MN House of Representatives, 2012).
- (2011) Minnesota again changes PCA program eligibility by restricting eligibility to applicants that require hands-on assistance with at least 2 ADLs, rather than 1. If the applicant requires assistance with only 1 ADL or has a behavioral problem like physical aggression, they are only eligible to receive a maximum of 2 units (30 minutes total) of PCA services per day (MN House of Representatives, 2012).
- (2011) Following the passage of the Affordable Care Act (ACA) in 2010, Minnesota adopted early roll out of Medicaid expansion, implementing eligibility track 2c (ACA expansion adults), limited to adults age 19-64 with monthly income below 75% of the FPL (Medicaid.gov, 2011).
- (2013) Minnesota began implementation of the MnCHOICES assessment used to determine eligibility for LTC programs. The MnCHOICES assessment consolidated 3 separate assessments used to determine eligibility for various programs: the Developmental Disabilities Screening, LTC Consultation, and Personal Care Assistance Assessment. This did not alter the contents of the assessments, but rather combined all 3 for a more streamlined process where assessors can use a single assessment system to determine eligibility for all benefit programs.

Overview

Long-term care (LTC) benefits in Minnesota are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Minnesota is administered at the state level by the Minnesota Department of Human Services (MNDHS) and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Minnesota are mostly provided through state plan benefit programs (Personal Care Assistance - PCA, Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Elderly Program).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. PCA and Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the Elderly Program are also able to receive a variety of LTC benefits if deemed medically eligible, such as adult day health care (ADHC).

Benefit programs vary in dependence requirements. PCA applicants must require some assistance with activities of daily living (ADL), Home Health requires the individual to have a medical necessity for services, and Nursing Facility and Elderly Program beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment prior to admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2025b)

Minnesota Law for Medicaid

- Minnesota Rules, Chapter 9505. Health Care Programs (Minn. Rules, 1997)
- Minnesota Statutes, Chapter 144. Department of Health (Minn. Stat., 2024a)
- Minnesota Statutes, Chapter 256B. Medical Assistance for Needy Persons (Minn. Stat., 1992, 1997, 2000, 2001, 2024b)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Minnesota Medicaid spending on beneficiaries in fiscal year 2001 was 51.11%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Minnesota Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information

for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Minnesota.

Eligibility for Medicaid in Minnesota for people needing LTC services is primarily attained by satisfying at least 1 of 4 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1b. 209(b) States
  Minnesota is 1 of a few states that can use more restrictive methodologies to determine Medicaid eligibility than those of the Supplemental Security Income (SSI) program.
  - ◇ Income requirements: Monthly income may not exceed 100% of the federal poverty level (FPL). In 2001, this was $716 for an individual and $968 for a couple. Additional income disregards exist when a person is institutionalized or enrolled in the Elderly Program and has a spouse residing in the community.[9] See Table 2 for historical income limits (MDHS HCPM Ch. 0909, 2006).
  - ◇ Asset requirements: Resources may not exceed $3,000 for an individual and $6,000 for a couple. An additional $200 for each additional legal dependent is added to the resource limit (Minn. Stat. § 256B.056, 2001). Additional asset disregards exist when a person is institutionalized or enrolled in the Elderly Program and has a spouse residing in the community.[10] See Table 3 for historical monthly spousal disregards.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[11]
    - Home equity limit: From 2006, the equity interest in the individual's home may not exceed $500,000, or else they will be ineligible for LTC services. From 2011, this figure increases annually with inflation. See Table 5 for historical home equity limits.
  - ◇ Citizenship/immigration requirements: The applicant must be an Minnesota resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals that entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See (SSA, 2023) for additional information.
  - ◇ Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
  - ◇ Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount. In 2001, this was $1,593 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). Additional income disregards exist when a person is institutionalized or enrolled in the Elderly Program and has a spouse residing in the community.[9] See Table 2 for historical income limits.
  - ◇ Asset requirements: Resources may not exceed $3,000 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). Additional asset disregards exist when a person is institutionalized or enrolled in the Elderly Program and has a spouse residing in the community.[10] See Table 3 for historical monthly spousal disregards.
    - Asset transfer & home equity limit: Same as eligibility track 1b.
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
  - ◇ Other requirements
    - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in a federally approved home and community-based services (HCBS) program (e.g., Elderly Program).
- 2c. Affordable Care Act (ACA) expansion adults
  - ◇ Income requirements: From 2011, monthly income may not exceed 75% of the FPL. In 2011, this was $681 for an individual and $919 for a household of two. See Table 2 for historical income limits. Implementation of this eligibility track is part of an early roll out period of Medicaid expansion under the ACA (Medicaid.gov, 2011).
  - ◇ Asset requirements: There is no asset test for this population.
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
  - ◇ Other requirements
    - Applicants must be age 19-64, ineligible for Medicare, and ineligible for other Medicaid eligibility tracks.

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled [12]
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income over a 1-month or 6-month period to be equal to or less than the medically needy income limit. In 2001, this was 70% of the FPL, or $501 for an individual and $677 for a couple. This limit increased to 75% of the FPL in 2002. Valid expenses include medical care and other types of remedial care. Additional income disregards exist when a person is institutionalized or enrolled in the Elderly Program and has a spouse residing in the community.[9] See Table 3 for historical monthly spousal disregards.
  - Asset requirements: Same asset requirements as eligibility track 1b. Additional asset disregards exist when a person is institutionalized or enrolled in the Elderly Program and has a spouse residing in the community.[10] See Table 3 for historical monthly spousal disregards.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Personal Care Assistance (PCA), Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit eligibility* section of this policy period).

Elderly Program

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65 (MNDHS, 2003; MNDHS, 2013; CMS, 2023).

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Community Access for Disability Inclusion (CADI)
- Community Alternative Care (CAC)
- Brain Injury Program

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the 4 largest programs are summarized below.

PCA

PCA provides personal care services, which include (MNDDC, 2002; Minnesota House of Representatives, 2012):

- Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with instrumental ADLs (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

The PCA program offers traditional PCA and PCA Choice. Both options require the beneficiary to select a PCA provider agency, direct their services, and assist in choosing their PCA worker. However, in traditional PCA, the agency is responsible for all employment-related tasks. In PCA Choice, the beneficiary is responsible for some employment-related activities, including recruiting, hiring, training, supervising, scheduling, and arranging for backup workers. From 2010, PCAs may also perform more complex health-related tasks like tracheostomy suctioning if they are trained to do so, this training is documented in the care plan, and the service is supervised by a registered nurse.

Home Health Services

Home Health provides (Minn. Stat. § 256B.0627, 2001; MNDHS, 2016a):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care
- Therapy: Respiratory therapy, rehabilitative and other therapeutic services

Prior authorization is required for home health services after the first 9 skilled nursing service visits in a calendar year (Minn. Stat. § 256B.0627 Subd. 5.a., 2001).

Nursing Facility Care

Nursing Facility Care does not provide home care.

Elderly Program

The Elderly Program provides (MNDHS, 2001a; MNDHS, 2003b; MNDHS, 2013):

- Extended personal care: PCA services with no limit on the amount of services provided
- Extended home health: Home health services with no limit on the amount of services provided
- Chore services: Services required to maintain a clean, sanitary, and safe home environment, such as heavy household chores (e.g., washing floors), general maintenance work, and rearranging furniture [13]
- Homemaker services: Home cleaning services and assistance with home management activities, such as IADLs and arranging for household repairs and transportation

To be eligible for extended personal care or home health services, beneficiaries must receive and exhaust the state plan benefit for each month the extended service is authorized. From 2004, extended personal care services may be consumer-directed, meaning the beneficiary can hire and manage the aide of their choice.[8]

Community care

Community care benefits vary by LTC health benefit program. The details of the 4 largest programs are summarized below.

PCA, Home Health Services, Nursing Facility Care

These programs do not provide community care.

Elderly Program

The Elderly Program provides Adult Day Health Care (ADHC). Centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (HHS p. 481, 1992; MNDHS, 2003b; MNDHS, 2013; CMS, 2023).[8]

Residential care

Residential care benefits vary by LTC health benefit program. The details of the 4 largest programs are summarized below.

PCA, Home Health Services, Elderly Program

These programs do not provide residential care.

Nursing Facility Care

Minnesota Medicaid covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (CFR, 1992; Minn. Stat. § 256B.0625, 1992; Minn. Stat. § 256B.0625, 2001; MNDHS, 2024c). Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Minnesota's largest home and community-based services (HCBS) program.

Minnesota Medicaid provides additional benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

Elderly Program

The Elderly Program provides the following services in addition to those offered under the state plan, unless otherwise noted (HHS p.481,1992; MNDHS, 2001a; MNDHS, 2003b; MNDHS, 2013;CMS, 2023): [7]

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Adult companion services: Non-medical care, supervision, and socialization provided to the beneficiary in accordance with a therapeutic goal, usually related to reducing social isolation
- Home-delivered meals: Delivers healthy meals to the beneficiary's home
- Specialized equipment and supplies: Additional equipment and supplies that are necessary to address the participant's functional limitations [8]
- Extended Transportation: Transportation to program services or other community services, activities, and resources
- Environmental accessibility adaptations (Home Modification): Physical adaptations made to the home to allow the enrollee to function with greater independence in the home and without which the enrollee would require institutionalization, including the installation of ramps and grab-bars, widening of doorways, or modification of bathroom facilities [8]
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Community transition services: Non-reoccurring expenses for people who are in the process of transitioning from a nursing facility to a community setting (e.g., moving expenses, housing deposits)
- Caregiver services: Instruction provided to a participant or caregiver to teach a variety of skills necessary for independent living, such as the use of specialized or adaptive equipment and assistance with ADLs, as well as counseling to assist with decision-making and problem solving [8]

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Minnesota Department of Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

PCA

Personal care services must be provided by qualified aides under the supervision of a registered nurse (MNDCC, 2002). From 2003, parents of adult recipients, adult children, and adult siblings of beneficiaries are permitted to provide PCA services without a hardship waiver (OLA, 2009). From 2010, PCAs may also perform more complex health-related tasks like tracheostomy suctioning if they are trained to do so, this training is documented in the care plan, and the service is supervised by a registered nurse (Minnesota House of Representatives, 2012).

Home Health Services

Skilled nursing services must be provided by a licensed registered nurse or practical nurse under the supervision of a licensed registered nurse. Home health aide services, such as personal care, assistance with medications, or ambulation, are provided by home health aides, but must be under the supervision of a licensed registered nurse (MNDHS, 2024b).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel (MNDHS, 2024c).

Elderly Program

The provision of care for program services will vary by authorized service (MNDHS, 2013).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by health benefit program. The details of the 4 largest programs are summarized below. Information on how level of care is assessed is detailed in the *Care Needs Assessment* section of this policy period.

PCA

Applicants must receive an assessment that determines personal care services to be medically necessary, and services must be ordered by the beneficiary's physician (MNDDC, 2002). The PCA program defines medically necessary as the individual having a need for assistance based on a disability, diagnosis, or chronic condition. However, there is no explicit criteria that defines medical necessity.

In 2009, the PCA program implemented explicit eligibility criteria. From January 2010, applicants must receive an assessment that determines at least 1 of the following (MN House of Representatives, 2012; MNDHS, 2024d):

- The applicant requires hands-on assistance or cueing and supervision to complete at least 1 activity of daily living (ADL)
- The applicant has a Level I behavior (physical aggression towards themselves or others, or destruction of property that requries an immediate response from another person)

From 2011, applicants must require hands-on assistance with at least 2 ADLs to be eligible for PCA services. Following this change, applicants who were eligible for PCA services under the old criteria described above (assistance needed with only 1 ADL or have a Level I behavior) are only eligible for reduced PCA services, which includes a daily maximum of 2 units (30 minutes total) of PCA services.

Home Health Services

Home health services must be medically necessary, ordered by the beneficiary's physician, and performed in accordance with a written plan of care (CFR, 1996; MNDHS, 2016a).

Nursing Facility Care, Elderly Program

Applicants must meet a nursing facility level of care (NFLOC) as determined by a Long-Term Care Consultation (LTCC), previously called the Preadmission Screening. Individuals are assessed based on need for acute or rehabilitative care and functional limitations (MNDHS, 2001).

For acute and rehabilitative care needs, an individual is determined to require an NFLOC if they meet any of the following:

- The person requires active restorative or rehabilitative treatment
- The person has unstable health
- The person requires special treatments
- The person requires complex management

If an applicant does not meet the criteria for acute and rehabilitative care needs, they may still qualify for an NFLOC if at least 1 of the following functional limitations applies to them:

- Needs at least periodic assistance (hands on care, supervision, or cueing) from another person in safely or appropriately performing ADLs
- Needs at least periodic assistance (hands on care, supervision, or cueing) from another person in safely or appropriately performing instrumental activities of daily living (IADLs)
- The person has a complicated medical condition
- The person has impaired cognition or frequent history of certain behaviors
- The individual is frail or vulnerable

See Box 4 for descriptions of the acute care needs, rehabilitative care needs, and functional limitations used to determine eligibility. In 2009, Minnesota passed legislation implementing MnCHOICES, a streamlined eligibility process that combines assessment instruments from multiple programs into a single system. MnCHOICES was used during a pilot stage beginning in 2013 to determine NFLOC, but it was not fully implemented during this policy period.

Duration of benefit

Reassessments of eligibility differ by program and service type. Below we detail reassessments for Medicaid, followed by reassessments for the 4 largest programs.

Medicaid
Federal law requires states to renew Medicaid eligibility at least every 12 months.

PCA, Elderly Program
Program participants must be reassessed at least every 12 months or more often as needed (Minn. Stat. § 256.0627, 1997; MNDCC, 2002; CMS, 2023; MNDHS, 2024e).

Home Health Services
The beneficiary's physician must review the plan of care for home health services at least once every 60 days (Minn. Stat. § 256.0627, 1997; MNDHS, 2024a).

Nursing Facility Services
Functional capacity of residents must be reassessed at least every 12 months. Additionally, quarterly reassessments are conducted by nursing facilities to develop and revise the resident's plan of care. Reassessments are documented on the Resident Assessment Instrument (RAI) (MNDHS, 2001b).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for the 4 largest programs.

Medicaid
There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

PCA, Home Health Services, Nursing Facility Care
There is no age requirement.

Elderly Program
The individual must be at least age 65 (MNDHS, 2003b; CMS, 2023).

Care needs assessment

Definition of dependence

Definitions of dependence vary depending on the health benefit program. The details are summarized below for the 4 largest programs.

PCA
Personal care services must be medically necessary as determined by a level of care assessment and must be physician ordered (MNDDC, 2002). The PCA program defines medically necessary as the individual having a need for assistance based on a disability, diagnosis, or chronic condition. However, there is no explicit criteria that defines medical necessity.

In 2009, the PCA program implemented explicit eligibility criteria. Applicants must receive an assessment that determines at least 1 of the following (MN House of Representatives, 2012; MNDHS, 2024d):

- The applicant requires hands-on assistance or cueing and supervision to complete at least 1 activity of daily living (ADL)
- The applicant has a Level I behavior (physical aggression towards themselves or others, or destruction of property that requries an immediate response from another person)

From 2011, applicants must require hands-on assistance with at least 2 ADLs to be eligible for PCA services. Applicants requiring assistance with only 1 ADL or exhibiting a Level I behavior as described above are eligible ot receive a maximum of 2 units (30 minutes total) of PCA services per day.

Home Health Services

Home health services must be medically necessary, physician ordered, and provided according to a written plan of care. Prior authorization from DHS is required for all Home Health services except for therapy services and the first 9 skilled nursing visits each year (MNDHS, 2016a).

Nursing Facility Care, Elderly Program

Applicants must be evaluated using the Long-Term Care Consultation (LTCC) assessment and meet a nursing facility level of care (NFLOC). The LTCC was previously called the Preadmission Screening. An NFLOC is satisfied when an applicant meets the thresholds for 1 of 2 categories (acute or rehabilitative care or functional limitations) (MNDHS, 2001c):

- Acute and rehabilitative care needs —individual meets NFLOC if they need any of the following:
  - The person requires active restorative or rehabilitative treatment
  - The person has unstable health
  - The person requires special treatments
  - The person requires complex management

  If the acute and rehabilitative care needs listed above do not apply, proceed to the functional limitations section.

- Functional limitations —individual meets NFLOC if they have at least 1 of the following:
  - Needs at least periodic assistance (hands on care, supervision, or cueing) from another person in safely or appropriately performing ADLs
  - Needs at least periodic assistance (hands on care, supervision, or cueing) from another person in safely or appropriately performing instrumental activities of daily living (IADLs)
  - The person has a complicated medical condition
  - The person has impaired cognition or frequent history of certain behaviors
  - The individual is frail or vulnerable

See Box 4 for descriptions of the acute care needs, rehabilitative care needs, and functional limitations used to determine eligibility.

Evaluation of dependence

Evaluations of dependence vary depending on the health benefit program. The details of the 4 largest programs are summarized below.

PCA

Applicants for PCA must be assessed in-person using the MN Health Status Assessment (HSA) in order to receive services. The HSA assesses the individual's need for assistance to (MNDDC, 2002):

- Perform activities of daily living (ADLs) and instrumental ADLs (IADLs)
- Complete health-related tasks, such as dressing a wound
- Address behavior-related issues

The assessor asks the individual about their need for assistance in these areas, and they observe accomplishment of the tasks, if appropriate. The assessor determines the daily number of minutes the individual needs for the 3 areas listed above (OLA, 2009). Guidelines detailing the process for determining the recommended daily number of minutes of service needed were not found. It is possible this process was subjective and based on the assessor's professional judgement.

From 2009, applicants will be determined eligible for PCA services if they meet at least 1 of the eligibility criteria detailed above in Definition of Dependence.

Home Health Services

Home health services must be medically necessary, ordered by the beneficiary's physician, and performed in accordance with a written plan of care. Physicians must review this plan of care at least once every 60 days (Minn. Stat. § 256B.0627, 2001).

Nursing Facility Care, Elderly Program

Applicants for nursing facility care and the Elderly Program must meet a nursing facility level of care (NFLOC) as determined by a Long-Term Care Consultation (LTCC), previously called the Preadmission Screening. Individuals are assessed based on need for acute or rehabilitative care and functional limitations, as described above in Definition of Dependence (MNDHS, 2001c).

See Box 4 for descriptions of the acute care needs, rehabilitative care needs, and functional limitations used to determine eligibility.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS) (42 CFR 483.100-138; UCSF, 2023). See Box 2 for more information on the PASRR, and Box 3 for the MDS.

Evaluators

Evaluators vary by health benefit program. The details of the 4 largest programs are summarized below.

PCA

Assessments are conducted by public health nurses employed by the county (Minn. Stat. § 256.0627, 2001; MNDCC, 2002; OLA, 2009). The beneficiary's physician must provide an order for services that states that services are medically necessary.

Home Health Services

Medical necessity for home health services must be certified by the applicant's attending physician (Minn. Stat. § 256.0627, 2001; MNDHS, 2016a).

Nursing Facility Care

A Long-Term Care Consultation (LTCC) is performed by social workers and public health nurses (MNHS, 2008).

Elderly Program

Level of care evaluations are conducted by service coordinators employed by the state (MNDHS, 2003b).

Benefit limitations

Can you mix LTC benefits?

All Minnesota Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the 4 largest programs.

Medicaid

As required by federal law, Minnesota enforces Estate Recovery. The acceptance of Medicaid in Minnesota creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (Minn. Stat. § 256B.15, 2001).

PCA, Home Health Services

Available Minnesota state documents do not detail policy on copayments or related charges for these programs during this policy period, but they are subject to federal maximum allowable cost standards that are very limited.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. See Table 3 for historical spousal impoverishment standards. In 2001, the PNA was $69 per month (LTC Ombudsman, 2010). See Table 4 for historical monthly PNAs.

Elderly Program

There are no copayments or similar charges imposed upon participants for program services (MNDHS, 2013).

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 3: Policy enacted 2014-2025

Policy change in 2014

In 2014, Minnesota adopted full Medicaid expansion following passage of the Affordable Care Act (ACA), creating a new eligibility track covering adults age 19-64 with incomes up to 138% of the federal poverty level (FPL), referred to here as eligibility track 2c (ACA expansion adults). Previously, Minnesota implemented early roll out, which allowed the state to provide coverage to adults age 19-64 with incomes up to 75% of the FPL.

In addition, Minnesota implemented new nursing facility level of care (NFLOC) criteria for most long-term care (LTC) benefit programs including the Elderly Program and nursing facility care. The Minnesota Legislature passed this new criteria in 2009, but it was not effective until January 2015 (MNDHS, 2016; MHCA, n.d.). From 2015, all applicants to the Elderly Program and nursing facility care must meet at least 1 dependency threshold from 5 categories of need: cognitive and behavioral, activities of daily living (ADLs), critical ADLs, clinician monitoring, or living arrangement and risk.

Other policy changes during this period:

- (2016-2022) Minnesota Medicaid implemented the following increases to the income limit for eligibility track 3a (Medically needy aged, blind, or disabled) throughout this policy period (ASPE, 2002; Black & Ireys, 2006; MNDHS, 2022a):
  - (2016) 80% FPL
  - (2019) 81% FPL
  - (2022) 100% FPL
- (2016) Minnesota restricts estate recovery only to nursing facility care, home and community-based services (HCBS), and associated hospital and prescription drug services. Prior to this, Minnesota recovered the costs of all Medicaid services rendered after an individual reached 55 years of age (CMS, 2016).
- (2017) Minnesota implements a face-to-face encounter requirement for home health service authorization as mandated by the federal government. A face-to-face encounter is a meeting between the practitioner and the beneficiary related to the primary reason the beneficiary requires home health services (CMS, 2017).
- (2024) The Personal Care Assistance (PCA) program permits parents of minors and spouses of beneficiaries to serve as paid personal care assistants (MNDHS, 2024).
- (2024) Minnesota implements Community First Choice Option (CFCO) under the ACA. The program provides extended HCBS, including personal care and adult day health care under the state plan, to individuals who meet an NFLOC. This means that the state cannot restrict access to this program based on location, population, or cap enrollment. In Minnesota, this program is referred to as Community First Services and Supports (CFSS). From October 2024, Minnesota began to transfer individuals enrolled in PCA to CFSS, which offers the same main services. PCA will phase out once the transfer of all participants to CFSS is complete (Minn. Stat. § 256B.85, 2024b). Because CFSS has not been fully implemented across Minnesota and eligibility for CFSS is determined using the same criteria as Medicaid, we do not detail this program in the document.

Overview

Long-term care (LTC) benefits in Minnesota are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Minnesota is administered at the state level by the Minnesota Department of Human Services (MNDHS) and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Minnesota are mostly provided through state plan benefit programs (Personal Care Assistance - PCA, Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Elderly Program).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. PCA and Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the Elderly Program are also able to receive a variety of LTC benefits if deemed medically eligible, such as adult day health care (ADHC).

Benefit programs vary in dependence requirements. PCA applicants must require some assistance with activities of daily living (ADL), Home Health requires the individual to have a medical necessity for services, and Nursing Facility and Elderly Program beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment prior to admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2025b)

Minnesota Law for Medicaid

- Minnesota Rules, Chapter 9505. Health Care Programs (Minn. Rules, 1997)
- Minnesota Statutes, Chapter 144. Department of Health (Minn. Stat., 2024a)
- Minnesota Statutes, Chapter 256B. Medical Assistance for Needy Persons (Minn. Stat., 1992, 1997, 2000, 2001, 2024b)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Minnesota Medicaid spending on beneficiaries in fiscal year 2014 was 50%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.[14]

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Minnesota Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Minnesota.

Eligibility for Medicaid in Minnesota for people needing LTC services is primarily attained by satisfying at least 1 of 4 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1b. 209(b) States
  Minnesota is 1 of a few states that can use more restrictive methodologies to determine Medicaid eligibility than those of the Supplemental Security Income (SSI) program.
  - Income requirements: Monthly income may not exceed 100% of the federal poverty level (FPL). In 2014, this was $973 for an individual and $1,311 for a couple. Additional income disregards exist when a person is institutionalized or enrolled in the Elderly Program and has a spouse residing in the community.[15] See Table 2 for historical income limits.
  - Asset requirements: Resources may not exceed $3,000 for an individual and $6,000 for a couple. An additional $200 for each additional legal dependent is added to the resource limit (Minn. Stat. § 256B.056, 2024b). Additional asset disregards exist when a person is institutionalized or enrolled in the Elderly Program and has a spouse residing in the community.[16] See Table 3 for historical monthly spousal disregards.

        - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[17]
        - Home equity limit: The equity interest in the individual's home may not exceed $543,000, or else they will be ineligible for LTC services. This figure increases annually with inflation. See Table 5 for historical home equity limits.
    - Citizenship/immigration requirements: The applicant must be an Minnesota resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals that entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See (SSA, 2023) for additional information.
    - Other requirements
        - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
    - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount. In 2014, this was $2,163 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). Additional income disregards exist when a person is institutionalized or enrolled in the Elderly Program and has a spouse residing in the community.[15] See Table 2 for historical income limits.
    - Asset requirements: Resources may not exceed $3,000 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). Additional asset disregards exist when a person is institutionalized or enrolled in the Elderly Program and has a spouse residing in the community.[16] See Table 3 for historical monthly spousal disregards.
        - Asset transfer & home equity limit: Same as eligibility track 1b.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
    - Other requirements
        - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in a federally approved HCBS program (e.g., Elderly Program).
- 2c. Affordable Care Act (ACA) expansion adults
    - Income requirements: Monthly income may not exceed 138% of the FPL. In 2014, this was $1,342 for an individual and $1,809 for a household of two. See Table 2 for historical income limits. Minnesota offered an early rollout period for this eligibility track from 2011-2014, which limited enrollment to individuals with an annual gross income below 75% of the FPL (Medicaid.gov, 2011).
    - Asset requirements: There is no asset test for this population.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
    - Other requirements
        - Applicants must be age 19-64, ineligible for Medicare, and ineligible for other Medicaid eligibility tracks.

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
    - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income over a 6-month period to be equal to or less than the medically needy income limit. In 2014, this was 75% of the FPL, or $729 for an individual and $970 for a couple. This limit increased to 80% of the FPL in 2016, 81% of the FPL in 2019, and 100% of the FPL in 2022, where it remains (MNDHS, 2022). Valid expenses include medical care and other types of remedial care. Additional income disregards exist when a person is institutionalized or enrolled in the Elderly Program and has a spouse residing in the community.[15] See Table 3 for historical monthly spousal disregards.
    - Asset requirements: Resources may not exceed $3,000 for an individual and $6,000 for a couple. Additional asset disregards exist when a person is institutionalized or enrolled in the Elderly Program and has a spouse residing in the community.[16] See Table 3 for historical monthly spousal disregards.
        - Asset transfer & home equity limit: Same as eligibility track 1b.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
    - Other requirements
        - The applicant must be at least age 65, blind, or disabled.[4]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Personal Care Assistance (PCA), Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit eligibility* section of this policy period).

Elderly Program

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65 (MNDHS, 2003; MNDHS, 2013; CMS, 2023).

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Community Access for Disability Inclusion (CADI)
- Community Alternative Care (CAC)
- Brain Injury Program
- Community First Services and Supports (CFSS) —from 2024

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the 4 largest programs are summarized below.

PCA

PCA provides personal care services, which include (MNDDC, 2002; MN Statutes § 256B.0659, 2024b; MNDHS, 2024d):

- Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with instrumental ADLs (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

The PCA program offers traditional PCA and PCA Choice. Both options require the beneficiary to select a PCA provider agency, direct their services, and assist in choosing their PCA worker. However, in traditional PCA, the agency is responsible for all employment-related tasks. In PCA Choice, the beneficiary is responsible for some employment-related activities, including recruiting, hiring, training, supervising, scheduling, and arranging for backup workers. From October 1, 2024, spouses and parents of minors may be paid to provide PCA services.

Home Health Services

Home Health provides (MNDHS, 2016a):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care
- Therapy: Respiratory therapy, rehabilitative and other therapeutic services

Prior authorization is required for home health services after the first 9 skilled nursing service visits in a calendar year (Minn. Stat. § 256B.0652 Subd. 5.a., 2024b).

Nursing Facility Care

Nursing Facility Care does not provide home care.

Elderly Program

The Elderly Program provides (CMS, 2023):

- Extended personal care: PCA services with no limit on the amount of services provided

- Extended home health: Home health services with no limit on the amount of services provided
- Chore services: Services required to maintain a clean, sanitary, and safe home environment, such as heavy household chores (e.g., washing floors), general maintenance work, and rearranging furniture
- Homemaker services: Home cleaning services and assistance with home management activities, such as IADLs and arranging for household repairs and transportation

To be eligible for extended personal care or home health services, beneficiaries must receive and exhaust the state plan benefit for each month the extended service is authorized. Extended personal care services may be consumer-directed, meaning the beneficiary can hire and manage the aide of their choice.[8]

Community care

Community care benefits vary by LTC health benefit program. The details of the 4 largest programs are summarized below.

PCA, Home Health Services, Nursing Facility Care

These programs do not provide community care.

Elderly Program

The Elderly Program provides Adult Day Health Care (ADHC). Centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (HHS p. 481, 1992; MNDHS, 2003b; MNDHS, 2013; CMS, 2023).[8]

Residential care

Residential care benefits vary by LTC health benefit program. The details of the 4 largest programs are summarized below.

PCA, Home Health Services, Elderly Program

These programs do not provide residential care.

Nursing Facility Care

Minnesota Medicaid covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (CFR, 1992; Minn. Stat. § 256B.0625, 1992; Minn. Stat. § 256B.0625, 2001; MNDHS, 2024c). Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Minnesota's largest home and community-based services (HCBS) program.

Minnesota Medicaid provides additional benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

Elderly Program

The Elderly Program provides the following services in addition to those offered under the state plan, unless otherwise noted (HHS p.481,1992; MNDHS, 2001a; MNDHS, 2003b; MNDHS, 2013;CMS, 2023): [7]

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Adult companion services: Non-medical care, supervision, and socialization provided to the beneficiary in accordance with a therapeutic goal, usually related to reducing social isolation
- Home-delivered meals: Delivers healthy meals to the beneficiary's home
- Specialized equipment and supplies: Additional equipment and supplies that are necessary to address the participant's functional limitations [8]

- Extended Transportation: Transportation to program services or other community services, activities, and resources
- Environmental accessibility adaptations (Home Modification): Physical adaptations made to the home to allow the enrollee to function with greater independence in the home and without which the enrollee would require institutionalization, including the installation of ramps and grab-bars, widening of doorways, or modification of bathroom facilities [8]
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Community transition services: Non-reoccurring expenses for people who are in the process of transitioning from a nursing facility to a community setting (e.g., moving expenses, housing deposits)
- Caregiver services: Instruction provided to a participant or caregiver to teach a variety of skills necessary for independent living, such as the use of specialized or adaptive equipment and assistance with ADLs, as well as counseling to assist with decision-making and problem solving [8]

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Minnesota Department of Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

PCA

Personal care services must be provided by qualified aides under the supervision of a registered nurse (MNDCC, 2002). Parents of adult recipients, adult children, and adult siblings of beneficiaries are permitted to serve as a personal care assistant to provide PCA services. PCAs may also perform more complex health-related tasks like tracheostomy suctioning if they are trained to do so, this training is documented in the care plan, and the service is supervised by a registered nurse (OLA, 2009; Minnesota House of Representatives, 2012; Minn. Stat. § 256B.0659, 2024b). From October 2024, spouses and parents of minors may be paid to provide PCA services (MNDHS, 2024d).

Home Health Services

Skilled nursing services must be provided by a licensed registered nurse or practical nurse under the supervision of a licensed registered nurse. Home health aide services, such as personal care, assistance with medications, or ambulation, are provided by home health aides, but must be under the supervision of a licensed registered nurse (MNDHS, 2024b).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel (MNDHS, 2024c).

Elderly Program

The provision of care for program services will vary by authorized service (CMS, 2023).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by health benefit program. The details of the 4 largest programs are summarized below. Information on how level of care is assessed is detailed in the *Care Needs Assessment* section of this policy period.

PCA

Applicants must receive an assessment that determines at least 1 of the following (MNDHS, 2024d):

- The applicant requires hands-on assistance or cueing and supervision to complete at least 1 activity of daily living (ADL)
- The applicant has a Level I behavior (physical aggression towards themselves or others, or destruction of property that requries an immediate response from another person)

Home Health Services

Home health services must be medically necessary, ordered by the beneficiary's physician, and performed in accordance with a written plan of care (CFR, 1996; MNDHS, 2016a).

Nursing Facility Care, Elderly Program

From 2015, applicants must be evaluated using the MnCHOICES assessment and meet a nursing facility level of care (NFLOC). An NFLOC is satisfied when an applicant meets 1 of the following categories of need (Minn. Stat. § 144.0724 Subd. 11, 2024a):

1. Cognitive and behavioral needs —see Table 6 for assessed items and corresponding threshold scores
2. ADLs: Applicant meets threshold criteria for at least 4 ADLs, or criteria for at least 1 critical ADL —see Table 7 for assessed items and corresponding threshold scores
3. Clinician monitoring: Applicant requires clinical monitoring at least once every 24 hours
4. Living arrangement and risk —see Table 8 for threshold criteria

Duration of benefit

Reassessments of eligibility differ by program and service type. Below we detail reassessments for Medicaid, followed by reassessments for the 4 largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months.

PCA, Elderly Program

Program participants must be reassessed at least every 12 months or more often as needed (Minn. Stat. § 256.0627, 1997; MNDCC, 2002; CMS, 2023; MNDHS, 2024e).

Home Health Services

The beneficiary's physician must review the plan of care for home health services at least once every 60 days (Minn. Stat. § 256.0627, 1997; MNDHS, 2024a).

Nursing Facility Services

Functional capacity of residents must be reassessed at least every 12 months. Additionally, quarterly reassessments are conducted by nursing facilities to develop and revise the resident's plan of care. Residents under age 65 must be reassessed within 80 days after admission, then every 12 months thereafter or more often as needed. Individuals at least age 65 must be reassessed 80 days after admission, but do not require additional subsequent assessments (MNDHS, 2023).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for the 4 largest programs.

Medicaid

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

PCA, Home Health Services, Nursing Facility Care

There is no age requirement.

Elderly Program

The individual must be at least age 65 (MNDHS, 2003b; CMS, 2023).

Care needs assessment

Definition of dependence

Definitions of dependence vary depending on the health benefit program. The details are summarized below for the 4 largest programs.

PCA

Applicants must receive an assessment that determines at least 1 of the following (MNDHS, 2024d):

- The applicant requires hands-on assistance or cueing and supervision to complete at least 1 activity of daily living (ADL)

- The applicant has a Level I behavior (physical aggression towards themselves or others, or destruction of property that requries an immediate response from another person)

Home Health Services

Home health services must be medically necessary, physician ordered, and provided according to a written plan of care. Prior authorization from DHS is required for all Home Health services except for therapy services and the first 9 skilled nursing visits each year (MNDHS, 2016a).

Nursing Facility Care, Elderly Program

From 2015, applicants must be evaluated using the MnCHOICES assessment and meet a nursing facility level of care (NFLOC). An NFLOC is satisfied when an applicant meets 1 of the following categories of need (Minn. Stat. § 144.0724 Subd. 11, 2024a):

1. Cognitive and behavioral needs —see Table 6 for assessed items and corresponding threshold scores
2. ADLs: Applicant meets threshold criteria for at least 4 ADLs, or criteria for at least 1 critical ADL —see Table 7 for assessed items and corresponding threshold scores
3. Clinician monitoring: Applicant requires clinical monitoring at least once every 24 hours
4. Living arrangement and risk —see Table 8 for threshold criteria

Evaluation of dependence

Evaluations of dependence vary depending on the health benefit program. The details of the 4 largest programs are summarized below.

PCA

Applicants for PCA must complete an in-person assessment using the MnCHOICES assessment. The MnCHOICES assessment includes 15 sections (called "domains"), including demographic information, activities of daily living (ADLs), instrumental ADLs (IADLs), and cognition. See Box 5 for a list of all domains, and MNDHS (2014b) to view the assessment form.

Applicants will be determined eligible for PCA services if they meet at least 1 of the eligibility criteria detailed above in Definition of Dependence (MNDHS, 2024d).

Home Health Services

Home health services must be medically necessary, ordered by the beneficiary's physician, and performed in accordance with a written plan of care. Physicians must review this plan of care at least once every 60 days if it includes skilled nursing services (MNDHS, 2016a).

From 2017, a face-to face encounter is required for the initial certification of medical necessity for home health services, and must occur no more than 90 days before or 30 days after the start of services. Face-to-face encounters are not required for recertifications.

Nursing Facility Care, Elderly Program

From 2015, Minnesota Medicaid implemented a new assessment system statewide. For details on the assessment process prior to 2015, see the previous policy period (chapter).

Applicants for nursing facility care and the Elderly Program must meet a nursing facility level of care (NFLOC) determined using the MnCHOICES assessment described above under PCA. An NFLOC is satisfied when an applicant meets 1 of the categories of need detailed in Definition of Dependence (Minn. Stat. § 144.0724 Subd. 11, 2024a). See Table 6, Table 7, and Table 8 for more information on eligibility thresholds and scoring criteria in the MnCHOICES assessment.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS) (42 CFR 483.100-138; UCSF, 2023). See Box 2 for more information on the PASRR, and Box 3 for the MDS.

Evaluators

Evaluators vary by health benefit program. The details of the 4 largest programs are summarized below.

PCA, Nursing Facility Care, Elderly Program

Level of care evaluations using the MnCHOICES assessment are conducted by state Medicaid agency-certified assessors that have completed assessment training (CMS, 2023).

Home Health Services

Medical necessity for home health services must be certified by the applicant's attending physician (MNDHS, 2016a). From 2017, the face-to-face encounter required at the start of services may be with the applicant's attending physician, physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife (MNDHS, 2024b).

Benefit limitations

Can you mix LTC benefits?

All Minnesota Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the 4 largest programs.

Medicaid

As required by federal law, Minnesota enforces Estate Recovery. The acceptance of Medicaid in Minnesota creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age or was permanently institutionalized. From 2016, the state seeks recovery for nursing facility care, home and community-based services (HCBS), and associated hospital and prescription drug services received after the recipient reaches 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (CMS, 2016; Minn. Stat. § 256B.15, 2024b).

PCA, Home Health Services

Available Minnesota state documents do not detail policy on copayments or related charges for these programs during this policy period, but they are subject to federal maximum allowable cost standards that are very limited. Later (2018) sources indicate that Minnesota does not have copayments for personal care services or home health services (KFF, 2018).

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. See Table 3 for historical spousal impoverishment standards. In 2014, the PNA was $95 per month MNDHS, 2014a). See Table 4 for historical monthly PNAs.

Elderly Program

There are no copayments or similar charges imposed upon participants for program services (CMS, 2023).

Taxation of benefits

In-kind benefits are not subject to taxation.

Tables and Formulas

Table 1: Minnesota Federal Medical Assistance Percentage (FMAP) for Medicaid (1992-2025)

Fiscal Year	FMAP
1992	54.43%
1993	54.93
1994	54.65
1995	54.27
1996	53.93
1997	53.60
1998	52.14
1999	51.50
2000	51.48
2001	51.11
2002	50.00
2003	51.47
2004	52.21
2005	50.00
2006	50.00
2007	50.00
2008	50.00
2009	60.89
2010	61.59
2011	56.81
2012	50.00
2013	50.00
2014	50.00
2015	50.00
2016	50.00
2017	50.00
2018	50.00
2019	50.00
2020	54.65
2021	56.20
2022	56.71
2023[1]	55.77
2024	51.87
2025	51.16

Source: Congress.gov (2020), U.S. DHHS (2023)

Notes: FMAPs displayed here apply to the federal fiscal year indicated unless otherwise noted, which runs from October 1 through September 30. For example, FY 2022 refers to the period from October 1, 2021 through September 30, 2022. FY 2020, FY 2021, FY 2022, and FY 2023 FMAPs reflect higher federal matching funding (6.2 percent increase in FMAP rates for all states) made available through the Families First Coronavirus Response Act for the duration of the public health emergency period.[1] The enhanced FMAP decreased from 6.2 to 5 percentage points from April to June 2023, 2.5 percentage points from June to September 2023, and 1.5 percentage points from October to December 2023.

Table 2: Minnesota Medicaid Income Limits (1992-2025)

Year	209(b) States (Individual)	209(b) States (Couple)	300% SSI (Individual)	138% FPL (Individual)	138% FPL (Couple)	Medically Needy (Individual)	Medically Needy (Couple)
1992 [1]	$420	N/A				$420	N/A
1993 [1]	420	N/A				420	N/A
1994 [1]	420	N/A				420	N/A
1995 [1]	420	N/A				420	N/A
1996 [1]	420	N/A				420	N/A
1997 [1]	420	N/A	$1,452			420	N/A
1998	467	583	1,482			467	583
1999	467	583	1,500			467	583
2000 [2]	482	602	1,539			482	602
2001	716	968	1,593			502	678
2002	739	995	1,635			554.25	746.25
2003	749	1,010	1,656			561.75	757.50
2004	776	1,041	1,692			582.00	780.75
2005	798	1,070	1,737			598.50	802.50
2006	817	1,100	1,809			612.75	825.00
2007	851	1,141	1,869			638.25	855.75
2008	867	1,167	1,911			650.25	875.25
2009	903	1,215	2,022			677.25	911.25
2010	903	1,215	2,022			677.25	911.25
2011	908	1,226	2,022	$681.00	$919.50	681.00	919.50
2012	931	1,261	2,094	698.25	945.75	698.25	945.75
2013	958	1,293	2,130	718.50	969.75	718.50	969.75
2014	973	1,311	2,163	1,342.00	1,809.00	729.75	983.25
2015	981	1,328	2,199	1,354.00	1,832.00	735.75	996.00
2016	990	1,335	2,199	1,367.00	1,843.00	792.00	1068.00
2017	1,005	1,354	2,205	1,387.00	1,868.00	804.00	1083.20
2018	1,012	1,372	2,250	1,397.00	1,893.00	809.60	1097.60
2019	1,041	1,410	2,313	1,437.00	1,945.00	843.21	1142.10
2020	1,064	1,437	2,349	1,468.00	1,983.00	861.84	1163.97
2021	1,074	1,452	2,382	1,482.00	2,004.00	869.94	1176.12
2022	1,133	1,526	2,523	1,564.00	2,106.00	1,133.00	1,526.00
2023	1,215	1,643	2,742	1,677.00	2,268.00	1,215.00	1,643.00
2024	1,255	1,704	2,829	1,732.00	2,352.00	1,255.00	1,704.00
2025	1,255	1,704	2,829	1,732.00	2,352.00	1,255.00	1,704.00

Source: CMS (1992), MN Legislative Resource Library (1995), Horvath (1997), Bruen et. al. (1999), AARP (2000), Medicaid.gov (2011), MNDHS (2014), KFF (2019), SSA (2025a), CMS (2024)

Notes: Supplemental Security Income (SSI) and federal poverty level (FPL) amounts for individuals and couples are monthly. Income limits at 300% SSI and 75% FPL begin in 1997 and 2011, corresponding to Minnesota's implementation of each track. Sources indicate that the 300% SSI track did not exist prior to September 1996, and the first mention of a special income standard can be found in the 1997 Minnesota Statutes. Minnesota implemented early roll out of Medicaid expansion following the passage of the Affordable Care Act (ACA), with an income limit at 75% of the FPL. This increases to 138% of the FPL in 2014. Income limits for the 209(b) states track change multiple times from 1992-2001, as detailed in Box 1. From 2001, the income limit for this track is 100% of the FPL for all applicants, where it remains. The income limit for the medically needy track is the same as 209(b) states until 2001, when it changes to 70% of the FPL. This increases to 75% of the FPL in 2002, 80% of the FPL in 2016, 81% of the FPL in 2019, and 100% of the FPL in 2022, where it remains.

[1] Minnesota statutes indicate that the income limits for both the 209(b) states and medically needy tracks during fiscal years 1992-1997 are equivalent to semiannual income less than 120% of the income standard by family size for the Aid to Families with Dependent Children (AFDC) program, of which authors were able to confirm dollar amounts for a household of 1 only. Income limits for couples were not found.

[2] In 2000, the income limit for the 209(b) and medically needy tracks is 133 1/3% of the AFDC income standard, as detailed in the table above. However, Minnesota statutes from 2000 indicate that the income limit for SSI beneficiaries under these tracks is the federal SSI benefit amount ($513 for an individual and $769 for a couple). In 2001, the income limit for all applicants under the 209(b) states track increases to 100% of the FPL, granting all SSI recipients automatic eligibility. Authors are unable to verify whether SSI recipients were eligible for Medicaid in Minnesota prior to 2000.

Box 1: Major Changes to Minnesota Medical Assistance Income Limits (1992-2022)

During the first policy period, Minnesota's financial eligibility requirements for eligibility track 1b (209(b) States) changed multiple times. Below is a timeline of important changes occuring between 1992 and 2001:

- (1992) Individuals must not have a semiannual income greater than 120% of the income standards by family size for the Aid to Families with Dependent Children (AFDC) program, which is $420 for an individual and unconfirmed for a couple
- (1998) Income limit increases to 133 1/3% of the income limit for AFDC, which is $467 for an individual and $583 for a couple
- (2000) Income limit remains 133 1/3% of the income limit for AFDC for individuals who are not SSI recipients, which is $482 for an individual and $602 for a couple [1]
- (2001) Income limit increases to 100% of the federal poverty level (FPL) for all applicants, which was $716 for an individual and $968 for a couple

During the first policy period (1992-2000), the spend down threshold for eligibility track 3a (Medically needy) is equivalent to the income limits for eligibility track 1b (209(b) States). Beginning 2001, the spend down threshold increases gradually over time, as follows:

- (2001) 70% of the FPL
- (2002) 75% of the FPL
- (2016) 80% of the FPL
- (2019) 81% of the FPL
- (2022) 100% of the FPL, where it remains

Source: Minn. Stat. (1992), Minn. Laws Ch. 407 (1998) , Minnesota Disability Law Center (2000), Minn. Stat. (2000), MNDHS (2000), MNDHS (2022a)

Notes: The AFDC program was replaced by the Minnesota Family Investment Program (MFIP) in 1997. However, Minnesota statutes continue to reference AFDC as the income standard for Medicaid through 2000.

[1] From January 1, 2000, Minnesota statutes explicitly state that SSI beneficiaries may retain income up to the federal SSI benefit standard. This statement is not present in previous versions of the statutes from 1992-1999, however individuals who are categorically eligible for SSI benefits are listed as an eligible Medicaid group in Minnesota statutes from 1992 onward. Authors are unable to verify whether SSI recipients were eligible for Medicaid in Minnesota prior to 2000.

Table 3: Minnesota Spousal Impoverishment Standards (1992-2025)

Year	Minimum MMNA	Maximum MMNA	Minimum CSRA	Maximum CSRA
1992	$984.20	$1,718.00	$13,740	$68,700
1993	1,148.75	1,769.00	14,148	70,740
1994	1,178.75	1,817.00	14,532	72,660
1995	1,230.00	1,871.00	14,964	74,820
1996	1,253.75	1,919.00	15,348	76,740
1997	1,295.00	1,976.00	15,804	79,020
1998	1,326.25	2,019.00	16,152	80,760
1999	1,356.25	2,049.00	16,392	81,960
2000	1,382.50	2,103.00	16,824	84,120
2001	1,406.25	2,175.00	17,400	87,000
2002	1,451.25	2,232.00	17,856	89,280
2003	1,492.50	2,266.50	18,132	90,660
2004	1,515.00	2,319.00	18,552	92,760
2005	1,561.25	2,377.50	19,020	95,100
2006	1,603.75	2,488.50	19,908	99,540
2007	1,650.00	2,541.00	20,328	101,640
2008	1,712.00	2,610.00	20,880	104,400
2009	1,751.00	2,739.00	21,912	109,560
2010	1,823.00	2,739.00	21,912	109,560
2011	1,823.00	2,739.00	21,912	109,560
2012	1,840.00	2,841.00	22,728	113,640
2013	1,892.00	2,898.00	23,184	115,920
2014	1,940.00	2,931.00	23,448	117,240
2015	1,967.00	2,980.50	23,844	119,220
2016	2,002.50	2,980.50	23,844	119,220
2017	2,002.50	3,022.50	24,180	120,900
2018	2,030.00	3,090.00	24,720	123,600
2019	2,057.50	3,160.50	25,284	126,420
2020	2,113.75	3,216.00	25,728	128,640
2021	2,155.00	3,259.50	26,076	130,380
2022	2,177.50	3,435.00	27,480	137,400
2023	2,288.75	3,715.50	29,724	148,620
2024	2,465.00	3,853.50	no minimum	154,140
2025	2,555.00	3,948.00	no minimum	157,920

Source: MNDHS (2014a), KFF (2019), CMS (2024), MNDHS (2025b)

Notes: Federal law requires states to set the minimum monthly maintenance needs allowance (MMNA) standard at 150% of the federal poverty level (FPL) for a couple, increasing each year with inflation, except for FY 1992, which was set at 133% of the FPL. MMNAs are calculated using FPLs for each year and are validated by state and federal sources. Some states round to the dollar, which may lead to minor variations between the calculated federal amounts and state-specific standards. For Community Spouse Resource Allowances (CSRAs), the minimum was set at $12,000 and the maximum at $60,000 as of September 30, 1989, increasing each year with inflation. CSRAs are calculated using the Consumer Price Index for urban consumers (CPI-U).

Box 2: Preadmission Screening and Resident Review (PASRR)

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR). The purpose of PASRR is to prevent individuals with mental illness, intellectual disability, developmental disability, or a related condition from inappropriate admission to a nursing facility. The process consists of a Level I screen, Level II evaluation (depending on the outcome of the Level 1 screening), and a final determination. All applicants of Medicaid certified nursing facilities receive a Level I screen to identify possible conditions. These screens generally consist of forms completed by hospital discharge planners, community health nurses, or others as defined by the state. Individuals who do or may have a mental condition as described above are referred for a Level II PASRR evaluation.

PASRRs were required on an annual basis until 1996, when the annual requirement was removed. Some states continue to conduct PASRRs on an annual basis.

Source: 42 CFR 483.100-138

Box 3: Minimum Data Set (MDS)

Nursing facilities are required by federal law to periodically assess each resident. The Minimum Data Set (MDS) is the uniform instrument used nationally to assess resident condition. The MDS collects resident data for a variety of purposes, such as to inform care plans or assess a resident's ongoing need for nursing home care. Assessments are performed every 3 months or more often depending on the resident's health condition.

The first MDS was implemented nationally in 1991. There have been two new versions of the MDS since then —one in 1995 (MDS 2.0), and another in 2010 (MDS 3.0). However, all versions generally assess the following domains: functional and cognitive status, behavioral symptoms, diagnoses and medications, geriatric syndromes, and psychosocial functioning.

Source: UCSF (2023)

Table 4: Minnesota Personal Needs Allowances (1992-2025)

Year	PNA (monthly)
1992	$54
1993	55
1994	57
1995	58
1996	60
1997	61
1998	64
1999	65
2000	67
2001	69
2002	71
2003	72
2004	74
2005	76
2006	79
2007	82
2008	84
2009	89
2010	89
2011	89
2012	92
2013	94
2014	95
2015	97
2016	97
2017	97
2018	99
2019	102
2020	104
2021	105
2022	111
2023	121
2024	125
2025	128

Source: Minnesota Legislature (1988), CGA (1998), AARP (2000), LTC Ombudsman (2010), MNDHS (2014a), KFF (2019), MNDHS (2025b)
Notes: Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). From 1988, Minnesota increases the PNA annually to reflect increases in the Social Security Cost-of-Living Adjustments (COLAs) rounded to the nearest dollar.

Table 5: Minnesota Home Equity Limits (2006-2025)

Year	Home equity limit
2006	$500,000
2007	500,000
2008	500,000
2009	500,000
2010	500,000
2011	506,000
2012	525,000
2013	536,000
2014	543,000
2015	552,000
2016	552,000
2017	560,000
2018	572,000
2019	585,000
2020	595,000
2021	603,000
2022	636,000
2023	688,000
2024	713,000
2025	730,000

Source: KFF (2019), CMS (2024), SSA (2024a), MNDHS (2025b)

Notes: Home equity limits begin in 2006, corresponding to Minnesota's implementation of the federal rule. The limit was $500,000 until 2011, when the equity limit began increasing annually with inflation. State sources were not found for all years, but they are subject to the federal minimum standards. We have included the federal standards for these years. Home equity limits are calculated using Social Security Cost-of-Living Adjustments (COLAs) and are validated by state and federal sources.

Box 4: Minnesota Nursing Facility Level of Care Criteria (prior to 2015)

Applicants to nursing facilities and the Elderly Program must meet a nursing facility level of care (NFLOC). The NFLOC criteria detailed below is confirmed to have existed from at least 2001, however it is possible that this criteria was also used prior to 2001. Minnesota fully implemented a new NFLOC assessment system (MnCHOICES) in 2015, so it is possible the criteria detailed below was in effect until 2015.

An individual may meet an NFLOC if they meet 1 of the following criteria:

1. Restorative and rehabilitative treatment: The person requires active restorative or rehabilitative treatment as part of a planned discharge, or such treatment is needed to foster a lower level of dependency
2. Unstable health: The person experiences episodes of active disease processes requiring immediate clinical judgements by licensed nurse, episodes come at unpredictable times of the day or night, and/or the person received medication requiring professional dosage adjustment or preadministrative monitoring, or licensed nurse observations for reactions, side effects, or drug interaction, including during the evening and night shifts.
3. Special treatment (individual requires any of the following direct care services by licensed nurses during the evening and night shifts):
    - Injections or intravenous medications
    - Sterile dressings or complex topical therapy
    - Lamp treatments or Catheter care (urinary or nasal)
    - Tube feeding, ostomy care, colostomy, ileostomy, or tracheostomy
    - Oxygen therapy or IPPB
    - Suctioning, Irrigations, or Positioning and alignment
4. Complex management: The person requires assistance with all or most activities of daily living (ADLs) because of extreme frailty, advanced dementia, or other cognitive impairments, or the need for intensive palliative care

If applicants do not meet any of the criteria listed above , they may meet an NFLOC based on functional or cognitive limitations instead. Applicants must meet limitation criteria in at least 1 of the 4 categories detailed below:

1. Functional limitations (individual must require 1 of the following levels of assistance from another person to safely perform instrumental activities of daily living (IADLs) or ADLs):
    - Ongoing assistance (hands on care, supervision, or cueing)
    - Periodic assistance (hands on care, supervision, or cueing)
2. Complicating conditions (individual must require 1 of the following):
    - Frequent medical or social intervention to safely maintain an acceptable health or developmental status
    - Frequent changes in service due to intermittent or unpredictable changes in his/her condition
    - A range of interventions (medical or social) due to a multiplicity of conditions which are either medical or cognitive in nature
3. Cognition or Behavior (individual must have 1 of the following):
    - Impaired cognition: Short term memory loss, disorientation of person, place, time or location, or impaired decision-making ability
    - Frequent history of the following behavior symptoms: Wandering, physical abuse of others, resistive to care, behavior problems requiring some supervision for safety of self or others, severe communication problems
4. Frailty or vulnerability (individual must have 1 of the following):
    - Self neglect: The person has not or may not obtain goods or service necessary to ensure reasonable care, hygiene, nutrition and safety, or to avoid physical or mental harm or disease
    - Neglect, abuse, or exploitation: The person's caregiver(s) or other persons cannot provide reasonable care to the person, or the person has been or may be physically and/or verbally abused, or the caregiver(s) or other persons have or may mis-manage the person's funds and/or possessions
    - The person has experienced frequent or recent hospitalization, nursing facility admissions, falls, or overall frailty

Source: Minn. Stat. 256B.0627 (2001), MNDHS (2001)

Notes: The ADLs assessed include eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning. The IADLs assessed include meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communication by telephone and other media, and getting around and participating in the community.

Table 6: MnCHOICES Cognitive and Behavioral Needs Threshold Scores (2015-2025)

Item	Threshold	Definition of minimum threshold score
Self-preservation	Score 2 or greater	The individual is mentally unable to have the judgement and physical ability to cope, make appropriate decisions and take action in a changing environment or a potentially harmful situation.
Orientation	Score 2, 3, or 4	(2) Partial or intermittent periods of disorientation (3) Totally disoriented; does not know time, place, identity (4) Comatose
Mental status (Mini-cog)	Score 3 or less	Individuals can score up to a total of 5 points on the mini-cog assessment (up to 3 points for a 3-word recall activity if they recall all 3 words, and up to 2 points for drawing a "normal" clock from memory with numbers in the correct sequence and position). A score of 3 points or less indicates cognitive need.
Behavioral need	Score 1 or greater	Needs and receives behavior management and staff intervention because person exhibits disruptive behavior such as verbally abusing others, wandering into private areas, removing or destroying property, or acting in a sexually aggressive manner. Person may be resistant to redirection.

Source: MHCA (n.d.), MNDHS (2021), MNDHS (2022b), MNDHS (2025a)
Notes: Applicants must meet 1 of the cognitive or behavioral threshold scores detailed in the above table. See MNDHS (2021) and MNDHS (2022b) for more information on scoring for cognitive and behavioral needs.

Table 7: MnCHOICES Activities of Daily Living (ADLs) and Critical ADL Threshold Scores (2015-2025)

ADL	Critical ADL?	Threshold	Definition of minimum threshold score
Dressing	No	Score 2 or greater	Needs some help from another person to put clothes on
Grooming	No	Score 2 or greater	Needs and gets daily help from another person to perform grooming activities
Bathing	No	Score 4 or greater	Needs and gets help washing and drying body
Eating	No	Score 2 or greater	Needs and gets help cutting food, buttering bread or arranging food
Walking	No	Score 2 or greater	Needs help from one person to walk
Bed mobility/positioning	Yes	Score 2 or greater	Always needs and gets help to sit up
Transferring	Yes	Score 2 or greater	Needs one other person to help get in and out of a bed or chair
Toileting	Yes	Score 1 or greater	Needs some help to get to and on the toilet but does not have "accidents"

Source: MHCA (n.d.), MNDHS (2022b), MNDHS (2025a)
Notes: An applicant can meet a nursing facility level of care (NFLOC) by either meeting at least 4 ADL thresholds, or 1 "critical" ADL (bed mobility/positioning, transferring, or toileting) threshold. See MNDHS (2022b) for more information on ADL point scoring.

Table 8: MnCHOICES Clinical Monitoring, Living Arrangement, and Risk Threshold Scores (2015-2025)

Item	Threshold Score and Definition of Threshold
Clinical Monitoring at least once every 24 hours	Score 1 or greater —requires 1-2 shifts of monitoring per day
Living Arrangement (must have 1 of the following)	Will live alone
	Will remain homeless
	Requires a shared living environment and support must be/continue to be available from others to mitigate risk
	Requires a shared living environment that is necessary for housing stability
Risk (at least 1 of the following)	Score 3 —at least 1 fall in the past 12 months that resulted in a fracture
	Score 2 or 3 on Vision —(2) difficulty seeing environmental objects, with or without correction or (3) does not have useful vision, even with correction
	Score 2 or 3 on Hearing —has (2) difficulty understanding speech in most situations, even with corrective aids, hears and responds to loud intense sounds, with or without corrective aids, or (3) does not have useful hearing, even with corrective aids
	True —Person is at risk of self-neglect
	True —Person is at risk of exploitation

Source: MNDHS (2025a)

Notes: Applicants must meet the clinical monitoring threshold score detailed in the above table if they do not met the threshold criteria for cognitive/behavioral needs (Table 6) or activities of daily living (Table 7). If they do not meet the clinical monitoring threshold, they must meet 1 of the living arrangement and risk threshold scores detailed in the above table. For living arrangement and risk, the applicant must fall into 1 of the listed iving arrangement categories and meet the threshold score for at least 1 of the listed risk criteria.

Box 5: MnCHOICES Assessment Domains (2015-2024)

The MnCHOICES assessment includes multiple sections (called "domains"):

1. Assessment information: e.g., date and reason for referral
2. Personal information: e.g., name, address, demographics
3. Assessment information: e.g., referral source, applicant's representative (if applicable)
4. Everyday life: e.g., instrumental activities of dailing living (IADLs), such as ability to use the telephone, manage shopping, prepare meals
5. Relationships and community connections: e.g., individual life preferences, future plans
6. Health: e.g., health self-report, current medications, health concerns, treatments, therapies
7. Functional assessment: e.g., ADLs, communication, orientation, behavior
8. Emotional and mental health: e.g., emotional status, mental status including memory test

Source: MNDHS (2014b)

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Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Activities of Daily Living (ADLs): Tasks performed on a daily basis that are considered necessary to live independently, including bathing or showering, dressing, toileting, eating, and transferring (mobility).

Adult Day Health Care (ADHC): A community-based long-term care benefit that provides comprehensive health care services in a congregate day setting. Services include nursing, case management, clinical management, medical, diagnostic, social, rehabilitative, recreational and personal care services on a routine or daily basis. Services are provided according to the assessed needs of the beneficiary.

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act (ACA) made a number of changes to Medicaid, most notably is the expansion of eligibility to adults with incomes up to 133 percent of the federal poverty level (FPL). Originally a requirement, the June 2012 Supreme Court ruling in National Federation of Independent Business v. Sebelius effectively made the Medicaid expansion an option. To date, over three-quarters of states have opted to expand.

Aid to Families with Dependent Children (AFDC): Public assistance program provided to low-income families with dependent children. This program was replaced the Minnesota Family Investment Program (MFIP) following changes to federal regulations in 1996. Until 1997, individuals may qualify for Medical Assistance (Medicaid) if their semiannual income did not exceed 120 percent of the AFDC income standard. From 1998-2000, individuals may qualify for Medical Assistance if their monthly income does not exceed 133 and one-third percent of the AFDC income standard. See Box 3 for more information.

Community Access for Disability Inclusion: Home and community-based services (HCBS) program for disabled children and adults under age 65 in need of a nursing facility level of care (NFLOC).

Community Alternative Care: Home and community-based services (HCBS) program for disabled children and adults under age 65 with a chronic illness in need of a hospital level of care. Applicants must also have a Community Supports Plan.

Community First Services and Supports (CFSS): Minnesota state plan home and community-based services program launched in 2024 for disabled or older adults that meet a nursing facility level of care. CFCO enrollees have a variety of services available to them, such as case management. This program replaced PCA services and the Consumer Support Grants program (CSG) in October 2024.

Community Spouse Resource Allowance (CSRA): Amount of countable assets a spouse residing in the community can retain if their spouse is institutionalized or requires home and community-based long-term care.

Consumer-directed: Care delivery option that allow Minnesota long-term care beneficiaries to choose, manage, and direct attendants of their choice to provide personal care, homemaker, and supportive home care aide services. From 2004, Elderly Program participants are permitted to receive consumer-directed PCA services. For Elderly Program participants, this is also referred to as Consumer-Directed Community Supports (CDCS).

Deficit Reduction Act of 2005: Federal legislation that established home equity limits and increased the look back period for all assets. Minnesota implemented a home equity limit of $500,000 beginning in 2006. From 2011, this amount increased annually with inflation. From 2006, the look back period is 60 months for all assets.

Early roll out: Following passage of the Affordable Care Act (ACA), states were not able to implement full Medicaid expansion until 2014. Minnesota opted to implement early roll out of Medicaid expansion in 2011, creating eligibility track 2c (ACA expansion adults) to provide care to adults age 19-64 with incomes up to 75 percent of the Federal Poverty Level (FPL). This income limit increases to 138 percent of the FPL in 2014 when Minnesota implements full Medicaid expansion.

Elderly Program: Minnesota home and community-based services program older adults that meet a nursing facility level of care. Elderly Program enrollees have a variety of services available to them, such as case management. Some services provided under the Elderly Program can be accessed using a consumer directed cummunity supports (CDCS) option.

Eligibility Track 1b. 209(b) States: The Social Security Act provides states the authority to apply more restrictive eligibility criteria than are used by the Supplemental Security Income (SSI) program. States that elect this option are called 209(b) states. Because eligibility for SSI does not guarantee Medicaid eligibility in a 209(b) state, these states do not cover the mandatory SSI Beneficiaries

group. Instead, 209(b) states can impose more restrictive criteria through the mandatory 209(b) group. A person receiving SSI can still be eligible for Medicaid in the mandatory 209(b) group, but that person must also meet the more restrictive eligibility requirements imposed by the state

Eligibility Track 2a. Institutional Rules: Optional coverage group under Medicaid that allows for expanded income limits, up to 300 percent of the federal poverty level, for individuals that are in an institution or who medically qualify for placement in an institution and are instead receiving home and community-based services (HCBS). Federal terminology separates the institutional and HCBS populations into two coverage groups: Individuals receiving HCBS under Institutional Rules, and Institutional Individuals Eligible under a Special Income Level. This is because some states do not extend this income limit to both coverage groups. For ease, we have combined the two groups under a single track, as regardless of whether it applies only to institutional care or extends to HCBS, the eligibility track uses institutional standards, e.g., institutional income/asset limits including spousal impoverishment disregards, as well as dependence requirements (NFLOC). It will be clearly noted in policy documents when a state does not extend this income limit to both populations.

Eligibility Track 2c. Affordable Care Act (ACA) Expansion Adults: Optional coverage group under Medicaid that allows for expanded income and asset limits for individuals ages 19-64 who are ineligible for Medicaid through any other group. States that choose to cover this group may cover adults up to 138 percent of the federal poverty level. There is no asset test for this population.

Eligibility Track 3a. Medically Needy Aged, Blind, or Disabled: Optional coverage group under Medicaid for aged, blind, or disabled individuals who would qualify for Medicaid under a different track if not for excess income. This track allows these applicants to "spend down" their excess income on medical bills and other related expenses in order to become eligible for coverage.

Eligibility Tracks: Requirements for an individual to qualify for Medicaid and start receiving long-term care benefits. An individual must satisfy only one eligibility track to qualify for Medicaid.

Estate Recovery: State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age. Minnesota did not limit recovery to the federally required minimum services and sought recovery of payments for all medical assistance received until 2016, when they changed their policy to only seek the federal minimums (e.g., nursing facility care, HCBS).

Federal Medical Assistance Percentage (FMAP): The percentage of Medicaid payments that the federal government pays as a share of both federal and state government payments for Medicaid services. The FMAP is computed from a formula that takes into account the average per capita income for each State relative to the national average. The minimum FMAP is 50 percent. The standard FMAP applies to most Medicaid spending on benefits, while the administrative rate nationwide is 50 percent with exceptions for some administrative activities such as training and compensation of skilled professionals (75 percent) and preadmission screening and resident review (75 percent)

Federal Poverty Level (FPL): Poverty threshold established by the Department of Health and Human Services (HHS) for administrative purposes, such as determining financial eligibility for federal programs. The Federal Poverty Level (FPL) is determined annually for different household sizes and financial eligibility for a program is generally a percentage of the FPL (e.g., 100 percent of the FPL), meaning households with annual/monthly income at or below 100 percent of the FPL would qualify based on financial eligibility.

Fee-for-service (FFS): A health care delivery system where providers are paid for each service performed.

Hardship waiver: Parents of adult recipients, adult children, or siblings of recipients of PCA services are permitted to serve as personal care assistants only if they meet certain hardship criteria. If the relative does at least 1 of the following in order to provide personal care to the recipient, they qualify for a hardship waiver: (1) resigns from a part-time or full-time job, (2) goes from a full-time to a part-time job with less compensation, (3) takes a leave of absence without pay, (4) incurs substantial expenses by providing personal care, or (5) because of labor conditions, special language needs, or intermittent hours of care needed, the relative is needed in order to provide an adequate number of qualified personal care assistants to meet the medical needs of the recipient. See Minn. Stat. § 256B.0627 (1997) for more information.

Home Health Aide Services: Home health aides assist with personal care as well as some semi-skilled tasks, such as observing vital signs, administering medication under the direction of a nurse, and more.

Home Health Services: Medicaid health benefit program that provides services in the patient's home to promote, maintain, or restore health or lessen the effects of illness and disability. Services may include part-time or intermittent nursing care, speech, physical and

occupational therapies, and home health aide services (personal care and semi-skilled tasks such as ostomy care). This service also includes medical equipment and supplies if medically necessary.

Home-and Community-Based Services (HCBS): Services designed to assist individuals in a home or community setting, such as an adult day center. HCBS are often designed to enable people to stay in their homes in lieu of nursing home admission.

Instrumental Activities of Daily Living (IADLs): Tasks related to independent living including preparing meals, managing money, shopping for groceries, performing housework, and using a telephone.

Long-Term Care Consultation (LTCC): The LTCC is the level of care evaluation used to determine nursing facility level of care (NFLOC) for applicants to nursing facilities and the Elderly program. Prior to 2001, this was called the Preadmission Screening (PAS).

Mandatory Categorically Needy: An eligibility track that states are required to cover under Medicaid. This track encompasses several categorical groups, including individuals receiving SSI, pregnant women, and some children.

Medicaid State Plan: Every state has a Medicaid State Plan, a comprehensive document that outlines the amount, scope, and duration of all services offered under the State's standard benefit package. In Minnesota, the state plan is also referred to as Medical Assistance(MA). All beneficiaries may receive all services in the standard benefit package (e.g., personal care, home health), however, benefit programs may have varying eligibility criteria (e.g., level of dependence). If eligible, some beneficiaries may enroll in an HCBS program. HCBS program enrollees may receive all state plan benefits as well as additional services under the program. If a beneficiary is enrolled in managed care, they may receive all state plan benefits through their managed care plan and may receive additional benefits as available.

Medically necessary: As defined by the U.S. Department of Health and Human Services, medically necessary services are health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. This is usually the dependence threshold that must be met to receive a Medicaid benefit. However, the exact dependence characteristics needed to meet this threshold vary by state, although it usually is met through a physician's order for services.

Medically Needy Income Limit (MNIL): The income standard that a Medicaid applicant must spend-down to meet if they are seeking Medicaid eligibility through eligibility track 3a (Medically needy aged, blind, or disabled). Typically, this standard is very low.

Medically Needy: A group states can elect to insure through Medicaid that would otherwise qualify for Medicaid through a categorically needy pathway if not for their income or assets (i.e., above SSI limits but below state determined limits for income or assets). This pathway for qualifying for Medicaid is a optional pathway.

Minimum Data Set (MDS): A federally mandated tool for implementing standardized assessment and for facilitating care management in nursing homes.

Minnesota Department of Human Services (MDHS): MDHS is Minnesota's single state agency that administers the state Medicaid Program.

Minnesota Family Investment Program (MFIP): Public assistance program provided to low-income families with dependent children. This program replaced the Aid to Families with Dependent Children (AFDC) in 1996, following changes to federal regulations. Until 1997, adults with disabilities or aged 65 or older may qualify for Medical Assistance (Medicaid) if their semiannual income does not exceed 120 percent of the AFDC income standard. From 1998-2000, individuals may qualify for Medical Assistance if their monthly income dos not exceed 133 and one-third percent of the MFIP (previously AFDC) income standard. See Box 3 for more information.

Minnesota Health Status Assessment (HSA): The Minnesota Health Status Assessment (HSA) is used to evaluate an applicant's need for Personal Care Assistance (PCA) prior to the implementation of MnCHOICES in 2015.

MnCHOICES: Level of care assessment tool implemented statewide in Minnesota beginning in 2015. This assessment tool combined the Developmental Disabilities Screening, LTC Consultation, and Personal Care Assistance Assessment.

Monthly Maintenance Needs Allowance (MMNA): Amount of countable income for a beneficiary's spouse residing in the community if the beneficiary is institutionalized or requires home and community-based long-term care.

Nursing facility care: Residential care that typically provides skilled nursing or medical care and related services, rehabilitation needed due to injury, disability, or illness, and health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition.

Nursing facility level of care (NFLOC): Level of care comparable to what an individual would receive in a nursing facility. This is often the minimum level of dependence required for long-term care programs.

Optional Categorically Needy: An eligibility track that states may opt in to cover. This track encompasses several groups, including aged and disabled individuals not receiving SSI, some individuals receiving long-term care, and more.

Other populations: The Gateway Policy Explorer Long-Term Care Series is primarily focused on individuals most likely to require long-term care, such as older adults or disabled individuals. There are additional eligibility tracks one may use to qualify for Medicaid that are out-of-scope for this Series. Some of these include pregnant women, children, and families with children.

Personal Care Assistance (PCA): Long-term care program that provides personal care services to help seniors and people with disabilities live independently in the community. Covered services are provided both in the recipient's home and in the community.

Personal Care Assistance Assessment: One component of MnCHOICES. Prior to 2015, this assessment was used independently to evaluate an applicant's need for personal care assistance.

PCA Choice: Consumer-directed service delivery option for the Personal Care Assistance (PCA) program available from 2000 which assigns responsibility for employment-related activites like recruiting, hiring, training, supervising, scheduling, and arranging backup workers for the personal care assistant they hire. In the traditional PCA program, the personal care agency is responsible for the activities listed above.

Personal Needs Allowance: Income that is exempt from contribution to nursing home cost that may be spent on any personal item by institutionalized beneficiaries.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996: Federal legislation that restricted most legal immigrants entering the United States after August 22, 1996, from receiving federally funded Medicaid or Supplemental Security Income (SSI) for at least five years after immigration or until they attain citizenship.

Preadmission Screening: The Preadmission Screening was used to determine nursing facility level of care (NFLOC) for Medical Assistance (Medicaid) applicants and included the cognitive Level I and II tests that are part of the PASRR, defined below. In 2001, this was renamed the Long-term Care Consultation (LTCC).

Preadmission Screening and Resident Review (PASRR): A federally required assessment for nursing facility applicants to ensure that individuals are not inappropriately placed in nursing homes for long term care. The initial Level I assessment screens for mental illnesses or other related conditions. If the Level I assessment indicates that the applicant has a mental illness or related condition, they will be directed to a Level II assessment and alternative residential care.

Prior authorization: An approval that is sometimes required before a service may be provided. Specifically, prior authorization is a determination by a utilization review entity that a covered service has been reviewed and, based on the information provided, satisfies the utilization review entity's requirements for medical necessity and appropriateness and that payment will be made for that health care service.

PRUCOL: An immigration status where Immigration and Naturalization Services knows of and permits the individual's presence in the country and does not contemplate enforcing their departure. Oftentimes, this status is for refugees or parolees.

Resident Assessment Instrument (RAI): Tool used to document functional capacity assessments of nursing facility residents

Skilled Nursing Services: Skilled nursing care consists of those services that must, under State law, be performed by or under the supervision of a licensed or certified nurse. These services include injections, tube feedings, catheter changes, observation and assessment of a patient's conditions, and more.

Social Security Administration (SSA): United States government agency that administers public assistance programs covering disability, retirement, and survivors' benefits. The SSA administers Supplemental Security Income (SSI) payments.

Social Security Disability Insurance (SSDI): Social Security Disability Insurance is a payroll tax-funded federal insurance program of the United States government. It is managed by the Social Security Administration and designed to provide monthly benefits to people who have a medically determinable disability that restricts their ability to be employed.

Spend Down: 209(b) states are required to allow individuals aged 65 and older, or who have blindness or a disability, to spend down

their income to qualify for Medicaid. They can do this either by offering eligibility track 3a. for medically needy individuals, or by allowing individuals to spend down their income by incurring healthcare costs or preapproved deductions (e.g., state supplementary payments, spousal support payments) to meet the state's elegibility track 1b. mandatory coverage group income standard. Minnesota allows individuals to spend down to the track 1b. income standard, and since 2001 the spend down threshold has gradually increased as detailed in Chapter 2, Chapter 3 and Box 1.

State Supplemental Payment (SSP): Small supplement to recipients of federal Supplemental Security Income (SSI) and some non-SSI recipients who are low-income persons with disabilities and older adults with limited resources to pay their living expenses.

Supplemental Nutritional Assistance Program (SNAP): Federal nutrition assistance program that provides benefits to eligible low-income individuals and families via an Electronic Benefits Transfer card. This card can be used like a debit card to purchase eligible food in authorized retail food stores.

Supplemental Security Income (SSI): The U.S. cash assistance program for aged, blind, and disabled persons of limited means.

Notes

This section reports notes from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

1. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep a Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 1992, the minimum MMNA in Minnesota was $984.20 per month, and the maximum was $1,718. This standard increases annually with inflation. See Table 3 for historical MMNAs.
2. Eligibility track 3a (Medically needy aged, blind, or disabled) requires applicants to "spend down" their income to a specified limit. During this policy period, individuals were allowed to spend down to the same income limit as eligibility track 1b (209 (b) States).
3. Spousal considerations for assets: The community spouse is also able to keep 50% of the couple's countable assets with a minimum of $13,740 and a maximum of $68,700 in 1992. This is referred to as the Community Spouse Resource Allowance (CSRA). Countable assets/property are real and personal property that are counted to determine eligibility. See Table 3 for historical CSRAs.
4. The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application.
5. Lawfully permanent residents and PRUCOL (i.e., Immigration and Naturalization Services knows of and permits their presence in the country and does not contemplate enforcing their departure, oftentimes refugees or parolees).
6. Applicants must meet strict requirements established by the Social Security Administration in order to qualify for SSI through a disability or blindness. See SSA (2023d) for more information on these requirements.
7. Authors have not been able to verify all services provided by the Elderly Program prior to 2001. Home care services including homemaker, home health aide, and personal care services have been confirmed, however, more services may have been offered to beneficiaries during this policy period that are not listed on available sources. See HHS (1992) for more information.
8. From 2004, the Elderly Program offers a consumer-directed service delivery option for multiple services including extended personal care services, day services, caregiver training, environmental adaptations (home modification), and supplies and equipment. This service delivery option is called "Consumer-Directed Community Supports (CDCS)." See MNDHS (2004) for more information.
9. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep a Monthly Maintenance Needs Allowance (MMNA) and can

allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2001, the minimum MMNA in Minnesota was $1,406.25 per month, and the maximum was $2,175. This standard increases annually with inflation. See Table 3 for historical MMNAs.

10. Spousal considerations for assets: The community spouse is also able to keep 50% of the couple's countable assets with a minimum of $17,400 and a maximum of $87,000 in 2001. This is referred to as the Community Spouse Resource Allowance (CSRA). Countable assets/property are real and personal property that are counted to determine eligibility. See Table 3 for historical CSRAs.
11. The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application. From 2006, Minnesota increased the look back period for asset transfers from 36 months (60 months for a trust) to 60 months for all assets.
12. Prior to 2001, applicants to Medicaid with income above the eligibility track 1b (209(b) States) standard were permitted to "spend down" their income to the 209(b) States income standard. Starting in 2001, the spend down thresholds were no longer equivalent to the income limit set for eligibility track 1b.
13. Chore services are covered by the Elderly Program from at least 2003, however the date these services were added has not been confirmed. Earlier sources indicate that chore services were not covered in 2001. See MNDHS (2001a) and MNDHS (2003b) for more information.
14. The Affordable Care Act (ACA) provides 100% matching funds for newly eligible adults with incomes up to 138% of the Federal Poverty Level between 2014-2016, gradually declining to 90% in 2020 where it remains indefinitely (ASPE, 2014).
15. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) or enrolled in the Elderly Program and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep a Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2014, the minimum MMNA in Minnesota was $1,938.75 per month, and the maximum was $2,931. This standard increases annually with inflation. See Table 3 for historical MMNAs.
16. Spousal considerations for assets: The community spouse is also able to keep 50% of the couple's countable assets with a minimum of $23,448 and a maximum of $117,240 in 2014. This is referred to as the Community Spouse Resource Allowance (CSRA). Countable assets/property are real and personal property that are counted to determine eligibility. See Table 3 for historical CSRAs.
17. The look back period is 60 months prior to the date of application for all assets.

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- 1.0 (May 2025): First version.