

General Assistance Medical Care: Unique Program Serves a Unique Population

*GAMC serves
Minnesota adults
living in extreme
poverty*

General Assistance Medical Care Targets a Challenging Population

General Assistance Medical Care (GAMC) was initially established in 1975 to provide health care coverage for very low-income adults without dependent children. It is a state-funded program that fills in the gap for adults, aged 21 to 64, who do not qualify for other public health care programs. In 2008, an average of 28,000 Minnesotans were enrolled in GAMC each month, or 70,000 over the course of the year. More than 40 percent of enrollees are people of color.

To qualify for GAMC, an individual must have an income below 75 percent of the federal poverty guideline, less than \$677 a month.¹ The Department of Human Services, however, reports that in 2008, more than 90 percent of GAMC enrollees had incomes below 25 percent of federal poverty guidelines (about \$203 a month).²

In addition to being extremely low-income, these individuals face other significant challenges. About one out of every four GAMC enrollees is homeless, 30 percent have one or more chronic medical conditions and 60 percent suffer from a mental health problem and/or chemical dependency.³

GAMC was designed with several unique features that serve the special needs of this population.

- Considering their extremely low incomes, there are no premiums for GAMC. There are copayments for some services and prescription drugs, but copayments for prescriptions are capped at \$7 a month.
- GAMC eligibility starts from the date of application. This is important because many individuals that are eligible for GAMC do not apply for coverage until they are facing a health care crisis. Once an individual is approved for GAMC, coverage is retroactive to the date of application, ensuring that health care providers receive payment for health services already provided.
- GAMC has no annual limit on inpatient hospital services, which is very important for a population with significant health issues.

*Health coverage
helps stabilize lives
and reduce costs to
the community*

Access to health care that is both affordable and sufficient to cover one's health care needs is not just beneficial for the individual, it benefits the community. When people with chronic health care conditions do not get reliable care, they rely more heavily on emergency room visits to manage their day-to-day health – lengthening waits for others needing emergency services and increasing costs in the health care system for everyone. And when individuals with mental health or chemical dependency issues do not receive medications or treatment, they can place a strain on other public safety and social services and divert resources from other important community needs. GAMC, however, helps stabilize the lives of many vulnerable Minnesotans, allowing them to make positive contributions in their families and communities.

GAMC Was Eliminated During the 2009 Legislative Session

Governor's line-item veto leaves vulnerable Minnesotans with few health care options

Near the end of the 2009 Legislative Session, Governor Pawlenty signed the omnibus health and human services bill into law, but he line-item vetoed funds for GAMC, effectively eliminating the program in FY 2011 (which began July 1, 2010). The Governor followed up by making further cuts to GAMC through the unallotment process in the summer of 2009, moving up the ending date to March 31, 2010.⁴

In November 2009, Minnesota's Department of Human Services (DHS) announced that GAMC enrollees would be automatically enrolled in Transitional MinnesotaCare for a limited time. Within six months of enrolling in the transitional program, all enrollees would be required to apply for regular MinnesotaCare. MinnesotaCare was created in 1992 to provide low-cost health insurance for working Minnesotans, a very different population from GAMC enrollees. It is funded through the Health Care Access Fund, which receives revenue from health care provider taxes and premiums from enrollees in MinnesotaCare.

MinnesotaCare is not a permanent solution

Although switching GAMC enrollees to Transitional MinnesotaCare would have provided some temporary coverage, it would not be a permanent solution.

- MinnesotaCare charges premiums and does not cap copayments for prescription drugs. Although these premiums are minimal (as low as \$4 a month) and counties would have been required to pick up the cost during a transitional period of up to six months, this would be a barrier over the long term. For individuals with incomes less than \$203 a month – the income of the vast majority of GAMC recipients – paying premiums and unlimited copayments could quickly present a significant financial burden to receiving needed health care.
- MinnesotaCare has a \$10,000 yearly limit on inpatient hospital stays. This limit would have applied immediately to all GAMC enrollees being moved onto either Transitional MinnesotaCare or regular MinnesotaCare. Many GAMC recipients, however, have significant health issues and require inpatient treatment for their conditions. They would quickly exceed a \$10,000 limit.
- The automatic enrollment in Transitional MinnesotaCare only applied to individuals enrolled in GAMC on March 31, 2010. Starting on April 1, any person who would have been eligible for GAMC would have to apply for Transitional MinnesotaCare. Although GAMC offered retroactive coverage, Transitional MinnesotaCare coverage does not take effect until after the application has been processed, the first premium paid and an individual is enrolled in a managed care plan – all of which could take three to four months, during which time the person has no coverage. This would have resulted in an increase in uncompensated care for health care providers.

Health Care Access Fund cannot afford to cover costs of GAMC

There is another important reason why transferring GAMC enrollees to MinnesotaCare would not be a long-term solution. The state projected that moving GAMC recipients to MinnesotaCare would have caused the Health Care Access Fund (HCAF), which funds MinnesotaCare, to begin running a deficit in FY 2011. The general fund is required to keep the HCAF solvent through the end of FY 2011. Starting in FY 2012, however, the HCAF would

More than 92,000 adults without children could lose their health care coverage under MinnesotaCare

start showing a deficit. By the end of the FY 2012-13 biennium, the projected deficit in the HCAF would have grown to \$839 million.

Once the HCAF runs a deficit, DHS is required by law to take actions to bring the fund back into balance. Under the Governor's auto-enrollment plan, DHS officials reported that they would have stopped any new enrollments for adults without dependent children in MinnesotaCare starting July 1, 2011. DHS would also have had to disenroll 44,000 adults without children from MinnesotaCare to eliminate the HCAF's deficit – that equates to half of all childless adults who receive health care coverage through MinnesotaCare. By FY 2013, nearly all adults without dependent children would need to be disenrolled. In other words, the elimination of GAMC and auto-enrollment in MinnesotaCare could eventually have resulted in more than 92,000 childless adults losing access to health care coverage.⁵

Policymakers Agree to Revised GAMC Program

After months of negotiations and discussions with key stakeholders, in late February 2010 the House and Senate passed a temporary solution to extend coverage for GAMC recipients. The Governor, however, vetoed the bill. Some additional negotiations led to a new agreement between the Governor and legislators to preserve access to health care for these very low-income individuals. This final agreement was signed into law in late March 2010.

The new program included a temporary bridge program that essentially extended the original GAMC program through April and May 2010, at a cost of \$28 million. Payments to health care providers under this temporary fee-for-service program were at 37 percent of previous reimbursement rates (except for prescription drugs, which were maintained at previous levels).

Plan delivers GAMC through Coordinated Care Delivery Systems

Starting June 1, 2010, the bill created two "tiers" of hospitals. The first tier consists of hospitals that currently serve a substantial share of the GAMC population (about 17 hospitals). These hospitals were encouraged to develop a "coordinated care delivery system" (CCDS) to serve the GAMC population in their area. The purpose of a CCDS is to coordinate all aspects of the health care needs of enrollees, helping patients receive preventative care and avoid costly emergency services.

To create the CCDS, hospitals could negotiate contracts with local health care providers and clinics to ensure that GAMC recipients can access all necessary care. The goal of the agreement was to ensure that 80 percent of the GAMC population had access to a CCDS. GAMC recipients would be required to enroll in one of the available CCDSs (or be assigned to one) and receive all non-emergency care through that system.

Hospitals would be paid through a lump sum reimbursement determined by the hospital's recent share of GAMC expenses. Non-hospital health care providers would negotiate their reimbursement rates with the hospital implementing the coordinated care delivery system. In all, there was \$71 million available in FY 2010-11 (and \$131 million in FY 2012-13) to reimburse these coordinated care delivery systems.

Agreement creates a temporary uncompensated care pool

The second tier consists of all other hospitals, currently serving about 20 percent of the GAMC population. For the first six months (June through November 2010), these hospitals would be reimbursed for providing hospital care to GAMC enrollees out of a \$20 million uncompensated care pool. It was hoped that during the six months, these smaller hospitals would work to develop a CCDS within their area. After those initial six months, the uncompensated care pool would end, and reimbursement for GAMC services could only be obtained if a health care provider was part of a CCDS.

The total cost of the program for FY 2010-11 came to \$164 million (\$28 million for the two-month bridge program, \$71 million for the coordinated care pool, \$20 million for the uncompensated care pool and \$45 million for prescription drugs). The bill was funded through a number of sources, including transfers from the Health Care Access Fund, drug rebate money, operating reductions to the Department of Human Services, reductions in adult mental health grants to counties, and reducing special payments to hospitals serving a large share of low-income patients.

Eligibility and prescription drug benefits are preserved

New GAMC Program Approved Despite Many Concerns

Given how quickly the final GAMC compromise was developed, the full implications of this new program were not immediately known. On the positive side, the compromise agreement:

- Maintained eligibility for the people it was intended to help - very low-income adults without dependent children.
- Preserved some of the important features of the initial program, including no premiums, eligibility from the date of application and no limits on hospital coverage.
- Ensured accessible and affordable prescription drug coverage. This is extremely important because many of these individuals face significant mental health issues and chronic health conditions.
- Protected the financial integrity of the Health Care Access Fund (HCAF) in the FY 2010-11 biennium.

Providers asked to bear financial burden and risk

However, some serious concerns about the compromise agreement arose almost immediately.

For example, although eligibility for the program was maintained, it was not clear what kinds of health care services would be included. With the exception of prescription drug coverage, coordinated care delivery systems could adopt a pre-defined benefit set, or they were able to develop their own benefit set (subject to approval by the Department of Human Services). Advocates were concerned about whether benefits would actually meet the significant health needs of the GAMC population.

The program was also severely underfunded. The reimbursement rates for hospitals and other providers would only be a fraction of what they had been receiving under the original GAMC program. In the new GAMC program, the state's costs were capped, while the hospitals' costs were not. In other words, hospitals would be asked to assume a significant amount of the risk and financial responsibility for delivering GAMC services. The loss of resources could cause participating hospitals to reduce staff and cut back on services for all of their patients.

Minnesota could expand MA to cover GAMC population

This led to another significant concern – would all participants have access to a CCDS? After the bill was signed into law, it started to become clear that nearly every “first tier” hospital was going to decline to create a CCDS due to the lack of funding and the administrative challenges.

Federal Health Care Reform Offers Another Option

After the agreement between the House, Senate and Governor had been reached, Congress passed federal health care reform legislation that offered a new option for providing health care coverage for this population. The change relates to Medicaid – a federal/state health care program for low-income people. Currently, Medicaid (which is known as Medical Assistance in Minnesota) serves families with children, the elderly and those with disabilities. The federal bill extends Medicaid to cover childless adults up to 133 of federal poverty guidelines (FPG) in 2014, with the federal government picking up 100 percent of the costs for the first three years.

Several states, including Minnesota, were given the option of covering childless adults up to 133 of FPG as early as April 1, 2010. Taking advantage of this “early expansion option” would offer some important advantages over the GAMC compromise, including higher reimbursement levels for providers, a clearly defined benefit set for participants, and the federal government covering half of the costs of health care services for these individuals. Starting in 2014, the federal government would pick up and even greater percentage of the costs.

In the final days of the session, the legislature passed a bill that would have taken advantage of this opportunity to cover low-income adults without children through Medicaid. The state would have invested an additional \$188 million in state resources and drawn down close to \$1.4 billion in federal dollars for health care. The Governor vetoed the bill.

Tweaks to GAMC program will still leave many without access to health care

Access to Health Care Remains Uncertain

The Governor’s veto meant the 2010 Legislative Session ended without assuring access to health care for low-income adults without children, although the final agreement does allow Governor Pawlenty or the next governor to make the decision to take advantage of the option to cover these individuals through Medicaid by January 2011.

The final agreement between the Governor and legislature also made some modifications to the GAMC compromise, including adding an additional \$10 million to the uncompensated care pool and allowing hospitals to cap the number of individuals they will serve in the program. It is hoped that reducing the financial risk will encourage more hospitals to participate in the program, especially in Greater Minnesota. As of July, however, only four Twin Cities metro-area hospitals had opted to create a CCDS. GAMC enrollees in Greater Minnesota are advised to sign up for a CCDS in the metro area, or seek “free or low-cost care from a local community clinic.”⁶

The outcome of the 2010 Legislative Session is that thousands of vulnerable Minnesotans will not have access to the comprehensive health care they need. With many of the key problems of the GAMC compromise left unaddressed, it is likely that this will continue to be an important topic of discussion in the 2011 Legislative Session.

¹ More precisely, to qualify for GAMC, an individual must be receiving General Assistance, be a resident of Group Residential Housing, or be an individual with income below 75 percent of the federal poverty guidelines (less than \$677 a month) and meet another qualifier (such as being homeless or waiting for a disability determination from the Social Security Administration).

² Minnesota House of Representative Research Department, General Assistance Medical Care, October 2009, <http://www.house.leg.state.mn.us/hrd/pubs/gamcib.pdf>.

³ *Ibid.*

⁴ Initially, it was estimated that GAMC would end on February 28. However, DHS determined in late January that expenses in the program were below initial projections, so there was enough money to keep the program going through the end of March.

⁵ Health Care Access Commission hearing, December 16, 2009.

⁶ Department of Human Services, FAQs about CCDSs and GAMC services on or after June 1.