

General Assistance Medical Care: An Overview

General Assistance Medical Care (GAMC) is a state-funded program that pays for certain health care services for low-income Minnesota residents who are not eligible for other health care programs. Most GAMC enrollees are low-income adults between the ages of 21 and 64 who do not have dependent children. The program is administered locally by the counties, under the supervision of the Department of Human Services (DHS), and is governed by [Minnesota Statutes, section 256D.03](#).

Eligibility

To be eligible for GAMC, an individual must meet the following criteria:

- Receive General Assistance (GA) or Group Residential Housing (GRH), or meet the GAMC income and asset limits and be exempt from enrollment in MinnesotaCare (see table below)
- Not be eligible for Medical Assistance (MA)
- Be a Minnesota resident; GAMC has a 30-day durational residency requirement
- Meet other program eligibility requirements

Eligibility Group	Income Limit	Asset Limit*	Covered Services	Cost-Sharing
1. GA and GRH recipients	GA limit (\$203/month for one person; \$260 for married couple) or GRH assistance standard	GA limit (\$1,000 per assistance unit) or GRH limit (\$2,000 aged, blind, or disabled; \$1,000 all others)	All covered services	Copayments
2. GAMC full coverage	75 percent of federal poverty guidelines (FPG)	\$1,000 per household	All covered services	Copayments
3. GAMC hospital-only coverage	Greater than 75 percent but not exceeding 175 percent of FPG	\$10,000 per household of one/\$20,000 per household of two or more	Inpatient hospital services and physician services provided during inpatient stay	\$1,000 deductible for each hospitalization

* The homestead, household goods, a vehicle, and other specified items are not counted as assets.

Since September 1, 2006, certain GAMC applicants and recipients have been enrolled in MinnesotaCare as adults without children, immediately following approval of GAMC coverage. GAMC applicants and enrollees who are eligible due to receipt of GA or GRH, are awaiting a determination of disability, who do not meet the MinnesotaCare residency requirement specified, or belong to other groups are exempt from this enrollment requirement.

Covered services

GAMC covers a range of medical services for individuals with incomes not exceeding 75 percent of federal poverty guidelines (FPG). These include, but

are not limited to, physician care, hospitalization, rehabilitation, dental, medical equipment and supplies, mental health, prescription drugs, and medical transportation.

Services not covered include: home health care services, nursing home services, therapy services provided by independently enrolled providers, pregnancy and related services (GAMC enrollees who are pregnant qualify for coverage of these services under MA and/or Emergency MA), and services in an intermediate care facility for persons with mental retardation and related conditions (ICF/MR).

Covered services for enrollees with incomes greater than 75 percent but not exceeding 175 percent of FPG are limited to inpatient hospital services and physician services provided during an inpatient stay.

Cost-sharing

Enrollees with incomes at or below 75 percent of FPG are subject to the following copayments:

- \$25 for eyeglasses
- \$25 for nonemergency visits to an emergency room
- \$3 per brand-name prescription and \$1 per generic, subject to a \$12-per-month limit. Antipsychotic drugs are exempt from copayments.
- 50 percent coinsurance for basic restorative dental services

Enrollees with incomes greater than 75 percent but not exceeding 175 percent of FPG are subject to a \$1,000 deductible for each inpatient hospitalization.

Provider reimbursement

The GAMC program reimburses providers under both a fee-for-service system and a managed care system (composed of prepaid GAMC and county-based purchasing initiatives). Under the fee-for-service system, health care providers bill DHS and are reimbursed at rates specified by state law. Under managed care, prepaid health plans (or counties in the case of county-based purchasing) receive a monthly capitation payment for each enrollee. The state does not set provider reimbursement rates; these rates are instead the result of negotiation between the health care providers and the prepaid health plan or county.

Funding and expenditures

GAMC is completely state-funded; there is no federal funding. During fiscal year 2007, the state spent \$281.1 million in payments to medical providers for GAMC services.

Recipients

In fiscal year 2007, an average of 33,824 persons were eligible for GAMC services each month. As of August 2008, 16,977 GAMC recipients were enrolled in prepaid GAMC or a county-based purchasing initiative.

Application procedure

Individuals interested in applying for GAMC should contact their county human services agency.

For more information: See the House Research information brief [*General Assistance Medical Care*](#), October 2008.

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