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State of Minnesota

Department of Human Services

Human Services Building
444 Lafayette Road N
St. Paul, Minnesota 55155

March 14, 1995

Ms. Maryanne Hruby
Executive Director, LCRAR
55 State Office Building
St. Paul, Minnesota 55155

Dear Ms. Hruby:

Pursuant to Minnesota Statutes, section 14.131, enclosed is a statement of need and reasonableness relating to the proposed amendments to the Rule of the Department of Human Services governing MinnesotaCare, Minnesota Rules, parts 9506.0010 to 9506.0400.

If you have any questions on the statement of need and reasonableness, please do not hesitate to contact me at 296-7815.

Sincerely,

Martha N. O'Toole

Martha N. O'Toole
Rulemaker

Encl.

IN THE MATTER OF THE PROPOSED ADOPTION OF AMENDMENTS TO RULES OF THE DEPARTMENT OF HUMAN SERVICES GOVERNING MINNESOTACARE, MINNESOTA RULES, PARTS 9506.0010 TO 9506.0400

MINNESOTA DEPARTMENT OF HUMAN SERVICES

STATEMENT OF NEED AND REASONABLENESS

INTRODUCTION

HISTORY

In 1992 the Minnesota Legislature enacted the HealthRight Act (Laws 1992, chapter 549), establishing a program of subsidized health coverage for uninsured Minnesota residents. Subsequently named MinnesotaCare, the program is administered by the Department of Human Services.

In 1993, as part of Minnesota's ongoing program of health care reform, the legislature directed the commissioner of human services to provide health services to MinnesotaCare enrollees where possible through managed care plans (Minnesota Statutes, section 256.9363). Since 1985 the department has been providing health services to medical assistance recipients on a prepaid, capitation basis; the Prepaid Medical Assistance Project (hereafter "PMAP") was originally established in three counties and has since been expanded to eight counties. The demonstrated success of that program (see Attachment A, reports on "Minnesota Prepaid Medicaid Programs," dated April 1991 and February 1993) prompted the department and the legislature to develop a statewide prepaid capitated approach to providing and paying for health services for the MinnesotaCare population.

The eventual goal of the legislature is to integrate the state's publicly funded health care programs (MinnesotaCare, medical assistance, and general assistance medical care), and the state has applied for a federal waiver to merge MinnesotaCare and medical assistance. (See Minnesota Statutes, section 256.362, subdivision 3; Laws 1994, chapter 625, article 5, section 3.) In developing the MinnesotaCare managed care program and this rule, the department has relied heavily on its experience with PMAP. The proposed amendment is consistent with the PMAP rule (Minnesota Rules, parts 9500.1450 to 9500.1464), and applicable PMAP rule provisions have been incorporated in anticipation of future program integration.

An emergency rule governing MinnesotaCare was adopted December 28, 1992, and was replaced by a permanent rule that became effective December 12, 1994. That rule, Minnesota Rules, parts 9506.0010 to 9506.0100, deals primarily with requirements and procedures related to MinnesotaCare eligibility and enrollment. The department originally intended to include rule provisions implementing the managed care program in the proposed permanent rule. A Notice of Solicitation of Outside Information or Opinions was published June 27, 1994 at 18 S.R. 2758, seeking additional advice on providing health services to enrollees through managed care health plans. Because of the complexity of implementing managed care and in order to have a permanent rule governing eligibility and other criteria affecting enrollees in place before expiration of the emergency rule, the department decided to propose the managed care provisions as a subsequent amendment to the permanent

MinnesotaCare rule. The department expects to implement managed care for MinnesotaCare enrollees through contracts with health plans and counties in 1995.

The Advisory Committee, convened to advise the department on the permanent rule, met on May 31, 1994; July 7, 1994; and September 26, 1994 to discuss the managed care provisions. Health plans that will be responsible for implementing managed care were specifically included in the July 7 and September 26 Advisory Committee meetings. Committee members and health plan representatives provided comments and suggestions at the meetings, in writing, and in conversations with department staff, and the proposed rule does incorporate their comments and recommendations. Advisory Committee members and health plan representatives are listed on Attachment B.

SPECIFIC RULE PROVISIONS

The above-entitled rule is affirmatively presented by the Department in the following narrative in accordance with the provisions of the Minnesota Administrative Procedure Act, Minnesota Statutes, chapter 14, and the rules of the Attorney General's Office.

9506.0010 **DEFINITIONS**

Subpart 1. **Scope.** This subpart is necessary to amend the permanent rule to incorporate the rule parts constituting this amendment.

Subpart 13a. **Managed care health plan or health plan.**
This subpart is necessary to describe the type of health services entity that will provide health services to enrollees, as required under Minnesota Statutes, section 256.9363, subd. 3. This subpart is reasonable because it describes the different types of vendor organizations authorized under Minnesota Statutes, section 256.9363, subd. 1: counties, organizations, vendors, integrated service networks. Section 256.9363, subd. 1 requires the commissioner where possible to contract with organizations on a prepaid capitation basis to provide health services. Because the department's experience under PMAP demonstrates that prepaid capitation payments are an efficient and economical payment mechanism (see Attachment A), it is reasonable to comply with the statutory preference and include in the definition only prepaid capitation payments as the method the department will use to pay for health services provided by health plans.

Subpart 15a. **Nonrisk contract.**
The 1994 legislature specifically authorized the commissioner to allow health plans to arrange for inpatient hospital services on either a risk or nonrisk basis (Laws 1994, chapter 625, article 8, section 60; codified at Minnesota Statutes, section 256.9363, subd. 9). This definition is necessary to distinguish the two types of contractual arrangements between the department and health plans for payment of inpatient hospital costs for enrollees. The definition is reasonable because it describes arrangements wherein the health plan is not at financial risk for changes in the cost of providing inpatient hospital services. It is similar to the definition of "nonrisk" in federal regulations governing contracts to provide health services to medical assistance recipients (42 C.F.R. section 434.2).

Subpart 17a. **Participating provider.**
This subpart is necessary to identify providers of health services who are part of a managed care plan provider network, as distinguished from other health services providers, because enrollees in managed care plans must receive their health care services from health care providers who are part of the managed care plan provider network. (Minnesota Statutes, section 256.9363

subd. 3). This definition is reasonable because it is the same definition used in PMAP (part 9500.1451, subp.14e), and experience under PMAP indicates no reason to change the definition.

Subpart 18a. **Risk contract.**
This definition is necessary because Minnesota Statutes, section 256.9363, subd. 9 authorizes the commissioner to allow health plans to arrange for inpatient hospital services on a risk or nonrisk basis. This definition is reasonable because it describes the type of contract under which the health plan is at financial risk for the cost of providing inpatient hospital services. Under a risk contract the department prepays for inpatient hospital services as part of the capitation payment to the health plan, and the health plan assumes responsibility for (bears the risk of) payment of inpatient hospital services for enrollees. This definition is similar to the definition of "risk" in federal regulations governing contracts for health services for medical assistance recipients (42 C.F.R. section 434.2).

9506.0050 COORDINATION OF MINNESOTACARE AND MEDICAL ASSISTANCE.

Subp. 5. **Continuing health plan participation.**
This subpart is necessary to ensure that persons consulting the rule are aware that an enrollee in a managed care health plan who is found eligible for medical assistance or general assistance medical care will remain enrolled in that same health plan if the health plan has a contract to provide health services to medical assistance or general assistance medical care recipients in that area. This subpart is reasonable because mandated under Minnesota Statutes, section 256.9363, subdivision 5.

9506.0070 APPEALS.

Subpart 3. **Health plan complaint and appeal procedure.**
Minnesota Statutes, section 256.9363, subd. 7, clause (4) requires health plans to establish an enrollee grievance process "as required by the commissioner and set forth in the contract...." This subpart is necessary to assure that persons consulting the rule are aware that health plans must have an internal complaint process and that exhausting that internal forum is not a necessary prerequisite to pursuing a state appeal. This is reasonable to assure enrollees are knowledgeable about pursuing a problem with their health plan as well as their state appeal rights and procedures. Because health plans are familiar with this procedure under PMAP, a process that is in place and working well, it is reasonable to incorporate the PMAP rule procedure (part 9500.1463) rather than establish a separate process.

9506.0090 COPAYMENTS AND ELIGIBLE PROVIDER REIMBURSEMENT.

Subpart 1. **Copayments required.**
This amendment is necessary to assure that providers, health plans, and enrollees are aware that under Minnesota Statutes, section 256.9363, subd. 6 adult enrollees in health plans remain responsible for copayments and must pay copayments to the health plan or its participating providers. It is reasonable, for rule brevity and comprehensiveness, to simply cite the statutory sections that establish copayment amounts and responsibilities. It is reasonable to direct adult enrollees who are not eligible for medical assistance to pay inpatient hospital charges over the annual benefit limit directly to the hospital; health plan representatives reported at an Advisory Committee meeting that it is customary practice to collect health services copayments at the point of service. The department anticipates that this situation (an adult enrollee with hospital costs exceeding $10,000 who is ineligible for medical assistance) will occur very rarely.

Subpart 2. **Reimbursement for covered health services.**
This amendment is necessary to clarify that payments to health plans under MinnesotaCare are not subject to the statutory reimbursement directive in Minnesota Statutes, section 256.9362, which apply to services provided on a fee-for-service basis. (Section 256.9362, subdivision 1 mandates payments to providers under sections 256.9351 to 256.9362 at the same rates established for medical assistance. Subdivisions 2 and 3 authorize special rates for certain providers and inpatient hospital services). A separate statutory section deals specifically with payment for services provided through managed care contracts, section 256.9363. This amendment is reasonable because payments to health plans will be the preferred payment methodology under section 256.9363, subd. 9., that is, actuarily-determined per capita, pre-paid rates.

Subpart 4. **Commissioner's access to enrollee medical records.**
This amendment is necessary to apply to managed care health plans the commissioner's responsibility to administer the MinnesotaCare program in a manner consistent with the goals of managed care under Minnesota Statutes, section 256.9363, subdivision 1: to select vendors who can provide the most economical care consistent with high medical standards, control utilization and ensure necessary services are provided. This amendment is reasonable because Minnesota Statutes, section 256.9363, subd. 7, clause [8] requires managed care plans to provide the commissioner data required for assessing enrollee satisfaction, quality of care, cost, and utilization of services.

Part 9506.0200 PREPAID MINNESOTACARE PROGRAM; GENERAL.

Subpart 1. **Designation of geographic area.**
This subpart is necessary to implement in rule the commissioner's mandate under Minnesota Statutes, section 256.9363, subdivisions 2 and 3 to designate geographic areas within which MinnesotaCare enrollees residing in those areas must receive their health services through managed care plans.

Item A. It is reasonable, for the information of persons consulting the rule and as requested by the Advisory Committee, to list factors the commissioner will consider in designating geographic areas. The factors listed -- area and population size, accessibility, and availability of health plans -- have been used by the department in designating geographic areas for PMAP. Because it is necessary to allow flexibility to respond to unanticipated future circumstances, it is reasonable to additionally provide for any considerations that promote the statutory goal of managed care, i.e., "provide the most economical care consistent with high medical standards...." (See Minnesota Statutes, section 256.9363, subd. 1).

Item B. It is reasonable to clarify that the commissioner may establish either a multiple health plan model or single health plan model in a particular area. Similar health care delivery systems are currently in operation under PMAP (part 9500.1453). Particularly in rural areas, which are unlikely to support more than one health plan, the optimal form of managed care will be the single health plan model. Minnesota Statutes, section 256.9363, subd. 1 requires the commissioner to select vendors who can provide the most economical care consistent with high medical standards; it is therefore reasonable to allow the commissioner discretion in selecting the most appropriate model in a particular geographic area.

Subitem (1). This definition is reasonable because it describes the system in geographic areas where more than one vendor organization will be able to provide health services, both financially and in terms of capability to

provide required covered services and an adequate network of providers and clinics. In these areas, enrollees will have a choice of health plan organizations and will receive their services from a provider participating in their chosen health plan. This model has been used in PMAP and a similar definition is in the PMAP rule (part 9500.1451, subp. 14a).

Subitem (2) is reasonable because it describes the health services delivery system in geographic areas where participation by more than one health plan is not feasible, financially or because of lack of service resources. In these areas, a single health plan or a county will contract with area providers, and MinnesotaCare enrollees will receive health services from participating providers. A similar model has been used in Itasca county under PMAP (see part 9500.1451, subp 14k, defining "primary care provider health plan model").

Item C. Minnesota Statutes, section 256.9363, subd. 1 requires the commissioner to select vendors who can provide the most economical care consistent with high medical standards in order to contain costs. Therefore it is reasonable to clarify in rule that the commissioner may limit the number of health plan contracts within a designated geographic area, in order to comply with the statutory goal. The commissioner has had authority to limit health plan contracts under PMAP (part 9500.1460, subp. 10). It is reasonable to list, for the information of persons consulting the rule, factors that will enter into the commissioner's decision whether to limit health plan contracts. These considerations have been used by the department in administering PMAP. The Advisory Committee requested that the criteria be included and no member has commented negatively on the list.

Subp. 2. **Contracts.**
This subpart is necessary to set forth in rule certain parameters governing the department's contracts with health plans.

Item A is reasonable because it is consistent with Minnesota Statutes, section 256.9363, subdivision 5, which requires contracts between the department and managed care plans to include MinnesotaCare and medical assistance and authorizes inclusion of general assistance medical care (GAMC).

Requiring inclusion of GAMC is consistent with Minnesota Rules, parts 9505.5200 to 9505.5240 ("Rule 101"), which requires vendors and health maintenance organizations to participate in all three programs as a condition of participation in public employee health insurance programs. Rule 101 establishes criteria under which health plans are required to submit bids, in response to department requests for proposals, to provide health services to recipients of medical assistance, general assistance medical care, and MinnesotaCare. Rule 101 also specifies certain conditions under which no response is required from a health plan. This subpart is consistent with Rule 101 in that, if a health plan is required to submit a response and a contract is eventually executed between the department and the health plan, recipients of all three programs must be covered under the contract.

This requirement is also consistent with the goal of the legislature to eventually integrate the three programs.

Item B is reasonable because it is consistent with Minnesota Statutes, section 256.9363, subd. 4 which requires contracts between the department and prepaid health plans or integrated service networks to comply with U.S.C., title 42, section 1396a(a)(23)(B), which requires open access to family planning services.

Item C is reasonable because the commissioner must have the flexibility to terminate a health plan contract where necessary. This is reasonable to achieve the statutory goal of containing costs by selecting vendors able to provide economical care consistent with high medical standards (Minnesota

Statutes, section 256.9363, subd. 1). Ninety days notice before termination allows sufficient time for health plans to wind up business under the contract and provide enrollees the 60 days notice required under part 9506.0400, subpart 14.

Subpart 3. **Multiple health plan model areas.**
This subpart is necessary to establish in rule the procedure by which MinnesotaCare applicants and enrollees may choose or be assigned to a managed care health plan. This subpart is necessary as well to assure an efficient as well as timely process for beginning the provision of health services through managed care.

It is reasonable to clarify that the process will begin after execution of contracts between the department and health plans, because signing the contracts will indicate MinnesotaCare managed care is operational. The department will either directly enroll MinnesotaCare enrollees in managed care or contract with an outside entity to manage the process. Other states, e.g. Massachusetts and Oregon, have used enrollment contractors to handle managed care enrollments. This subpart is reasonable also because the procedures under items A to C are essentially the same enrollment procedures used successfully under PMAP (part 9505.1453, subp. 2 and 3).

Item A. It is reasonable to state that applicants and enrollees will be provided written notice of available health plan options and when selection of a plan and participation must occur. This item assures applicants and enrollees adequate opportunity to make an informed choice, i.e. sufficient time to study the written information about available health plans and to notify the department in writing of their choice. This procedure, which has worked well under PMAP, will assure an efficient and problem-free process for health plans, enrollees and the department.

Item B. Minnesota Statutes, section 256.9363, subd. 3 requires enrollees in a designated geographic area to participate in managed care. It is reasonable to state that enrollees and applicants who fail to make a choice will be assigned to a health plan, to assure these persons are covered in compliance with the statute (i.e. in a managed care plan).

Item C. It is reasonable to state in rule that enrollees will be notified of their assigned health plan before participation begins, to reduce confusion or misunderstanding. This item was requested by the Advisory Committee.

Subpart 4. **Single health plan model areas.**
This subpart is necessary to establish in rule the procedure by which MinnesotaCare applicants and enrollees will begin participation in managed care in a geographic area with a single managed care health plan. This subpart is necessary as well to assure an efficient and timely process for beginning the provision of health services through managed care in those areas. This subpart is reasonable also because it is essentially the same enrollment procedure used successfully under the PMAP rule (part 9505.1453, subp. 2 and 3).

Item A. It is reasonable to provide assurance that enrollees will receive written information about available primary care providers and when health plan participation begins, for the reasons discussed in subpart 2.

Item B. It is reasonable to state in rule that the health plan may require enrollees to select a primary care provider, consistent with Minnesota Statutes, section 256.9363, subdivision 3. It is reasonable to allow health plans to assign a primary care provider to enrollees who fail to designate one when required, because Minnesota Statutes, section 256.9363, subd. 3. authorizes managed care plans to require a designation.

C. It is reasonable to require health plans to notify enrollees of their assigned provider before the enrollee is to begin participation. Written notice will reduce confusion or misunderstanding, and health plan representatives reported that the process is very quick. This item was requested by the Advisory Committee.

Subpart 5. **Changing health plan or primary care provider.**
This subpart is necessary to provide in rule a process for enrollees to change health plan or primary care provider, as authorized under Minnesota Statutes, section 256.9363, subd. 3.

Item A. In areas with multiple health plans, it is reasonable to authorize enrollees to change health plan once within the first year of initial enrollment, and subsequently at the time of the annual open enrollment period, as required under Minnesota Statutes, section 256.9363, subd. 3. This practice is common in the health insurance industry.

Item B authorizes a change of primary care provider in areas with a single health plan under the same circumstances as in item A. It is reasonable to make this item consistent with change options in multiple health plan areas to assure similar treatment of enrollees regardless of which model is operative in their geographic area. This item is consistent with Minnesota Statutes, section 256.9363, subd. 3, which requires that enrollees be permitted to change their designated primary care provider upon request to the managed care plan but allows the managed care plan to limit requests to once annually. It is reasonable to require health plans to notify enrollees of change options, to ensure enrollees are fully informed of their rights under statute and rule. This item is also consistent with PMAP (part 9500.1453, subp. 6).

Item C is reasonable because the enrollees' situation (participation in a new health plan because the contract between the department and their former health plan has been terminated) is similar to initial health plan participation and occurs without enrollee input or control. This option is allowed under the PMAP rule (part 9500.1453, subpart 5).

Item D is reasonable because these types of changes have been authorized under the PMAP rule without requiring a state appeal (part 9505.1453, subparts 7 and 8). The department's experience under PMAP has shown that in situations where it is apparent that travel time to an enrollee's primary care provider is more than 30 minutes, or when the enrollee's choice is incorrectly designated due to department error (usually a clerical error in processing the health plan enrollment form), requiring enrollees to submit an appeal in order to change provider is an unnecessary expenditure of time and money. It is reasonable to provide MinnesotaCare enrollees the same options as are available to medical assistance recipients, particularly since the two programs will ultimately be merged.

It is reasonable to require these requests to be submitted in writing, for administrative efficiency and recordkeeping. It is also reasonable to respond to these requests within 30 days so that the enrollee is not unduly inconvenienced.

Subpart 6. **Family participation in a health plan.**
This subpart is necessary to assure the most economical care consistent with high medical standards, as required under Minnesota Statutes, section 256.9363, subd. 1. Requiring all family members enrolled in MinnesotaCare to participate in the same health plan promotes the administrative efficiency of both the health plans and the department by reducing paperwork and enhancing coordination of treatment. This requirement also enhances the quality of medical care provided families: requiring all family members to enroll in the same health plan is consistent with the case management approach, which is particularly appropriate in treating family members because a family may have

common health problems and one member's health problems may impact the rest of the family. This requirement is reasonable as well for the convenience of families with members enrolled in MinnesotaCare, enabling families to avoid multiple visits to different providers depending on each family member's individual source of coverage. This requirement is common practice; for example, state employees and their dependents enroll in the same health plan.

This subpart also prevents disruptions in care by preventing individuals from being screened out of health plans on the basis of current eligibility for medical assistance or general assistance medical care. Under Minnesota Statutes, section 256.9363, subd. 5, MinnesotaCare enrollees who become eligible for those programs must remain in the same health plan if it has a contract for that population of eligibles.

PART 9506.0300 HEALTH PLAN SERVICES; PAYMENT.

Subpart 1. **Covered services; additional health services.**
This subpart is necessary to set forth in rule the health services that must be provided under managed care. This subpart is consistent with Minnesota Statutes, section 256.9363, subd. 7, clause (1), which requires health plans to provide enrollees the health services listed in Minnesota Statutes, section 256.9353. It is reasonable to clarify that payment for inpatient hospital and out-of-plan services are treated separately, in subparts 2 and 3, for the reasons discussed below.

It is reasonable to clarify that health plans may offer services not required under the MinnesotaCare statute. One of the goals of managed care is to provide health services at a lower cost. It is reasonable to allow health plans flexibility to provide additional services and to pay for these services at no extra cost to the MinnesotaCare program if the health plan concludes such services are medically appropriate and cost-effective. It is reasonable to allow these additions because it expands the list of services available to enrollees. This has been the experience of the department under PMAP (part 9500.1457, subp. 2).

Subp. 2. **Payment for inpatient hospital services.**
This subpart is necessary to establish in rule the methods for payment of inpatient hospital services for enrollees in managed care health plans, depending on whether the department or the health plan bears the risk for inpatient hospital costs. Minnesota Statutes, section 256.9363, subd. 9 authorizes the commissioner to allow health plans to arrange for inpatient hospital services on a risk or nonrisk basis.

Item A establishes procedures for nonrisk contracts, i.e. a contract under which the costs of inpatient hospital services would not be included in the aggregate capitation payment to the health plan and the department would bear the risk of inpatient hospital costs, up to the annual benefit limit for adults. (No benefit limit applies to children.)

(1) It is reasonable to require enrollees to receive inpatient hospital services from health plan participating providers, to allow the health plan to manage the enrollee's plan of care and provide effective case management. This is consistent with Minnesota Statutes, section 256.9363, subd. 3, which requires enrollees generally to receive their health services from network providers.

(2) It is reasonable to require health plans (which under a nonrisk contract would arrange for inpatient hospital services and pass through MinnesotaCare payments) to comply with medical assistance rules governing inpatient hospital payment rates, standards for services, and hospital admission certification requirements. Under Minnesota Statutes, section 256.9362, payments by

MinnesotaCare to eligible providers must be at the same rates and conditions established for medical assistance (with specified exceptions). It is reasonable to ensure these same criteria are met when MinnesotaCare pays for services provided through managed care plans as well. Minnesota Statutes, section 256.9353, subd. 3, requires certification of admissions for inpatient hospital services paid for under section 256.9362, subd. 3.

Subitem (3) is reasonable because if the department entered into a nonrisk contract, the department would be responsible for payment for inpatient hospital services, making payment to the health plan to pass through to the hospital. It is reasonable, for rule brevity, to simply reference the rule provision establishing standards for hospital payments under MinnesotaCare.

(4) It is reasonable to direct the hospital to collect copayments and amounts not covered by either MinnesotaCare (which has a $10,000 annual benefit limit for inpatient hospital services for adults) or medical assistance (which may impose a spend-down) from the enrollee. According to Advisory Committee members, it is the customary practice to collect copayments at the point of service. This subitem is consistent with Minnesota Statutes, section 256.9363, subd. 6.

(5) It is reasonable to require the health plan to report enrollee admissions to the department within 30 days to enable the department to determine whether the enrollee should apply for medical assistance. If the enrollee is eligible for medical assistance, the department is able to draw federal financial participation for the hospitalization costs, rather than relying solely on state funds.

Item B establishes the procedures to be utilized when the health plan bears the financial risk for the cost of enrollee inpatient hospital services. Subitems (1) and (3) are reasonable for the same reasons described in item A. Subitem (2) is reasonable because by definition a risk contract is one where the health plan pays for inpatient hospital services, subject to the statutory annual benefit limit for adult enrollees. Subitem (4) is reasonable because requiring health plans to report enrollee admissions even under a risk contract assists the department to collect data needed for program efficiency, cost containment and rate setting, as well as to draw down federal financial participation.

Subp. 3. **Payment for out-of-plan services.**
Minnesota Statutes, section 256.9363, subd. 3 requires health plan enrollees to receive their health care services from providers who are part of the managed care plan provider network unless authorized by the managed care plan, in cases of medical emergency, or when otherwise required by law or by contract. This subpart is necessary to establish in rule the payment responsibilities of health plans when enrollees receive health services from out-of-network providers.

Item A. It is reasonable to clarify that health plans are not liable for payment for services provided by out-of-network providers except for the situations set out in Minnesota Statutes, section 256.9363, subd. 3. It is reasonable to define emergency services by reference to the medical assistance statute (Minnesota Statutes, section 256B.0625, subd. 4) because under MinnesotaCare "covered health services" means, generally, health services reimbursed under medical assistance (Minnesota Statutes, section 245.9353, subd. 1). It is reasonable to be consistent with medical assistance and to provide clear criteria for what constitutes an emergency, based on long experience under that program.

Item B. It is reasonable to clarify that the department is not liable to nonparticipating providers for unauthorized services. Department payment for such services would be inconsistent with the statutory requirement that

enrollees receive services from participating providers (Minnesota Statutes, section 256.9363, subd. 3) as well as the statutory goal of managed care to contain costs (Minnesota Statutes, section 256.9363, subd. 1). This same provision is in the PMAP rule (part 9500.1460, subp. 11).

Subpart 4. **Enrollee costs.**
This subpart is necessary to clarify in rule that, except for copayments and costs exceeding the adult inpatient hospital benefit limit, enrollees are not liable for any payment for covered services or for authorized out-of-plan health services. This is reasonable because the goal of managed care is to contain MinnesotaCare costs, not to shift costs to enrollees. Minnesota Statutes, section 256.9363, subd. 3, specifically allows enrollees to receive services from nonparticipating providers when authorized by the managed care plan.

Subpart 5. **Payment to health plans.**
This subpart is necessary to clarify in rule how payment rates for managed care will be established.

Item A is reasonable because it complies with Minnesota Statutes, section 256.9363, subd. 9, which requires that managed care rates be prospective, per capita, where possible, and directs the commissioner to consult with an independent actuary in determining rates. It is reasonable to clarify that inpatient hospital costs may be established on either a risk or non-risk basis because the commissioner is authorized to enter into both risk and non-risk-based contracts for managed care under section 256.9363, subd. 9.

Item B. It is reasonable to inform health plans when they will be paid for providing covered services to MinnesotaCare enrollees. These are the payment dates under PMAP (part 9500.1459, subpart 1). Making both program payments on the same date is administratively more efficient for both the department and health plans.

Item C. It is reasonable to inform people consulting the rule that payment rates and contracts are available to the public. These materials are data collected and maintained by the department and are public data under the Minnesota Government Data Practices Act (Minnesota Statutes, section 13.03, subd. 1). This item was requested by Advisory Committee members and is consistent with PMAP (part 9500.1459).

PART 9506.0400 OTHER MANAGED CARE HEALTH PLAN OBLIGATIONS

Subpart 1. **Financial accountability.**
This subpart is necessary to clarify the financial obligations of health plans vis-a-vis the department and the state of Minnesota. It is also necessary to clarify that the state and health plan enrollees are to be held harmless for the payment of obligations incurred by the health plan if the health plan or a participating provider becomes insolvent and the state has made the payments due the health plan. This requirement is consistent with Minnesota Statutes, section 256.9363 subd. 7, clause (7), which requires managed care plan contractors to demonstrate capacity to accept financial risk according to requirements specified in the contract with the department. PMAP contractors are subject to the same requirement (part 9500.1460, subpart 13).

Subp. 2. **Educational materials.**
This subpart is necessary to establish in rule standards for the educational material that a health plan must provide applicants and enrollees. This is a requirement of PMAP contractors (part 9500.1460, subp. 14).

A. It is reasonable to require health plans to obtain prior approval before distributing this material because it is consistent with Minnesota Statutes, section 256.9363, subd. 7, clause (8), which requires health plans to submit information required by the commissioner. Federal medical assistance regulations require prepaid health care contracts to specify methods by which the HMO will assure its marketing materials are not misleading. As a result of HMO direct marketing tactics used in California that misled or coerced beneficiaries, the federal health care financing administration has developed marketing guidelines for states to use in assessing health plan materials (GAO Report, N. GAO/HRd-93-46, March 1993).

B. It is reasonable to require health plans to provide enrollees a certificate of coverage, identification card, list of providers, and description of the complaint and appeal procedures. These items provide the minimum information necessary for enrollees to access health services and to make informed decisions about their health care providers. Further, providing this information in writing reduces the likelihood of misunderstanding and disagreements over coverage, availability of providers, and dispute resolution. Health maintenance organizations are required by statute to provide this information to enrollees (Minnesota Statutes, sections 62D.09 and 62D.07).

It is also reasonable to require that the materials be understandable to a person reading at the seventh grade level, consistent with Minnesota Statutes, section 256.016. This subpart assures that the information disseminated by different health plans is consistent, comparable, and sufficiently informative to enable enrollees to make an informed choice.

Subp. 3. **Case management.**
This subpart is necessary to establish in rule standards for case management under managed care. Managed care by definition offers a comprehensive approach to health services delivery, with a goal of providing high quality medical care in the most cost-effective way. Managed care for clients on public programs is built on a concept of integrated networks of physicians and hospitals and relies on primary care physicians to manage care, promote preventive care, and ensure that enrollees receive all necessary care while curbing costly over-treatment.

Requiring health plans to implement a system of case management assures an enrollee's individual medical needs are assessed to determine the appropriate plan of care. Since each individual's medical situation is unique, a single standard for medical case management is unrealistic. However, it is reasonable to require an individual plan of care to be developed, implemented, evaluated, monitored, revised, and coordinated with other health care providers as appropriate. This is consistent with the commissioner's mandate under Minnesota Statutes, section 256.9363, subd. 1, to select managed care plans that will provide health services economically, control utilization, and provide safeguards to ensure necessary services are provided. PMAP contractors are subject to the same requirement (part 9500.1460, subp 15), with satisfactory results.

Subpart 4. **Submission of information.**
This subpart is necessary to ensure that consistent data are submitted to the department by health plans. It is reasonable to require this information to assure that the MinnesotaCare managed care program is being operated appropriately and to enable the department to analyze the program and apply its analysis to future decision-making. Further it is reasonable for any government operation to require accountability for expenditures of public monies. This subpart is consistent with Minnesota Statutes, section 256.9363, subd. 7, clause (8) which requires health plans to submit information as required by the commissioner.

Subpart 5. **Quality assurance.**
This subpart is necessary to establish in rule measures to assess the quality of health services provided by health plans participating in the MinnesotaCare managed care program and to enable the department to monitor the quality of care provided. Minnesota Statutes, section 256.9363, subd. 7, clause (8) requires managed care plan contractors to submit information required by the commissioner for assessing enrollee satisfaction, quality of care, cost, and services utilization.

Items A to D are reasonable because they are the same quality assurance requirements as under PMAP (part 9500.1460, subp. 17). [PMAP is subject to the requirement under section 1902(a)(30)(C) of the Social Security Act for an annual quality assurance review of the medical assistance services provided by each prepaid health plan with which the state has entered in a risk-based contract.] The specific requirements under items A to D are in accordance with the Minnesota Department of Health quality assurance rules, parts 4685.0100 to 4685.2100; these rules are based on federal requirements for quality assurance programs of federally qualified health maintenance organizations.

Subpart 6. **Third party liability.**
This subpart is necessary to implement the commissioner's mandate to use cost avoidance techniques to ensure coordination of any other health coverage for eligible persons enrolled in MinnesotaCare (Minnesota Statutes, section 256.9355, subd. 3). It is reasonable to assure coordination of benefits to the extent required under Minnesota Statutes, section 62A.046 (requiring coordination of benefits by insurers and HMOs) and part 9506.0080, which establishes in rule the commissioner's mandate to use cost avoidance techniques for MinnesotaCare enrollees). Health plans are required to coordinate benefits this way under PMAP (part 9500.1455) as well.

Subpart 7. **Enrollee acceptance.**
This subpart is necessary to prevent health plans from screening out enrollees on the basis of health status. This is reasonable to prevent adverse selection, i.e. a health plan enrolling only healthy persons, resulting in an unfair financial advantage and lack of access to health services for less healthy enrollees. This subpart is reasonable because it is consistent with Minnesota Statutes, section 256.9363, subd. 7, clause (6) which requires managed care plan contractors to accept all eligible enrollees without regard to health status or prior utilization of health services.

Subpart 8. **Financial capacity.**
Minnesota Statutes, section 256.9363, subd. 7, clause (7) requires managed care plan contractors to demonstrate capacity to accept financial risk according to requirements specified in the contract with the department. This subpart is necessary to establish the parameters for demonstrating financial capacity that must be met by contracting health plans as a condition of participating in managed care.

In order to inspire enrollee and provider confidence in the managed care program, health plans must be able to demonstrate sufficent financial capacity to ensure covered health services will be continuously available to enrollees. Although the demonstration of financial capacity need not necessarily come from reserve funds, there should be evidence of financial capacity that satisfies both the department and the providers who contract with the health plan. It is also necessary to assure that enrollees will not be denied health services because of their health plan's financial problems.

Therefore, it is reasonable to require health plans to show that participating providers are comfortable with the health plan's financial risk capacity. This is reasonable as well because the different health plans in Minnesota utilize differing methods to maintain fiscal control over their participating

providers. It is reasonable to clarify that health plans licensed as an HMO, nonprofit health plan, an ISN or CISN need only demonstrate the financial risk capacity required under their respective governing statutes, both for administrative simplicity and because the statutes establish standards representing adequate financial risk capacity.

Subpart 9. **Chemical dependency assessments.**
This subpart is necessary and reasonable to inform persons consulting the rule that Minnesota Statutes, section 256.9363, subd. 8 requires health plans to assess the need for and to provide chemical dependency services to enrollees in accordance with the rules governing chemical dependency treatment for public assistance recipients.

Subpart 10. **Immunization.**
This subpart is necessary and reasonable to inform persons consulting the rule that Minnesota Statutes, section 256.9363, subd. 10 requires health plans to collaborate with local public health agencies to ensure enrollees are immunized and to provide families with a schedule of recommended immunizations.

Subpart 11. **Second medical opinion.**
This subpart is necessary to guarantee enrollees a second medical opinion and to establish a process for assuring that right. It is also necessary to ensure that enrollees are informed of this right. It is reasonable to require this information be included in the certificate of coverage, which is a document that must be provided every enrollee describing the services and rights available to them (see subpart 2, item B).

Item A is reasonable because providing a second opinion within the plan is the common practice within health plans currently and is consistent with the PMAP rule (part 9500.1462, item A).

Item B, requiring a health plan to obtain a second opinion from a qualified non-participating provider when the health plan determines that a chemical dependency or mental health problem does not require structured treatment, is reasonable because it is required of HMOs and participating providers under Minnesota Statutes, section 62D.103. It is reasonable and equitable to apply the same requirement to managed care contractors that may not be subject to the HMO statute. This is also a requirement in the PMAP rule (part 9500.1462, item B).

Minnesota Statutes, section 256.9361 provides MinnesotaCare enrollees the right to appeal a determination of the commissioner under section 256.045. Item C is reasonable because it is consistent with section 256.045, subd. 3a, paragraph (b) which provides that a state appeals referee may order a second medical opinion for a recipient in a prepaid health plan under a PMAP contract. It is reasonable and equitable to provide MinnesotaCare managed care enrollees the same right as PMAP enrollees. It is a procedure and right health plans are familiar with under PMAP.

Subpart 12. **Data privacy.**
Data on individuals maintained by the department of human services are classified as private data and are generally accessible only to the data subject. It is necessary to assure that the health plans under contract with the department are included within the welfare system, as authorized under Minnesota Statutes, section 13.46, subd. 1, paragraph (c), in order to provide health plans access to enrollee information that is needed to carry out their responsibilities. It is also reasonable to state that health plans must comply with the Minnesota Government Data Practices Act, as well as any applicable federal privacy law, to safeguard enrollee information from being divulged to unauthorized parties. A similar provision is in the PMAP rule (part 9500.1458).

Subpart 13. **Complaint and appeal procedure.**
Minnesota Statutes, section 256.9363, subd. 7, clause (4) requires health plans to establish an enrollee grievance process as required by the commissioner and set forth in the contract. It is reasonable to utilize the complaint procedure established under PMAP, which has worked well, for MinnesotaCare enrollees. The health plans governed by this rule will be familiar with the PMAP procedures and it would be unduly burdensome to require them to establish a separate complaint procedure for MinnesotaCare.

Subp. 14. **Contract termination.**
It is reasonable to require a health plan to notify enrollees sixty days before a contract with the department terminates, so that enrollees have adequate opportunity to make an informed decision about a new health plan and the health plan has time to transfer records. This subpart is consistent with the PMAP rule (part 9500.1460, subp. 12).

SMALL BUSINESS CONSIDERATIONS

In preparing these rules the Department considered the requirements of Minnesota Statutes, section 14.115 but believes that any impact on small business falls within the exemptions in section 14.115, subd. 7, clause (3) for providers of medical care.

AGRICULTURAL LAND

Because the proposed rule does not have a direct and substantial adverse impact on agricultural land in Minnesota, Minnesota Statutes, section 14.11. subd. 2 is not applicable.

EXPERT WITNESSES

If this rule is heard in public hearing, the Department does not intend to have outside expert witnesses testify on its behalf.

Dated: 2-22-95

MARIA R. GOMEZ
Commissioner

Attachment A

Minnesota Prepaid Medicaid Programs

Analysis of Cost Savings Calendar Years 1987 — 1989

Prepared by:
THE MINNESOTA DEPARTMENT OF HUMAN SERVICES
444 Lafayette Road
St. Paul, Minnesota 55155-3854

April 1991

MINNESOTA
PREPAID MEDICAID
PROGRAMS

Analysis of Cost Savings
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TABLE OF CONTENTS

STATE OF MINNESOTA
PREPAID MEDICAID PROGRAMS
ANALYSIS OF COST SAVINGS
1987 - 1989

This document describes a Department of Human Services study which examined the cost experience of Minnesota's prepaid Medicaid programs and estimated the cost savings as a result of these programs. For all three of Minnesota's prepaid programs, the calendar year 1989 experience was examined. These programs are the Prepaid Medicaid Demonstration Project (PMDP), Aid to Families with Dependent Children (AFDC) Voluntary Program, and General Assistance Medical Care (GAMC) Prepaid Program. For the PMDP, the 1987 and 1988 experiences were also studied. The results of the study are summarized below, followed by detailed results and a description of the study design.

SUMMARY OF RESULTS

- For the **Prepaid Medicaid Demonstration Project,**

	total estimated program savings:	total prepaid expenditures:
1987	**$ 5.7 million**	$ 29.2 million
1988	**6.5 million**	29.5 million
1989	**1.5 million**	36.5 million

- For the **AFDC Voluntary Program,**

	total estimated program savings:	total prepaid expenditures:
1989	**$ .4 million**	$ 1.8 million

- For the **GAMC Prepaid Program,**

	total estimated program savings:	total prepaid expenditures:
1989	**$ 3.9 million**	$ 11.1 million

- For **all programs,**

	total estimated program savings:	total prepaid expenditures:
1989	**$ 5.8 million**	$ 49.4 million

- Estimated savings per person per month of MA eligibility, Demonstration Project:

1987	$ 20.75	Average rate:	$105.16
1988	19.30		86.75*
1989	5.03		117.91

- Estimated savings per person per month of MA eligibility, AFDC Voluntary Program:

1989	$ 18.31	Average rate:	$ 83.07

- Estimated savings per person per month of GAMC eligibility, GAMC Prepaid Program:

1989	$ 65.38	Average rate:	$185.76

* Rates declined, due to disenrollment of the blind/disabled population.

BACKGROUND

One of the goals of Minnesota's prepaid Medical Assistance (MA) and General Assistance Medical Care (GAMC) programs is to provide health care services at a lower cost to the State through cost-effective management of health service delivery. A capitation program provides incentives for contracting health plans to manage health services effectively, as the health plans are at risk for costs incurred by enrollees. Thus, the State pays health plan contractors at approximately 90% (AFDC and GAMC)) or 95% (aged, blind and disabled) of the projected fee-for-service cost. The use of discounted rates is based on the premise that the health plan's management of health services results in reduced service costs to the plan. The 5% or 10% discount on the rates constitutes the gross prepaid capitated program savings.

From this gross savings, the State must deduct additional State expenses. The additional expenses for the project are as follows:

- Additional reimbursement to the health plans, outside the capitation payments, i.e., risk sharing or reinsurance payments and any fee-for-service reimbursement (e.g., enhanced perinatal services).

- Administrative expenses incurred by the State or counties which are over and above normal administrative costs.

Because rates are based on a percentage of expected costs for a comparable fee-for-service population, the actual savings achieved may be more or less than the 5% or 10% discount minus additional state expenses. This difference occurs if the actual fee-for-service expenditures differ from the estimate.

A fee-for-service comparison group is used in this study to estimate cost savings from prepaid programs. Because the Minnesota MA fee-for-service program already has some managed care components, e.g., prior authorization, hospital preadmission certification, etc., some may view it as a less than perfect comparison group. However, for our purposes, it is the most accurate measure of the success of the prepaid health plan approach. Since it is our goal to compare prepaid programs with the current fee-for-service delivery system and not with unbridled uncontrolled utilization, it is the only logical approach. In addition, the fee-for-service experience is the standard federal measure of prepaid program savings, as

prepaid capitation payments must not exceed fee-for-service payments for equivalent Medicaid populations.

The Minnesota Department of Human Services (DHS) currently operates three distinct prepaid programs. This study examines the cost experience of each. Part 1 deals with the Prepaid Medicaid Demonstration Project, while parts 2 and 3 cover the calendar year 1989 cost savings experience of the AFDC Voluntary and GAMC Prepaid Programs respectively.

PART 1 - Prepaid Medicaid Demonstration Project

STUDY DESIGN

To determine cost savings for the PMDP, a comparison was made between costs incurred for demonstration populations and costs incurred for comparable fee-for-service populations.

- Costs for Demo Populations

  Actual capitation payments are made on behalf of demonstration project enrollees by county by population. For 1989, the health plans' liability for long-term care costs was deducted.*

  Counties: Dakota, Hennepin, Itasca

  Populations: 1987: AFDC/Needy Children, Blind/Disabled, and Aged
  1988-1989: AFDC/Needy Children and Aged

  * Health plans were responsible for the first 90 days of nursing home or home care for elderly persons and for 20% of these costs after the 90th day.

- Costs for Comparison Groups:

  Actual fee-for-service expenditures made on behalf of MA recipients by county by population.

  Counties: Anoka and Washington (Dakota comparison)
  Hennepin (Hennepin comparison)
  Crow Wing and Beltrami (Itasca comparison)

  The comparison counties for Dakota and Itasca were chosen because of similarities in demographics and MA experience. The experience of these counties was also utilized for 1989 rate-setting. For Hennepin, the 65% fee-for-service control group provides a valid comparison group.

  Populations: Population breakdowns are the same as for the demonstration group.

- Excluded Populations

  Because the project excludes certain MA recipient groups, the following groups were also eliminated from the fee-for-service comparison populations.

- medical spenddown cases
- refugee cases
- foster care cases
- subsidized adoption cases
- state institution residents

For 1989, all of the above plus:

- persons with private HMO coverage
- blind and disabled persons

- Time Period

The experience for calendar years 1987, 1988 and 1989 was examined. 1986 was not utilized, since only a small proportion of the demonstration population was enrolled at that time. The vast majority of those enrolled were AFDC recipients.

- Additional State Expenses

As noted, additional state expenses are deducted from gross savings to determine the estimated program savings.

These expenses are as follows:

- Additional plan reimbursement

1987
a. Aggregate risk sharing (estimated)*
b. Inpatient hospital stop-loss (actual)
c. (Long-term care stop-loss) deduction (estimated)*
d. Medical education reimbursement (estimated)*

1988
a. Inpatient hospital stop-loss (actual)
b. (Long-term care stop-loss) deduction (estimated)*
c. Medical education reimbursement (estimated)*

1989
a. Inpatient hospital (estimated)
b. Medical education reimbursement (estimated)

* Most settlements have been completed, therefore, actual figures are used. However, for the one or two health plans for which settlement is still outstanding, estimates are used.

- Administrative Costs

County - For the project, the State agreed to pay the 50% county share of administrative expenses incurred due to

implementation and administration of the project. Thes expenses include: personnel, management time, overhea and equipment, data processing, travel, mailing cost: and costs for outside contractors.

State - Costs incurred by the State over and above norma operating expenses are included. These expens categories are similar to those listed above for th counties.

PROCESS

A. Determine the average cost per eligibility month for th fee-for-service comparison groups. (Divide total cost by total eligibility months for each population for eac county.)

B. Determine total capitation expenditures for demonstratic enrollees for each population for each county. (For 198 deduct health plan LTC liability from these figures.)

C. Determine total eligibility months for demonstratic enrollees by population by county.

D. Multiply demonstration eligibility months (C) by th average monthly fee-for-service cost (A) to determin what MA costs would have been for the demonstratic population.

E. Subtract demonstration costs (B) from fee-for-servic comparison costs (D) to arrive at gross program savings

F. Determine additional state expenses for the project. Fo this study, actual expenditures or estimates c additional plan reimbursement were used.

G. Deduct additional state expenses (F) from gross progra savings (E) to determine estimated net program savings

RESULTS

- Estimated Gross Program Savings (Costs)

1987	Dakota	Hennepin	Itasca	Total
AFDC/ Needy Children	$1,986,880	$5,932,337	$624,063	$8,543,280
Blind/Disabled	(66,479)	847,516	115,850	896,887
Aged	(130,078)	(653,573)	(47,213)	(830,864)
Total	$1,790,323	$6,126,280	$692,700	$8,609,303

1988	Dakota	Hennepin	Itasca	Total
AFDC/ Needy Children	$694,167	$4,593,362	$157,916	$5,445,445
Aged	318,416	2,952,639	365,813	3,636,868
Total	$1,012,583	$7,546,001	$523,729	$9,082,313

1989	Dakota	Hennepin	Itasca	Total
AFDC/ Needy Children	$1,196,686	$3,743,502	$ 566,726	$5,506,912
Aged	(510,851)	(1,242,346)	45,488	(1,707,709)
Total	$ 685,835	$2,501,154	$ 612,214	$3,799,203

- **Estimated Net Program Savings (Costs)**

1987 - Total savings:			$8,609,30?
Additional state expenses:			
Additional plan reimbursement:		$1,590,502	
Administrative Costs:		$1,258,423	
		$2,848,925	($2,848,9?
			$5,760,3?
Federal savings:	$3,076,618		
State savings:	$2,617,121		
County savings:	$ 67,106		
1988 - Total savings:			$9,082,313
Additional state expenses:			
Additional plan reimbursement:		$1,287,321	
Administrative Costs:		$1,238,260	
		$2,525,581	($2,525,58
			$6,556,?3
Federal savings:	$3,539,324		
State savings:	$2,941,973		
County savings:	$ 75,435		
1989 - Total savings:			$3,799,203
Additional state expenses:			
Additional plan reimbursement:		$1,055,790	
Administrative Costs:		$1,183,602	
		$2,239,392	($2,239,39?
			$1,559,81?
Federal savings:	$825,140		
State savings:	$716,304		
County savings:	$ 18,367		

LIMITATIONS OF THE STUDY

- The experience of 1987 reflects a partially implemented program. The disabled and aged populations continued to be phased into the project in year 2; therefore, many of the disabled and aged remained on fee-for-service for a portion of the year.

- Initial fee-for-service months and costs (pre-enrollment in the project) are included in the fee-for-service comparison group. These months may represent utilization experience which is higher or lower than average.

- Retroactive months of eligibility are included in the fee-for-service comparison. Costs incurred in these retro months should be higher than average.

- For Dakota and Itasca counties, the actual experience could not be used. Although the comparison counties are similar, their experience is less valid than the actual county experience.

- For 1987 and 1988, the study results reflect the actual experience of a capitation program with a fixed inflation increase. It does not reflect savings which can normally be expected, given the 5% or 10% discount on the rates.

DISCUSSION

1987-1988

This study provided a limited estimation of capitation program savings because of the above limitations. Inclusion of retroactive eligibility months in the fee-for-service experience and the atypical use of a fixed inflation factor, in particular, distort the savings estimates. MA service costs for retroactive months of eligibility are higher than average because they usually involve inpatient hospital costs. The current MMIS cannot identify retroactive months of eligibility, because there is no fixed date from which these months can be counted. Retroactive months and costs were, therefore, included in the capitation payments. However, enrollment in a health plan is always for a future date, as it is unfair to require that the health plan be liable for costs over which it has no control. Because health plans are not responsible for these higher cost retroactive months, theoretically, the health plans may be somewhat overpaid. The State retains the liability for these months, while including the costs in the capitation payments.

Inclusion of the higher cost retroactive months in the fee-fc service comparison group inflates the costs of this group a exaggerates the program savings overall. There is currently information available on retroactive costs as distinct fro ic retroactive costs. Therefore, it is not possible to estimate the costs.

As noted, another major limitation of the study relates to the u of fixed inflation increases. The capitation rates for this peri were set on base year, SFY82, for Hennepin and Itasca counties a for SFY83 for Dakota County. Rates were trended forward to calend year 1985, using 13.9% for non-institutionalized populations a 15.2% for institutionalized populations. For Dakota Count prorated figures were used, 9.27% and 10.13% respectively. straight 5% annual increase was then utilized for contract yea 1986, 1987 and 1988.

For 1989, rates were rebased or recalculated based on the mo current SFY87 experience and trended forward by 3.4% plus 3.8% pl 2.25%. Rates for 1990 utilize the SFY88 experience. The rat setting policies used in 1987 and 1988, with a fixed base year a inflation factor, differ significantly from the current policy utilizing the most current base year available and calculating t inflation factor in accordance with expected future increases Medicaid costs. Thus, estimates of cost savings achieved in 19 and 1988 will not accurately reflect expected savings in capitat programs. The experience for 1989, when the new rate-setti policies were implemented, should better reflect expected saving

1989

As predicted, the 1989 analysis yields more moderate savings due rebasing of rates to a more current year's experience. Overal prepaid health plan capitation rate payments for AFDC and Nee Child populations were 83% of the estimated fee-for-servi experience. For the Aged population, payments were 124% of the fe for-service estimates. For all populations, payments were 90.33% the fee-for-service estimates.

One possible explanation for the inflated payments for the prepa aged population is the effects of Medicare catastrophic coverage 1989. The implementation of expanded Medicare coverage, in the fo of reduced coinsurance and deductibles, resulted in reduced cos for fee-for-service Medicaid recipients. Capitation payments f 1989 reflected the historical fee-for-service experience of SFY8 which predates Medicare catastrophic. No adjustment was made to t 1989 rates to account for increased coverage by Medicare.

PART 2 - AFDC Voluntary Program

STUDY DESIGN

The AFDC Voluntary program is a prepayment option available in the Twin City metropolitan area. Under this option, AFDC recipients may enroll in one of the participating health plans without being "locked into" the health plan for any specific time period. During calendar year 1989, there were two AFDC Voluntary health plans available for recipients in Hennepin County, but only one health plan option was available to recipients residing in the remaining portion of the metropolitan area.

To determine cost savings for the AFDC Voluntary program, a comparison was made between costs incurred for the AFDC Voluntary participants and costs incurred for a comparable fee-for-service population in the metropolitan area.

- Costs for AFDC Voluntary Participants

  Actual capitation payments made on behalf of AFDC voluntary program enrollees. An aggregate figure for all counties was used.

  Participating Counties: Hennepin, Ramsey, Anoka, Scott, Washington and Carver (metro)

- Costs for Comparison Group:

  Aggregate fee-for-service expenditures made on behalf of AFDC recipients in the Twin City metropolitan area.

  Counties: Hennepin, Ramsey, Anoka, Scott, Washington and Carver (metro)

- Excluded Populations

  Because the AFDC Voluntary project excludes certain AFDC client groups, the following groups were also eliminated from the fee-for-service comparison population.

  - medical spenddown cases
  - refugee cases
  - foster care cases
  - subsidized adoption cases
  - state institution residents
  - persons with private HMO coverage

- Time Period

  The experience for calendar year 1989 was examined.

- Additional State Expenses

  NONE

PROCESS

A. Determine the average cost per eligibility month for fee-for-service comparison group. (Divide total costs by eligibility months)

B. Determine total capitation expenditures.

C. Determine total prepayment eligibility months.

D. Multiply eligibility months (C) by the average mo fee-for-service cost (A) to determine what MA costs would been.

E. Subtract capitation costs (B) from fee-for-service compa costs (D) to arrive at net program savings.

RESULTS

- Estimated Net Program Savings

1989 -	Total savings:	$ 405,567
	Federal savings:	$ 214,545
	State savings:	$ 181,471
	County savings:	$ 9,551

PART 3 - GAMC Prepayment Program

STUDY DESIGN

The GAMC prepayment program is consistent with section 256D.03, subdivision 4 of the Minnesota Statutes. Under the provisions of this section, the Commissioner is authorized to "select vendors of medical care who can provide the most economical care consistent with high medical standards" and to "contract on a prepaid capitation basis to provide these services." In calendar year 1989, the GAMC prepayment program was operational in three counties. Each county was served by a single health plan option. To determine cost savings for this program, a comparison was made between costs incurred for GAMC prepayment participants and costs incurred for a comparable fee-for-service population.

- Costs for GAMC Prepayment Participants

  Actual capitation payments made on behalf of GAMC prepayment enrollees by participating county.

  Participating Counties: Ramsey
  Itasca
  Lake

- Costs for Comparison Groups

  Actual fee-for-service expenditures made on behalf of GAMC recipients in the metropolitan or non-metropolitan area. For Ramsey county, the experience of the fee-for-service population in the metropolitan area was used. For Itasca and Lake counties, the aggregate experience fee-for-service population in all non-metropolitan counties was used.

- Excluded Populations

  Because the project excludes certain GAMC recipient following groups were also eliminated from the fee-for- comparison populations.

  - medical spenddown cases
  - refugee cases
  - Institution for Mental Disease (IMD) recipients
  - state institution residents

- Time Period

  The experience for calendar year 1989 was examined.

- Additional State Expenses

The State provides reinsurance to the health plans for p... inpatient hospital costs exceeding $15,000, based o... t state's hospital reimbursement system. The state's estimat liability for inpatient hospital stop-loss reinsurance ... added to the capitation expenditures in step B below.

PROCESS

A. Determine the average cost per eligibility month for fee-for-service comparison groups. (Divide total costs total eligibility months)

B. Determine total capitation expenditures for GAMC prepaym enrollees in each county. Add to this the state's estima inpatient hospital stop-loss liability to arrive at to prepayment expenditures.

C. Determine total eligibility months for GAMC prepaym enrollees in each county.

D. Multiply eligibility months (C) by the average mont fee-for-service cost (A) to determine what the GAMC costs wo have been for the prepayment population.

E. Subtract prepayment costs (B) from fee-for-service comp... costs (D) to arrive at program savings.

RESULTS

- Estimated Net Program Savings - Calendar Year 1989

RAMSEY	ITASCA	LAKE	TOTAL
$3,712,913	$184,087	$20,484	$3,917,484

State savings: $3,525,736
County savings: 391,748

DISCUSSION

Estimated savings for the GAMC prepaid program exceeded expectations due to two possible factors. The first factor was changes affecting the fee-for-service comparison group in state fiscal year 1989. Ninety-five percent of the estimated GAMC prepaid savings was savings realized by the Ramsey County experience. The comparison group used for Ramsey County was the seven county metropolitan area minus Ramsey County. Thus the comparison group was weighted heavily by expenditures for Hennepin County. Hennepin experienced a 17% to 18% increase in GAMC expenditutres for SFY 1989, compared with the previous fiscal year. Some of this increase can be traced to the lifting of ratable reductions for some services, resulting in increased expenditures for the GAMC fee-for-service program.

A second possible explanation for the exaggerated savings due to GAMC prepaid programs may be the inclusion of costs for residents of Institutions for Mental Disease (IMDs) in the fee-for-service comparison group. This group is not part of the prepaid experience. Since costs for this population are higher than average, the fee-for-service comparison group reflected a higher cost experience.

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