**Testimony of Dr. Susan Hasti, MD, to the Senate Health and Human Services Budget Division on behalf of the Minnesota Universal Health Care Coalition on February 16, 2005.**

I am speaking today on behalf of the Minnesota Universal Health Care Coalition, which consists of 13 organizations. Our purpose in testifying is not only to oppose the cuts that Governor Pawlenty is proposing for MinnesotaCare, but to urge you to investigate immediately a cost-cutting measure for MinnesotaCare, Medical Assistance, and General Assistance Medical Care that has been overlooked by the Governor and the Legislature for nearly a decade – the removal of HMOs from those programs.

Oddly, DHS has never done a study, at least one they were willing to acknowledge, to determine whether privatization – the forced enrollment of MinnesotaCare, MA and GAMC beneficiaries in HMOs – saved DHS money. In a December 16, 2004 letter to Rep. Matt Entenza, DHS Commissioner Kevin Goodno stated DHS had no data to indicate whether privatization saved DHS money. Specifically, he stated, "We do not have a methodology that could accurately assess whether managed care has cost us more or less than fee-for-service" (see copy of letter attached).[1]

Commissioner Goodno's statement is consistent with a 1994 report in the *Star Tribune* indicating that DHS at that time did not have any idea whether privatization of MA was saving DHS money, primarily because neither DHS management nor the HMO industry wanted the Legislature and the public to know whether privatization had saved money. The *Star Tribune* reported that a DHS employee named Steven Foldes, who subsequently went to work for Blue Cross Blue Shield, had prepared a report in May 1993 that was suppressed by DHS at the request of the HMOs. This report, according to the *Star Tribune*, was "the first attempt by the Minnesota Department of Human Services to see whether the state was saving money by sending medical-assistance patients to health-maintenance organizations, rather than private doctors." Judging from *the Star Tribune* report and Commissioner Goodno's letter to Rep. Entenza, Mr. Foldes' report was the first and last attempt DHS made to determine whether privatization of MA saved money. According to the *Star Tribune*, DHS eliminated Mr. Foldes's job after he turned in his report.[2]

We suspect DHS does have, or can get, the data necessary to determine whether privatization saved DHS money. Dozens of studies have been done to determine whether permitting HMOs to enroll Medi*care* beneficiaries saved the taxpayer money. Nearly all of these studies concluded that the partial privatization of Medicare cost the taxpayer money.[3] In a 1999 report, the US General Accounting Office stated, "[N]umerous studies conducted by us, the Physician Payment Review Commission, HCFA, and others demonstrated that the Medicare program spent more on beneficiaries enrolled in health plans than it would have if the same individuals had been in FFS [the traditional

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[1] "Fee for service" refers to the non-privatized programs.

[2] Joe Rigert and Carol Command, "Study shelved after HMOs complained," *Star Tribune*, March 13, 1994, A1.

[3] For example, the US General Accounting Office reported in 1997, "Ten years of research on Medicare's costs under HMOs has found that the program's rate-setting method results in excess payments to HMOs because HMO enrollees would have cost Medicare less if they had stayed in the fee-for-service sector [of Medicare]" (US General Accounting Office, *HCFA Could Promptly Reduce Excess Payments by Improving Accuracy of County Payment Rates*, 1997, Washington DC, 1).

Medicare program]."[4] Senator Durenberger recently stated in the Star Tribune that Medicare is now overpaying HMOs by 23 percent.[5]

It is true that Medicare, unlike DHS's programs, still has a fee-for-service sector against which researchers can compare HMO costs (88 percent of Medicare enrollees are in Medicare's traditional FFS program while the remaining 12 percent are in Medicare HMOs). But the complete destruction of fee-for-service sectors in DHS's programs has occurred only in the last decade. Medical Assistance and GAMC were privatized gradually during the 1980s and early 1990s.[6] Thus, DHS could, if it wanted to, assess whether privatization saved money either by comparing the cost of those programs prior to and after privatization, or, in the case of MA by comparing the costs of HMO enrollees with FFS enrollees in the mid-1990s when the program was still split between an HMO and a FFS sector.

It is worth remembering that prior to the privatization of the DHS programs there were no studies showing that HMOs were more efficient than non-HMOs, including public insurers such as Medicare and Medicaid. HMO advocates simply assumed HMOs were more efficient than other types of insurers, and their incessant lobbying and marketing led legislators to accept their claim without documentation.[7]

Thus it is that we find ourselves in the year 2005, two decades after privatization began, with no reports from DHS or anyone else on whether privatization saved Minnesota taxpayers money. Evidence does exist, however, which indicates that privatization has raised DHS's costs, reduced reimbursements to doctors, damaged quality of care, or all three of the above.

Removing HMOs from MinnesotaCare, MA, and GAMC will save money for one, and possibly three, reasons. The first reason – an indisputable reason – is that HMOs cannot allocate all of the revenue they receive from payers, in this case the Department of Human Services, to doctors, hospitals and other providers. HMOs, like virtually all human enterprises, have to spend a portion of their revenues on administering their operations. These administrative costs include marketing, supervising doctors, lobbying, high salaries for management, surpluses (called "profits" in the for-profit sector), and taxes. In their annual reports on their total expenditures to the Department of Health, HMOs claim their administrative costs absorb only 10 percent of revenues. But the true figure is probably around 20 percent.

A second possible reason why deprivatizing DHS programs will save money is that privatization may have driven up DHS's own administrative costs. The state agencies that administered Medicaid programs in the 1990s typically spent 4 to 5 percent of their

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[4] US General Accounting Office, *Medicare+Choice: Reforms Have Reduced, but Likely Not Eliminated, Excess Plan Payments*, June 1999, 2.

[5] "For health care security, Kerry has the better plan," *Star Tribune*, October 27, 2004, A17.

[6] Even now those programs are not under the control of HMOs in all parts of the state. In many rural areas, county coalitions administer their MA programs, apparently using some form of managed care [check: do they also administer GAMC?]. According to the administrator of one of these coalitions, their overhead costs are lower than those of HMOs [cite] *Minnesota Physician*, September 2004,

[7] HMOs could demonstrate that they cut medical services. But they could never demonstrate that they could cut total costs – medical services plus administrative costs. One might think that the fact that HMO premiums tended to be lower than non-HMO premiums constitutes evidence that HMOs did in fact cut total costs. But experts dismiss the premium differentials on the ground that HMOs enrolled healthier people.

revenues on administration and the other 95 to 96 percent went directly to providers.[**cite**] It is quite possible that the cost of administering privatized Medicaid systems is higher than the cost of administering the non-privatized fee-for-service systems.

A third possible reason why deprivatizing DHS programs will save money is that deprivatization will probably reduce the overhead costs of providers who currently must deal with HMOs. What little research has been done on the impact of managed care on provider overhead costs indicates managed care has driven provider costs up.[8]

Let me illustrate the higher costs that privatization created for DHS with a worst- and best-case scenario. In the best-case scenario, HMO overhead has always been around 10 percent. In that event, privatization raised total administrative costs from 5 percent of DHS revenues to 15 percent. In the old non-privatized or fee-for-service system, DHS took 5 cents on the dollar to run its shop and paid 95 cents to providers. In the privatized system, DHS took 5 cents off the top and paid 95 cents on the dollar to HMOs, and the HMOs took another 10 cents off the top for administrative costs and passed the remaining 85 cents to providers.

Under the rosy assumption that HMO overhead costs are only 10 percent, HMOs would have either needed a subsidy from DHS equal to 10 percent of what DHS had been paying to FFS providers per patient, or HMOs would have had to cut medical costs by 10 percent, either by cutting reimbursement rates to providers or by cutting services to patients. Commissioner Goodno denies the HMOs cut reimbursements to providers.[9] If that's true, that means HMOs had to make up the entire 10 percent with cuts in services.

It is extremely unlikely, however, that the HMOs achieved a 10 percent cut in services.[10] HMOs, despite their rhetoric, have never been better than FFS doctors at using

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[8] J. Alexander and C. Lemak, "The effects of managed care on administrative burden in outpatient substance abuse treatment facilities. *Med Care* 1997;35:1060-1068;.David Himmelstein et al., "Who administers? Who cares? Medical administrative and clinical employment in the United States and Canada," *Am J Public Health* 1996;86:172-178; T. Burton, "Firms that promise lower medical bills may increase them: Cost police pile paper work on physicians, hospitals, which pass on expense," *Wall Street Journal*, July 28, 1992, A1. Whether this form of savings – reduced provider overhead costs – will accrue to DHS will depend on whether DHS chooses to lower its reimbursement rates to providers to capture this savings.

[9] Commissioner Goodno stated in a November 2, 2004 letter to Rep. Entenza, "Overall it appears that plans pay at or above the rate otherwise paid by DHS fee-for-service." In the same letter, he also claimed HMOs were not harming quality of care. He based this latter claim on research comparing the rate at which plans provide preventive services to DHS enrollees and private-pay enrollees. On the other hand, Mathematica reported, after a site visit to Minnesota, "We found little data ... from which we could evaluate whether [Medical Assistance] clients today have better access than in the premanaged-care environment" (Mathematica Policy Research, *Managed Care and Low-Income Populations: A Case Study of Managed Care in Minnesota*, prepared for Henry J. Kaiser Family Foundation and The Commonwealth Fund, May 1996, 28).

[10] According to the Congressional Budget Office, which was asked by Congress to estimate the savings HMOs achieve by reducing services, HMOs reduce utilization of services by 4 percent compared to traditional, unmanaged indemnity plans (*The Effects of Managed Care and Managed Competition*, February 1995, Washington DC, 6). The fact that United HealthCare abandoned utilization review for most services on the ground that it was costing it about as much money as it was saving is further evidence that managed care tactics cannot cut utilization sufficiently to offset the new administrative costs required to engage in managed care tacits (T. Bonfield, "HMO change may set trend doctors want," *Cincinnati Enquirer*, November 6, 1999).

preventive services.[11] Encouraging greater use of preventive services would be especially hard for the MA and GAMC populations, and possibly the MinnesotaCare enrollees because turnover is even higher in these groups than it is in the private sector (the average enrollee is in the MA program for only eight or nine months whereas the average private-sector enrollee stays for two or three years). There is some evidence from other states that HMOs reduced emergency room use of MA recipients, but ER expenditures constitute a small portion of total spending. In short, it is highly unlikely that HMOs were able to cut medical utilization rates by 10 percent by encouraging more preventive care and more appropriate use of ER facilities.

If HMOs have not cut rates to providers, as Commissioner Goodno claims, and if they have not cut services by at least 10 percent, that means the HMOs manage to make a profit off DHS enrollees solely or primarily because DHS is paying them more per enrollee than DHS had paid FFS providers per enrollee prior to privatization. That DHS has long overpayed HMOs was suggested by an internal DHS memo described by the *Star Tribune* in the previously mentioned1994 article which reported on the study that DHS suppressed at the request of the HMO industry. The article said, "Documents obtained by the *Star Tribune* . . . include a memo from a department [DHS] staff member expressing concern that the HMOs had responded to the upcoming study 'by taking the offensive, and believing that as usual DHS will cave in.' The memo also said that some HMOs 'have a vested interest in keeping information from [DHS] because a large profit currently is being made which would be revealed if the data were submitted accurately in some areas.' . . ."

Obviously, the probability that DHS had to subsidize the HMOs, and thereby raise the total costs of MinnesotaCare, MA, and GAMC, is even higher if the true HMO overhead cost is 20 percent, not 10 percent. The evidence indicates (a) that Minnesota's HMOs have been playing bookkeeping games to keep their reported administrative costs down and (b) that 20 percent is the more accurate figure.

In its 1993 analysis of the Minnesota HMO market, the Citizens League noted that Minnesota's HMOs began to play games with their annual reports to the Department of Health in the early 1990s. The League stated:

> Medica made an important change in its 1992 annual statement to the Department of Health. . . . In previous years, Medica reported all of the management fee paid to United HealthCare [the national insurance company that Medica hired to "manage" Medica] as an administrative expense. For 1992, Medica allocated a

[11] According to a review of the literature on the effect of managed care on Medicaid, "Although it is often argued that managed care promotes the use of preventive services, access to preventive care does not appear to either improve or decline under most Medicaid managed care arrangements. Use of immunizations and prenatal care seems to remain unaltered, while changes in access to well-child visits and gynecological exams vary across the studies" (The Kaiser Commission on the Future of Medicaid, *Medicaid and Managed Care: Lessons from the Literature*, Washington DC, March 1995, 17). According to the 1993 DHS study that the HMOs suppressed, the five HMOs serving Medical Assistance enrollees at the time were providing mammograms to MA women at a rate equal to 36 percent of the rate at which HMOs provided mammograms to women insured by their employers. Similarly, the report found that HMOs were providing Pap smears to MA women at only 79 percent of the privately insured rate. The study also reported mixed evidence on whether HMOs were saving money by keeping MA enrollees out of emergency rooms.

portion of the management fee to medical services. It argued that fees for quality assurance, nurses, and related medical management services provided by United were medical, rather than administrative, costs.[12]

The following year, Alan Baumgarten, author of the Citizens League report, stated in a new report that he authored in his own name:

> Frankly, . . . some HMOs keep changing their allocation of costs to administration and medical care, and it is hard to be confident that the figures in the state filings portray an accurate picture. Last year, Medica reallocated part of the management fee it paid to United HealthCare from administrative costs to medical costs. Other HMOs have apparently picked up on that change and have also reallocated portion of their management fees paid for utilization review, medical management or sometimes provider relations, to medical costs.[13]

Judging from the data in Exhibit 1, the subcategory of "medical spending" that the HMOs chose to allocate administrative costs to was the "other professional services" category. This category is a garbage bag category that includes not only professionals, such as psychologists and optometrists, but "clinical personnel such as ambulance drivers, technicians, paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel, and medical record clerks." Looking at Exhibit 1, you can see that from 1991 to 1997, "other professional services" costs soared while administrative expenses declined slightly.[14]

The data in Exhibit 2 show that four of the nation's largest insurers have very large overheads (according to the 10K reports they file with the Securities Exchange Commission) compared with the 10 percent overheads claimed by Minnesota's HMOs. The overheads range from 18 to 33 percent. The difference between these rates and the official Minnesota HMO overhead rates cannot be explained by the fact that Minnesota HMOs are by law nonprofit. The profits of for-profit HMOs are not that much larger than the "surpluses" reported by nonprofits, and in any case profits constitute only 3 to 4 percent of for-profit insurer expenditures.[15] Note moreover that the overhead figures in Exhibit 2 are for insurers that are much larger than Minnesota's HMOs, a factor which probably should raise their administrative costs as a percent of revenues. If the companies listed in Exhibit 2 are representative of all insurers, and if economy of scale is a factor in

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[12] Citizens League, *Minnesota Managed Care Review*, 1993, Minneapolis, MN (no publication date listed), 30.

[13] Allan Baumgarten, *Minnesota Managed Care Review* 1994, 23.

[14] But according to a January 22, 2004 letter from Kent Peterson to Dr. Lee Beecher, president of the Minnesota Physician-Patient Alliance, "other professional services" took an astonishing drop, from 19 percent of HMO revenues in 1997 to 6 percent in 2002. Nevertheless, the average administrative-expenditures-to-revenues figure for the HMOs fell slightly from 9.6 percent in 1997 to 8.9 percent. Mr. Peterson offered no explanation for this drop.

[15] The Centers for Medicare and Medicaid Services reported a 4.4 percent profit rate for for-profit insurers in 2002. Total overhead for all for-profits was 24 percent. *Health Care Industry Market Update: Managed Care*, March 2003, http://www.cms.hhs.gov/reports/hcimu/hcimu_03242003.pdf, accessed May 19, 2004. United Health Group, one of the most profitable US health insurance companies, enjoyed earnings equal to 7 percent of revenues in the fourth quarter of 2004 (David Phelps, "United's earnings, outlook both rise," *Star Tribune*, January 21, 2005, D1).

**Exhibit 1: Expenditures as a percent of HMO revenues, 1991 and 1997**

| | 1991 | 1997 | Change |
|---|---|---|---|
| Medical and hospital expenditures | | | |
| Physicians | 31 | 31 | 0 |
| **Other professional services** | **8** | **19** | **11** |
| Outside referrals | 5 | 3 | -2 |
| ER and out-of-area | 3 | 3 | 0 |
| Occupancy + depreciation | 1 | 1 | 0 |
| Inpatient | 26 | 22 | -4 |
| Incentive pools | 1 | 1 | 0 |
| Other medical and hospital | 11 | 12 | 1 |
| Less reinsurance/other credits | –2 | -1 | 1 |
| Total med and hosp exps | 84 | 91 | 7 |
| | | | |
| Administrative expenditures | | | |
| Compensation | 8 | 4 | -4 |
| Interest expense | 0 | 0 | 0 |
| Occupancy + depreciation | 1 | 1 | 0 |
| Marketing | 1 | 2 | -1 |
| Other administrative | 3 | 3 | 0 |
| **Total administrative** | **12** | **10** | **-2** |
| | | | |
| Total expenditures | 96 | 100 | |
| | | | |
| Net income (loss) | 4 | 0 | |

Source: Allan Baumgarten, Memo to David Giel, Senate Counsel and Research, September 17, 1998.

**Exhibit 2: The four largest health insurance companies and their overhead**

| Company | Number of people insured* | Overhead* |
|---|---|---|
| United Health Group | 16.2 million | 18% |
| Aetna | 14.4 million | 25% |
| Cigna | 13.3 million | 33% |
| Wellpoint | 13.1 million | 25% |
| Total | 57.0 million | |

* Data on number insured is for 2002; data on overhead is for 1999.

* Overhead is defined as the percent of revenues not spent on medical care.

Sources: Enrollment data from Milt Freudenheim, "Cigna to feel major loss in customers," *New York Times*, October 29, 2002, C4; overhead figures from Steffie Woolhandler and David U. Himmelstein with Ida Hellander, *Bleeding the Patient: The Consequences of Corporate Health Care*, Common Courage Press, Monroe, ME, 2001, 109.

overhead, then the slightly smaller surpluses of Minnesota HMOs should be offset by slightly higher administrative costs.

Perhaps the single best study of the overhead costs of Minnesota HMOs was done by Attorney General Mike Hatch between 2000 and 2002. Mr. Hatch's audit of Allina, and later of HealthPartners, appear to be the only two independent audits ever done of a Minnesota HMO. In February 2000, Hatch announced that he would audit Allina's books. Allina put up fierce resistance, but was ultimately forced by a court order to let Mr. Hatch's auditors examine their books. Hatch reported that Medica (then the HMO division of Allina) had much higher overhead costs than it was reporting to the Department of Health. Specifically, Mr. Hatch found:

> Medica reported administrative expenses [to MDH] . . . in 2000 equal [to] 12.7 percent of its premium revenue, . . . 12.6 percent . . . in 1999, and . . . 12.5 percent . . . in 1998. . . . In contrast, Medica reported in its December 2000 *internal* financial statement that its overall administrative expenses for 2000 were 17.1 percent of revenue. . . . The State concluded that Medica's administrative expenses in 2000 were approximately 18.7 percent of revenue, in 1999 at least 19.1 percent, and in 1998 . . . at least 17.6 percent of revenue.[16]

**Conclusion**

The evidence indicates that Minnesota HMOs cannot make money off MinnesotaCare, MA, and GAMC unless they can figure out some way to offset their overhead costs. The only options open to them are getting paid a subsidy by DHS, reducing reimbursements to providers, and cutting services to patients. According to DHS, the HMOs are not cutting their costs by reducing provider reimbursements. According to research, HMOs can only cut services by about 4 percent. If in fact Minnesota HMOs did not reduce provider fees, were unable to cut services by more than 4 or 5 percent, had overhead costs that were even as low as 10 percent, and were not receiving a subsidy from the taxpayer, Minnesota HMOs serving DHS programs have to be operating in the red. Clearly they are not. We believe the HMOs are not operating in the red because they are receiving handsome subsidies from the taxpayer, subsidies that should be going to patients.

MUHCC believes that after two decades of privatization, it's time to deprivatize. We believe it is wrong to cut people and services from MinnesotaCare, MA and GAMC, and very wrong to cut funding without even discussing the option of cutting the HMOs out of these programs. We recognize that the evidence for cutting the HMOs out of these programs is not peer-reviewed. But on the other hand, the evidence for privatizing was almost nonexistent. But that didn't stop the legislature and the governor from proceeding with privatization. We believe the evidence we have presented is more than enough to warrant deprivatizing MinnesotaCare, MA, and GAMC immediately. We urge you to do so.

Thank you.

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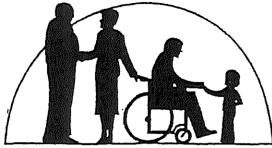
[16] Chapter 7: Administrative Costs of Medica HMO, 8-9; italics in original.



Minnesota Department of **Human Services**

December 16, 2004

The Honorable Matt Entenza
Minnesota House of Representatives
267 State Office Building
St. Paul, MN 55155-1298

Dear Representative Entenza:

Thank you for your follow-up letter regarding the impact of the managed care delivery system on the State's payment for health care services and on payment rates for Minnesota Health Care Program (MHCP) providers.

In your letter you asked for a specific response regarding the amount of savings that is attributable to managed care contracts. The Department of Human Services (DHS) has been contracting with managed care organizations (MCOs) to serve clients on the MHCP for a number of years. We began enrolling certain Medical Assistance (MA) and General Assistance Medical Care (GAMC) eligible individuals in managed care in 1987. In 1996, we began enrolling the MinnesotaCare eligible population. There no longer remains a credible comparison group of fee-for-service recipients against whom to compare the groups now enrolled in managed care. We do not have a methodology that could accurately assess whether managed care has cost us more or less than fee-for-service. The managed care rates do reflect managed care experience, but DHS also takes into consideration overall spending in MCHP. In 2004, rates for MCOs contracting for MHCP increased just over 6 percent overall. For 2005, the rate increase will be approximately 7.5 percent overall. This is well within the projected range of 8 to 12 percent for commercial plans for this timeframe.

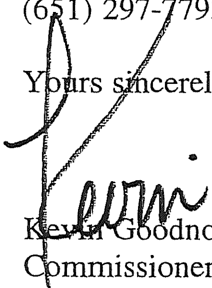
There are a number of benefits to managed care that accrue both to enrolled recipients and to the State. Managed care organizations are required to provide access to all medically necessary covered services. Under fee-for-service (FFS) there is no comparable requirement for an enrolled provider to serve all recipients who present for care. Managed Care Organizations provide customer services, nurse triage services, care coordination and are required by state and federal law to have in place a structure to provide quality assurance for the care delivery process. In addition, from the State's point of view, we are better able to predict costs under a managed care structure because we know exactly what the State's cost will be for an individual of a specified age, gender and living arrangement.

You also asked for specific information regarding the differences between rates paid by the DHS fee-for-service (FFS) program and the rates paid by health plans. Each MCO negotiates its own

contracts with its provider network. The Department of Human Services does not have complete, comparable data regarding payment by the managed care plans. We do collect information regarding charges; however, the reported payment amounts are not necessarily comparable either to FFS payment amounts or to actual amounts paid by MCOs. For instance, DHS pays for office visits on the basis of a set fee for a certain procedure code; a managed care organization may pay for the same service on a specified fee basis, or the MCO many have a capitation arrangement under which it pays a monthly fee to a clinic for each enrollee who has chosen that clinic as their primary care site, regardless of what services are used by an individual enrollee in a given month. In order for you to gain more detailed information regarding MCO payment rates, I would recommend that you contact each health plan.

If you would like assistance in setting up appropriate contacts, Karen Peed, a member of Department staff, would be happy to work with your staff. Ms. Peed can be reached at (651) 297-7793.

Yours sincerely,



Kevin Goodno
Commissioner

# Federal and State Revenue Reductions to HCMC (1998 - 2004)

# FEDERAL

**-Fiscal Consequences to HCMC of federal Balanced Budget Act of 1997-**

- Medical Education (1998-2002) total loss $18.76M - avg. annual loss of $3.13M
- Disproportionate Share-Hospital (1998-2002) total loss $4.7M - avg. annual loss of $783,000.
- Transfer Cases Redefined (1998-2002) total loss $3.15M - avg. annual loss of $630,000.
- PPS/TEFRA Inflation Eliminated (1998-2002) total loss $6.93M - avg. annual loss of $1.15M.
- Outpatient PPS (2000-2002) total loss $2.36M - avg. annual loss of $787,000.
- ASC Formula Driven Overpayment (1998-2002) total loss $3.51M – avg. annual loss $584,000.

**Total estimated loss of federal funding for HCMC $39.41M – average annual loss $6.57M**

# State of Minnesota

**Fiscal Consequences to HCMC of Budget Balancing Decisions** (2003 thru 2005)

- Reduced MA/GAMC Hospital Payments (2003-2005) total $6.5M – annual loss $2.17M
- No MA Rebasing & IGT ratable reductions (2003-2005) total $1.3M – annual loss $431,084.
- No GAMC PMAP-GME rate, MERC/MEIF loss (2003-2005) total $3.7M – annual loss $1.23M
- Reduced MA/GAMC PMAP rate (2% for 2003-2005) total $2.1M – annual loss $694,000.
- GAMC/MA Eligibility/Access Reductions (2003-2005) total $14.3M – annual loss $4.75M
- Other Public Program Eligibility Reductions (2003-2005) total $2.7M – annual loss $905,000
- Losses From Unpaid/Non-reimbursed Co-Pays (2003-2005) total $1.6M – annual loss $526,000

**T al Estimated loss due to State of Minnesota Reductions** (2003-2005) **$32.2M – annual loss $10.7M**

STATE & FEDERAL REVENUE REDUCTIONS TO HCMC – 1998 THRU 2005

## Total of $71.61M or, $8.95M per year.

# UNCOMPENSATED CARE *COSTS* AT HCMC*

| 1999 | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| $20.996M | $20.642M | $23.824M | $23.067M | $22.799M | $31.408M (est.) |

- A 37.8 percent increase between 2003 and 2004.
- In 2003, 693 HCMC admissions were uninsured whereas, in 2004 that number had risen to 1,194 – a 73 percent increase.
- **34,812** different uninsured outpatients received HCMC medical services 80,281 times in 2002;

  **37,812** different uninsured outpatients received HCMC medical services 84,013 times in 2003;

  **45,754** different [currently uninsured*] outpatients received HCMC medical services an estimated 125,667 times in 2004.
- Approx. 24% of HCMC's uncompensated care is incurred by non-Hennepin County residents – **includes bad debt and charity care from outside Minnesota.**

* Number may lessen as applications for public programs are finalized or insurance materializes.

# GOVERNOR PAWLENTY'S BUDGET PROPOSALS

MINNESOTA'S 2006/2007 BIENNIUM (July 1, 2005 - June 30, 2007)

## *ESTIMATED IMPACT TO HCMC*

- A five percent reimbursement rate reduction in MA/GAMC & MinnesotaCare results in an estimated annual loss to HCMC of **$8.72 million.**

- Eligibility changes within the MinnesotaCare Program will have a financial impact on HCMC as well, i.e., fewer Minnesotans covered by public program insurance inevitably results in further increases to HCMC, and others, uncompensated care level. Estimated annual impact to HCMC is conservatively estimated at **$3.32 million** or higher.

Should Governor Pawlenty's entire budget recommendations prevail, HCMC conservatively estimates our annual losses may well exceed this **$12.04M** total.

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## OVERVIEW

1. Over the last seven years (1998 - 2004) Congress and the State of Minnesota have reduced HCMC's scheduled revenues by approximately $70M.

2. HCMC witnessed a 38 percent increase in uncompensated care **costs** between 2003 and 2004 - $22.8M to $31.4M respectively.

3. 34,800 different uninsured individuals were treated 80,300 times by HCMC in **2002; by 2004** that number had risen to 45,800 different uninsured individuals treated 125, 700 times – a 31% increase in uninsured individuals and a 56% increase in uninsured HCMC visits.

4. An estimated 20% of HCMC's uncompensated care **costs** are incurred by uninsured Minnesotans who reside outside of Hennepin County – approx.$6.2M per year.

**HCMC can not fully sustain our statewide healthcare safety-net mission and responsibilities if Congress and the State of Minnesota continue reducing reimbursement rates and public program eligibility and enrollment.**

February 16, 2005

MN Senate Committee Members
Health & Human Services Budget Division

Dear Senator:

You may be wondering what the enclosed check is for. Based on estimates from the MN Department of Human Services, this is the amount ($1,027,019.00) that the state of Minnesota wasted on non-medically necessary infant circumcisions in 2002 through the Medical Assistance (Medicaid) program. This figure does not take into account inflation since 2002, or many of the indirect costs of circumcision, which would increase the total eight- to ten-fold. (See enclosed cost calculations.)

As a taxpayer in this state, I urge you to stop wasting precious health care dollars on this outdated cosmetic surgery and instead use this money on necessary services for the low-income citizens of Minnesota. This would be a prudent step to take at any time, but it is especially important now, with the $700 million+ deficit that is looming over our state. We simply cannot afford to continue wasting money this way, and must get our priorities straight.

Here are a few common myths and facts regarding non-therapeutic infant circumcision:

**Myth:** Infant circumcision is ordered by a doctor.
***Fact: Infant circumcision is a non-therapeutic, cosmetic surgery; therefore, it is NOT ordered by a doctor to treat a medical condition.*** It is done by parental request or consent (often woefully *un*informed consent) for religious or cultural reasons, *not* medical reasons. Compounding this is the fact that many Medical Assistance recipients *think* circumcision is necessary since MA pays for it.

**Myth:** Infant circumcision is medically necessary.
***Fact: No national medical organization in the world recommends newborn circumcision (see enclosed), and they all recognize that it is an elective procedure.*** In addition, circumcision causes extreme pain and trauma for the newborn during and after the surgery, and has been shown to cause reduced sexual sensitivity later in life.

**Myth:** Circumcision is a community standard, and therefore should be covered by Medical Assistance.
***Fact: Circumcision rates in the U.S. have fallen over the last two decades; currently just over half of all infant boys in the U.S. are circumcised. Therefore, it is no longer a "community standard." Furthermore, medical necessity is what should determine coverage, not someone's outdated idea of community standards.*** On a worldwide basis, 85% of the world's male population is intact. National health plans in the United Kingdom, Canada, New Zealand and Italy have not covered unnecessary circumcisions for years, and in December 2004, the Netherlands also dropped coverage (see enclosed).

**Myth:** Circumcision is a low-cost, low-risk procedure.
***Fact: Unnecessary circumcisions cost Minnesota over one million dollars per year in direct costs alone. There are risks associated with any surgery, and complications related to circumcision commonly occur, resulting in additional costs, as well as pain and trauma to the infant.*** A recent cost-utility study of neonatal circumcision that was published in the Nov-Dec 2004 issue of *Medical Decision Making*[1] showed that the indirect cost of treating botches, complications, additional hospital costs, etc. increased the direct costs of circumcision by a factor of about 8. This means that Minnesota's total cost for this non-medically necessary surgery is over ***$8 million per year.***

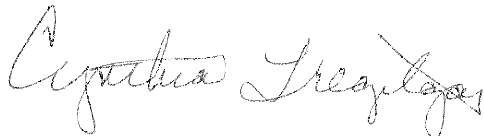
**Myth:** Circumcision is covered by everyone else.
***Fact: Thirteen (13) states have already defunded unnecessary circumcisions, and more states will soon follow suit. Many private insurance carriers don't cover it, and the Center for Medicare and Medicaid Services (CMS) lists the code for circumcision (ICD-9-CM code V50.2) as a non-covered expense, meaning that it may be unlawful to use federal funds to pay for it.*** It is interesting to note that the ICD-9 CM code for circumcision (V50.2) is listed in the same category of non-covered services as hair transplants and ear piercing (see enclosed).

**Myth:** Not covering circumcision hurts the poor.
***Fact: It is harmful to the poor that many of their legitimate medical needs go unmet, while the state continues to pay for an unnecessary cosmetic procedure. Every health care dollar spent on a medically unnecessary service is a dollar that is not available to cover medically necessary and beneficial services.*** Over the last two years, thousands of low-income Minnesotans have lost MA coverage, which often means they get virtually no medical care at all. Yet, astoundingly, the state continues to pay for unnecessary circumcisions rather than use this money for medical services that are truly needed. Furthermore, without Medical Assistance payment, a parent can continue to choose to have their infant boy circumcised, they just need to pay for it themselves rather than having it provided (and tacitly recommended) at taxpayer expense.

Enclosed is a petition that has been signed by forty-eight (48) people in Minnesota so far. This demonstrates that many **people all over the state are opposed to using taxpayer dollars to pay for medically unnecessary circumcisions. Please listen to your constituents and ensure that our scarce healthcare dollars are not used for non-therapeutic, cosmetic procedures, just medically necessary ones.** Also enclosed is a copy of The Medical Director's Guide to Male Circumcision that provides further information about circumcision, along with a Model Male Circumcision Policy that is based on the North Carolina and Mississippi Medicaid policy statements.

I look forward to hearing what steps you are taking to use the enclosed check in a more responsible fashion. Several other states, such as North Carolina, Montana and Florida recently saved Medicaid millions of dollars by including a provision to eliminate funding for non-medically necessary circumcisions in their Medicaid budget bills. As one legislator in Florida said, "you have to spend Medicaid dollars on medically necessary services. It really is a no-brainer."

Sincerely,



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[1] Van Howe RS. A cost-utility analysis of neonatal circumcision. *Med Decis Making* 2004; 24: 584-601.

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# Current Position Statements of Medical Societies in English-Speaking Countries

## 2002 Royal Australasian College of Physicians (RACP):

"After extensive review of the literature the RACP reaffirms that **there is no medical indication for routine male circumcision**. The possibility that routine circumcision may contravene human rights has been raised because circumcision is performed on a minor and is without proven medical benefit. Review of the literature in relation to risks and benefits shows there is no evidence of benefit outweighing harm for circumcision as a routine procedure."

## 2000 American Medical Association (AMA):

"Virtually all current policy statements from specialty societies and medical organizations do not recommend routine infant circumcision...The AMA supports the general principles of the 1999 Circumcision Policy Statement of the American Academy of Pediatrics."

## 1999 American Academy of Pediatrics (AAP) Circumcision Policy Statement:

"Existing scientific evidence demonstrates potential medical benefits of newborn male circumcision; however these data are not sufficient to recommend routine neonatal circumcision...if a decision for circumcision is made, procedural anesthesia should be provided...it should only be done on infants who are stable and healthy."

## 1996 Canadian Paediatric Society, Fetus and Newborn Committee:

"[The Committee] does not support recommending circumcision as a routine procedure for newborns."

## 1996 British Medical Association Guidelines, Circumcision of Male Infants:

"To circumcise for therapeutic reasons where medical research has shown other techniques to be at least as effective and less invasive would be unethical and inappropriate."

## 1996 Australasian Association of Paediatric Surgeons:

"We do not support the removal of a normal part of the body, unless there are definite indications to justify the complications and risks which may arise. In particular, we are opposed to male children being subjected to a procedure, which had they been old enough to consider the advantages and disadvantages, may well have opted to reject the operation and retain their prepuce [foreskin]."

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*No national medical organization in the world recommends routine circumcision of male infants.*

canada.com **News**

# Unkind cut: Dutch medicare halts coverage for male circumcision

Canadian Press

*December 17, 2004*

AMSTERDAM, Netherlands (AP) - The Dutch national health insurance will no longer pay for male circumcision, the Heath Ministry said Friday.

The ministry decided to halt compensation following reports that up to 90 per cent of circumcisions are carried out for religious, rather than health reasons, as specified in Dutch law, ministry spokesman Bas Kuik said.

Muslims and Jews routinely circumcise boys at birth. Around 8.5 per cent of children born in the Netherlands are circumcised, or about 17,000 a year. The average cost at birth, when there are no complications, is around $650 Cdn.

Female circumcision - sometimes called genital mutilation - is outlawed in the Netherlands, and the government plans a law making it possible to prosecute parents who travel to foreign countries to have their daughters circumcised.

Justice Minister Piet Hein Donner said in October the government has no plans to outlaw male circumcision, which is classified as a cosmetic surgery if not medically necessary.

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# <u>ICD-9 CM Codes</u> (included in list of Non-Covered Items by CMS)

## V50 Elective surgery for purposes other than remedying health states

**V50.0** Hair transplant

**V50.1** Other plastic surgery for unacceptable cosmetic appearance

Breast augmentation or reduction
Face-lift

**Excludes:** plastic surgery following healed injury or operation (V51)

**V50.2** Routine or ritual circumcision

Circumcision in the absence of significant medical indication

**V50.3** Ear piercing

**V50.4** Prophylactic organ removal

**Excludes:** organ donations (V59.0-V59.9)
therapeutic organ removal code to condition

**V50.8** Other

**V50.9** Unspecified

September 2004

# The Medical Director's Guide to Male Circumcision

*Published by*
*Doctors Opposing Circumcision,*
*George C. Denniston, MD, MPH, President*
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Medical expenses are rising faster than available resources. Consequently, there is great interest in reducing unnecessary expenses. We offer this information regarding male circumcision so that medical directors may have full information about the advisability of discontinuing coverage of male circumcision, especially that of the newborn.

Infant boy screams in agony as doctor uses a blunt probe to destroy his natural balano-preputial lamina, the protective membrane that fuses the foreskin to the glans, a normal anatomical feature of all healthy infants, prior to starting the actual circumcision.

There are no medical indications for circumcision of newborn infants.[1] [2] No disease of the foreskin is present in newborn male infants, so no therapeutic action is required. The Council on Scientific Affairs of the American Medical Association classifies neonatal male circumcision as a *non-therapeutic* procedure.[3] The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, in a joint

[1] Foetus and Newborn Committee. FN 75-01 Circumcision in the Newborn Period. *Canadian Paediatric Society News Bulletin Supplement* 1975;8(2):1-2.
[2] Committee on Fetus and Newborn: *Standards and Recommendations for Hospital Care of Newborn Infants*. Sixth Edition. American Academy of Pediatrics; Evanston, IL, 1977: 66-7.
[3] Council on Scientific Affairs, American Medical Association. Report 10: Neonatal circumcision. Chicago: American Medical Association, 1999. Available at URL: http://www.ama-assn.org/ama/pub/article/2036-2511.html

publication, *Guidelines for Perinatal Care*, have re-classified neonatal circumcision as an "*elective procedure to be performed at the discretion of the parents*."[4] [5] This re-classification removes any suggestion that newborn circumcision is a normal part of hospital routine or a medically recommended procedure. Medically unnecessary non-therapeutic infant circumcision, therefore, is not presently the American standard of care.

A few doctors have expressed the *opinion* that there are medical or prophylactic benefits from circumcision. The medical *evidence*, however, does not support these claims. Recent evidence-based statements from the American Academy of Pediatrics,[6] the American Medical Association,[7] the American Academy of Family Physicians,[8] and the American College of Obstetricians and Gynecologists[9] firmly establish that circumcision is *not* medically necessary. All decline to recommend the procedure. All emphasize that circumcision is an *elective* procedure to be performed only at patient request.

Medical societies worldwide find that the *alleged* benefits do *not* exceed the *known* risks.[10] [11] They counsel that circumcision should *not* be *routinely* performed, meaning that circumcision should *not* be performed without a specific medical indication.

Medical studies support removal of non-therapeutic neonatal circumcision from the schedule of covered procedures. Cadman *et al.* studied the economics of elective neonatal non-therapeutic circumcision. They found it to be uneconomic and recommend that public health care dollars not be expended on neonatal circumcision.[12] They argue that funds spent on this wasteful procedure should be spent on medically useful services. They recommend that parents bear the cost of this unnecessary elective surgery. Spilsbury *et al.* have studied the effects of insurance coverage of elective non-therapeutic circumcision.[13] They find that coverage of non-therapeutic circumcision should be discontinued to encourage parents to elect the medically preferred option of non-circumcision. *Non-circumcision is the preferred medical choice for infants.*[14] [15] [16] [17] [18] [19] [20] [21] [22] [23] [24] [25] [26] [27]

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[4] American Academy of Pediatrics & American College of Obstetricians and Gynecologists. *Guidelines for Perinatal Care*, Fourth Edition, 1997.

[5] American Academy of Pediatrics & American College of Obstetricians and Gynecologists. *Guidelines for Perinatal Care*, Fifth Edition, 2002.

[6] American Academy of Pediatrics Task Force on Circumcision. Circumcision Policy Statement. *Pediatrics* 1999;103(3):686-93. URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;103/3/686

[7] Council on Scientific Affairs, American Medical Association. Report 10: Neonatal circumcision. Chicago: American Medical Association, 1999. Available at URL: http://www.ama-assn.org/ama/pub/article/2036-2511.html

[8] Commission on Clinical Policies and Research. *Position Paper on Neonatal Circumcision*. Leawood, KS. American Academy of Family Physicians, 2002. URL: http://www.aafp.org/policy/camp/4.html

[9] ACOG Committee Opinion Number 260: Circumcision. *Obstetrics & Gynecology* 2001; 98(4):707-8.

[10] Fetus and Newborn Committee, Canadian Paediatric Society. Neonatal circumcision revisited. (CPS) *Can Med Assoc J* 1996; 154(6): 769-780. URL: http://www.cps.ca/english/statements/FN/fn96-01.htm

[11] Beasley S, Darlow B, Craig J, *et al.* Position statement on circumcision. Sydney: Royal Australasian College of Physicians, 2002. URL: http://www.racp.edu.au/hpu/paed/circumcision/

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[25] Fetus and Newborn Committee, Canadian Paediatric Society. Neonatal circumcision revisited. (CPS) *Can Med Assoc J* 1996; 154(6): 769-780. URL: http://www.cps.ca/english/statements/FN/fn96-01.htm

[26] Beasley S, Darlow B, Craig J, *et al.* Position statement on circumcision. Sydney: Royal Australasian College of Physicians, 2002. URL: http://www.racp.edu.au/hpu/paed/circumcision/

## Medicaid Specific Information

Congress designates federal dollars for *medically necessary* services by state Medicaid programs.[28] The U.S Government Center for Medicare and Medicaid Services (CMS) has designated elective non-therapeutic circumcision at parental request (ICD-9-CM code V50.2) as a *medically unnecessary* service, which is inappropriate for coverage by Medicare.[29] Therefore, the lawfulness of the use of federal funds by state Medicaid programs for a medically unnecesary non-therapeutic procedure is in doubt.

The Code of Federal Regulations requires states to institute usage controls.[30]

The United States Code requires fraud controls to control fraudulent claims.[31]

The Medicaid programs of thirteen states (26%) — Arizona, California, Florida, Maine, Mississippi, Missouri, Montana, Nevada, North Carolina, North Dakota, Oregon, Utah, and Washington — have discontinued covering unnecessary non-therapeutic circumcision. California, the first, delisted medically unnecesaary circumcision in 1982; Maine, the most recent, delisted circumcision in February 2004. Other states actively are considering delisting circumcision.

The British National Health Service stopped payment for unnecessary non-therapeutic circumcision in 1950. Canada has 13 provincial and territorial health insurance plans, of which twelve (92.3%) have dropped coverage of circumcision. New Zealand's health plan discontinued coverage over 40 years ago.

A growing number of private insurers decline to reimburse for medically unnecessary procedures such as non-therapeutic circumcision.

Based on the above, we believe that deleting coverage of non-therapeutic circumcision is a responsible and reasonable action to reduce costs. It is appropriate to shift the cost of this *elective* medically-unnecessary non-therapeutic surgery and its complications to those who *elect* to have a circumcision performed.[32] [33]

### Additional Costs

The total cost for circumcision is likely to be much higher than one would expect because, if circumcision is performed, both mother and baby tend to remain in hospital longer and consume more services.[34]

When circumcisions are performed, complications frequently occur and must be treated at additional expense. The most common complications of circumcision are bleeding and infection. Infection may be minor or major. Major infections include meningitis,[35] tuberculosis,[36] and necrotizing fasciitis requiring extensive surgical

[27] Spilsbury K, Semmons JB, Wisniewski ZS, Holman CD. Routine circumcision practice in Western Australia 1981–1999. *ANZ J Surg* 2003;73(8):610-4.
[28] 42 U.S.C. 1396.
[29] Centers for Medicare and Medicaid Services. *Medicare National Coverage Determinations Manual (NCD).* Baltimore: Centers for Medicare and Medicaid Services, 2003: p. 14. URL: http://www.cms.hhs.gov/coverage/manual3.pdf
[30] 42 C.F.R. 456.3
[31] 42 U.S.C. 1396b-(q)
[32] Cadman D, Gafni A, McNamee J. Newborn circumcision: an economic perspective. *Can Med Assoc J* 1984;131:1353-5.
[33] Spilsbury K, Semmons JB, Wisniewski ZS, Holman CD. Routine circumcision practice in Western Australia 1981–1999. *ANZ J Surg* 2003;73(8):610-4.
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[35] Scurlock JM, Pemberton PJ. Neonatal meningitis and circumcision. *Med J Aust* 1977;1(10):332-4.
[36] Holt LE. Tuberculosis acquired through ritual circumcision. *JAMA* 1913;LXI(2):99-102.

debridement of infected tissue.[37] Some examples are: Van Howe reported a case in which the baby was unable to nurse after circumcision, resulting in a four-day hospital stay,[38] and Connelly *et al.* reported a case of gastric rupture secondary to neonatal circumcision, which resulted in a 25-day hospital stay.[39] Botched circumcisions sometimes result in cases of inconspicuous penis that require surgical attention.[40] Penile ablation is a complication of circumcision, usually treated by costly surgical reconstruction of a phallus[41] or a sex change operation with psychosexual follow-up.[42] Unfortunately, there are no data to indicate the total cost of treatment for complications of circumcision.

Meatitis, meatal ulceration, and meatal stenosis occur only in circumcised boys who lack the protection of the foreskin. Meatal stenosis usually requires a meatotomy. Circumcised boys also tend to be troubled with adhesions – caused by the raw residual foreskin healing to the raw glans penis – which may require a lysing.[43]

When circumcisions are avoided, these additional costs, which fall on the health insurance provider, also are avoided.

**The Normal Foreskin in the Child**

Many doctors see only circumcised boys and may not be familiar with the normal intact foreskin.

The prepuce of infants and children is quite different from that of adults because the penis is developmentally immature at birth. The inner surface of the prepuce is attached to the underlying glans penis.[44] The foreskin often extends well beyond the tip of the glans penis of the infant.[45] [46] The opening of the foreskin usually is narrower than the glans penis, so the foreskin cannot be retracted. The long narrow non-retractile foreskin provides certain health benefits.[47] It protects the glans penis from contact with the ammonia from urine and prevents meatitis, meatal ulceration, and meatal stenosis—conditions seen only in circumcised boys. Furthermore, the narrow sphincter-like foreskin opening prevents admission of fecal material with bacteria to the vicinity of the urethra and helps to prevent urinary tract infection. A long, narrow non-retractile foreskin, therefore, is completely normal, healthy, and advantageous in infants and children.

The penis matures during the childhood and pubertal years. The inner surface of the foreskin gradually separates from the glans penis; the shaft of the penis lengthens, and the apparently excessive foreskin ceases to exist; the opening of the foreskin widens; and the foreskin becomes retractable.[48] The rule of thumb is that 50 percent of boys have a retractile foreskin by puberty, and the hormones of puberty complete the process for the majority of others. After puberty, the penis assumes its adult appearance without the need for surgery.

Redundant prepuce refers to a prepuce that someone thinks is too long. However, there is no objective standard to determine how much is too long, just as there is no objective standard to determine whether someone's nose is too long. So-called "redundant prepuce" is not a medical problem.[49]

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[37] Bliss Jr DP. Healey PJ, Waldhausen JHT. Necrotizing fasciitis after Plastibell circumcision. *J Pediatr* 1997;31:459-62.
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[49] Fleiss PM, Hodges FM. *What your doctors may not tell you about circumcision*. New York: Warner, 2002: 171, 199.

### Code Information

ICD-9-CM 64.0 is the code for a circumcision operation, which may or may not be medically necessary. The medical industry provides guides for doctors to assist them in obtaining payments from health insurance providers. One such guide[50] recommends using ICD-9-CM code V.50.2 to obtain payment for circumcision. Code V50.2 is for elective circumcision at parental request, which denotes a circumcision in the *absence* of any medical indication, and which CMS has determined to be *medically unnecessary*. This guide also recommends the use of ICD-9-CM Code 605, which, as we indicate in the discussion above, denotes a *normal* condition in the newborn, child, and youth. ICD-9-CM Code 605 denotes phimosis, adherent prepuce, or redundant prepuce, conditions that are normal physiology in a male infant, and *do not* indicate pathology or disease. Up-coding of ICD-9-CM V50.2 circumcision to ICD-9-CM 605 is fraudulent and abusive.

Current Procedure Terminology (CPT) codes also are used to obtain payment for non-therapeutic circumcision of the newborn. Codes are available for non-therapeutic procedures. The existence of these codes does not imply that the procedure is beneficial or necessary.

| Code | Description |
|---|---|
| 54150 | circumcision, using clamp or other device: newborn |
| 54160 | circumcision, surgical excision other than clamp, device or dorsal slit: newborn |
| 54163 | repair incomplete circumcision. |

The American College of Obstetricians and Gynecologists now is advising its members to use anesthetic codes to obtain payments for non-therapeutic circumcisions.[51] They specifically recommend code 00920 (anesthesia for procedures on male genitals not otherwise specified) and code 64450 (injection, anesthetic agent; other peripheral nerve or branch). These codes should raise a red flag when submitted by an obstetrician.

There is no medical purpose for these procedures, which, when performed, create an abnormal physical appearance. The American Academy of Family Physicians now classifies neonatal circumcision as a "cosmetic" procedure.[52]

### Recommendations

Doctors Opposing Circumcision makes the following recommendations:

1. No payment should be allowed under any circumstances for CPT Codes 54150, 54160, and 54163 because 54150 and 54160 are for non-therapeutic neonatal circumcision for which there is never a medical indication. CPT Code 54163 is a non-therapeutic cosmetic procedure to excise more tissue. (The American Medical Association describes neonatal circumcision as a 'non-therapeutic' procedure.[53])

2. ICD-9-CM code V50.2 should not be recognized as a valid diagnostic code because this is for medically unnecessary non-therapeutic circumcision at parental request. (The CMS says this is a medically unnecessary service.)

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3. ICD-9-CM diagnostic code 605 should not be recognized as a valid diagnostic code in children because this code describes conditions that are normal prior to the completion of puberty, and which are pathological only in adults. Code 605 in infants is a fraudulent up-coding from Code V50.2.

4. Conservative treatment should be required prior to approval of a request for therapeutic circumcision.[54]

5. Prior approval for coverage of a therapeutic circumcision should be required. Evidence of need must be submitted with the application. Such evidence should include a complaint, diagnosis of a disease, and a pathologist's report on the actual existence of preputial disease (usually balanitis xerotica obliterans or BXO[55 56]). In the absence of documented evidence of disease, requests for circumcision payments should be refused.

6. In the alternative, claims for payment for a therapeutic circumcision must be accompanied by a pathologist's report showing disease for which circumcision is the treatment of choice, or payment should be refused in the absence of the pathologist's report of disease (BXO).

Implementation of these measures should greatly reduce the number of payments for circumcision procedures, the vast majority of which are medically unnecessary. DOC believes that these measures are sufficient to satisfy the requirements of federal Medicaid law.

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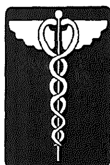
[56] Spilsbury K, Semmens JB, Wisniewski ZS. *et al.* Circumcision for phimosis and other medical indications in Western Australian boys. *Med J Aust* 2003 178 (4): 155-158. URL: http://www.mja.com.au/public/issues/178_04_170203/spi10278_fm.html



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***"Fear, pain, crippling, disfigurement and humiliation are the classic ways to break the human spirit. Circumcision includes them all."***

## Model Male Circumcision Policy for Health Insurance Providers

Male circumcision is an elective operation to excise the foreskin from the penis. It seldom is medically necessary. The operation destroys the evidence of disease or lack of disease so the operation is prone to abuse and fraud. This policy identifies medically necessary circumcision, controls usage, and prevents fraud.

1. Prior approval is required.

2. Only medically necessary procedures are covered.

3. Circumcision of the newborn (CPT 54150, using clamp; CPT 54160, surgical excision) is not covered because it is medically unnecessary.

4. Circumcision revision (CPT 54163) is not covered because it is a medically unnecessary cosmetic procedure.

5. Applications for approval of post-neonatal circumcision (CPT 54152 and 54161) must include full supporting data including diagnosis and a pathologist's report. A trial of conservative treatment is required in cases of balanitis or phimosis before approval.*

6. Diagnosis code ICD-9-CM V50.2 (Circumcision at patient (or parental request)) does not support medical necessity and is not covered.

7. Diagnosis code ICD-9-CM 605 (Phimosis, redundant prepuce, adherent prepuce, paraphimosis, and tight foreskin) does not support medical necessity for circumcision in infants and children and is not covered for patients under the age of 18.

8. Ballooning of the foreskin during urination is not an indication for circumcision.

9. Diagnoses supporting medical necessity include irreparable physical trauma, frostbite, gangrene, malignancy, yeast infection secondary to diabetes mellitus, and balanitis xerotica obliterans (lichen sclerosus et obliterans).

*Phimosis may conservatively be treated medically with topical steroid ointment or surgically with preputioplasty.

09/04

# Petition for the Elimination of Taxpayer Funding of Medically Unnecessary Infant Circumcisions in Minnesota

To: **Commissioner, MN Department of Human Services**
444 Lafayette Road North
Saint Paul, MN 55155

**MN House – Health Policy and Finance Committee**
**MN Senate – Health and Family Security Committee**
**MN Senate – Health and Human Services Budget Division**

***We, the undersigned citizens of Minnesota, petition the Minnesota Department of Human Services and the Minnesota Legislature to ban the use of taxpayer dollars to fund non-therapeutic male infant circumcisions. Routine infant circumcision is not recommended by any national medical organization in the world, including the American Academy of Pediatrics, the American Medical Association, and the American College of Obstetricians and Gynecologists. We object to taxpayer dollars being used to fund medically unnecessary procedures.***

Petition Title: Elimination of Taxpayer Funded, Medically Unnecessary Circumcisions in Minnesota

Petition Target: Minnesota Dept of Human Services Commissioner and the Minnesota Legislature

| Name | Address | District | Comments |
| --- | --- | --- | --- |
| Cynthia Tregilgas | 670 Norell Ave. N., West Lakeland, MN 55082 | 56A | Medically unnecessary circumcisions should not be funded with taxpayer dollars! |
| Jackie Jeffery | 17169 40th St. SW, Cokato, MN 55321 | 18B | This is a non-medical procedure that should not be funded with public money. |

| Name | Address | District | Comments |
|---|---|---|---|
| John V. Geisheker, JD, LI.M. | MN Attorney #136360 | N/A | Best Wishes from this MN attorney who knows non-therapeutic amputation surgeries on minors is unethical medicine and fraud. |
| Bill Werb | 2340 Walnut Grove Ln. N., Plymouth, MN 55447 | 33A | |
| Brian Keller-Heikkila | 4820 14th Ave. S., Mpls., MN 55417 | 62B | There's no reason that taxpayer dollars should be wasted on a medical procedure that has no medical benefits. |
| Whitney Hanson | 701 Turners Xrd S., Mpls., MN 55416 | 44B | |
| Gary Pauly | 11787 Kandi Swift Rd. NW, Kerkhoven, MN 56252 | 20A | I am appalled that my tax dollars are being spent on a needless barbaric surgical procedure that is nothing less than needless torture for the baby. |
| Michaelle Wetteland | N/A | N/A | |
| Marcus Poplawski | 5905 Vincent Ave. S., Mpls, MN 55410 | 63A | Please stop this. Thank you. |
| Brian Witte | 7365 Howard Lane, Apt. 337, Eden Prairie, MN 55346 | 42A | |
| Martin Appelbaum | 1171 Charles Ave., St. Paul, MN 55104 | 66B | Let's quit wasting money on useless, unnecessary and morally reprehensible cosmetic surgeries that the victims never give consent to. It's way past time to stop funding these abuses. |
| Mark D. Rasmussen | 556 McIndoe St., Owatonna, MN 55060 | 26A | |
| Kathy Lee | 825 Ashland Ave., St. Paul, MN 55104 | 64A | Circumcision hurts little boys! Don't encourage it by funding it! |

| Name | Address | District | Comments |
|---|---|---|---|
| Jon Burek | MN 55433 | | |
| Mona Banks | 1418 Willmar Ave. SW, Willmar, MN 56201 | 13B | Save the babies. |
| Dr. Henry Edward Johnson, MD | 230 Oak Grove St., Apt. 103, Mpls., MN 55403 | 60A | |
| Rich Tregilgas | 670 Norell Ave. N., West Lakeland, MN 55082 | 56A | The money spent on unnecessary circumcisions should be put to better use. |
| Cherida McCall | 1442 Como Blvd. E., St. Paul, MN 55117 | 66B | |
| Kari Michalski | 3226 19th Ave. S., Mpls., MN 55407 | 62A | This concept should apply to infant formula as well! |
| Adit Panchal | N/A | N/A | |
| Barbara Gottstein | 1085 Montreal Ave., St. Paul, MN 55116 | 64B | I'm handicapped and on much needed Medical Assistance. It is very necessary for me. Taking it away from me is a crime. I'm on a fixed income and can't afford any medical costs. If taken away this would mean my certain death. |
| Chris Pollard | N/A | N/A | |
| David L. Sayler | 419 North 14th St., Breckenridge, MN 56520-1710 | 09B | Infant Circumcision is not medically necessary, nor cost-effective based on a New York Times article. |
| Jeremiah Zortman | 757 California Ave W., St. Paul MN 55117 | 66A | Please act. |

| Name | Address | District | Comments |
|---|---|---|---|
| Lisa Marie Jokela | 28600 Sunny Beach Road, Grand Rapids, MN 55744 | 03B | I'm so glad we decided not to circumcise any of our 3 sons! |
| John Jokela | 28600 Sunny Beach Road, Grand Rapids, MN 55744 | 03B | |
| William Stringer | N/A | N/A | Why is it OK to mutilate a male but not a female? |
| David Seaman | 129 E. Sanborn St., Winona, MN 55987 | 31A | |
| Marlene Hardy Poukka | 87 Hart St., Brainerd, MN 56401 | 12A | |
| Robin Bratt, RN, Bsn | 2015 25th Ave. S., Mpls., MN 55406 | 62A | |
| James Bratt | 2015 25th Ave. S., Mpls., MN 55406 | 62A | |
| Amy Langenfeld | 1306 16th St. W., Hastings, MN 55033 | 57B | |
| Charlotte Badillo | 1561 Rapids Rd., Ely, MN 55731 | 06A | |
| Michelle Dynes | 1316 22nd St NW, Rochester, MN 55901 | 29B | |
| Edith Ziegler, CNM | 3508 Tara Ln, St. Paul, MN 55125 | 56B | |
| Karlyn Peterson, CNM | 3206 Summer Fields Ct., Stillwater, MN 55082 | 52B | |
| Sarah Sundberg | 5801 Russell Ave. S., Mpls., MN 55410 | 63A | |

| Name | Address | District | Comments |
|---|---|---|---|
| Margaret A. Plumbo, RN, MS, CNM | 2249 Case Ave., St. Paul, MN 55119 | 55B | |
| Brentt Helland | 2300 Lexington Ave. S., Mendota Heights, MN 55120 | 39A | |
| Renee McNeill | 112 6th Ave. E., Shakopee, MN 55379 | 35A | |
| Troy Diggins | 505 13th St N, Benson, MN 56215 | 20A | |
| Colleen Drum | 16643 Kentucky Ave., Lakeville, MN 55044 | 36A | |
| Dane McFarlane | Minneapolis, MN 55414 | N/A | |
| Roy Driscoll | 55413 | N/A | |
| Osiokegbhai Ojior | N/A | N/A | |
| Chris McPadden | N/A | N/A | |
| Juanita Cutler | N/A | N/A | |
| Molly Duepner | N/A | N/A | |

# MN Medical Assistance (Medicaid) payments for infant male circumcisions - 2002

## SUMMARY

| CPT Code | Description |
|---|---|
| 54150 | Circumcision, using clamp or other device; newborn |
| 54152 | Circumcision, using clamp or other device; except newborn |
| 54160 | Circumcision, surgical excision other than clamp, device or dorsal slit; newborn |
| 54161 | Circumcision, surgical excision other than clamp, device or dorsal slit; except newborn |

## GRAND TOTAL BY CPT CODE

| CPT Code | Total Physician, Misc. Fees | Total Outpatient Facility Fees | Grand Total |
|---|---|---|---|
| 54150 | $517,504 | $487,170 | **$1,004,674** |
| 54152 | $63,833 | $11,430 | **$75,263** |
| 54160 | $17,580 | $4,764 | **$22,345** |
| 54161 | $298,191 | $59,862 | **$358,052** |
| | $897,107 | $563,227 | **$1,460,334** |

**Newborn sub-total = $1,027,019**

# MN Medical Assistance (Medicaid) payments for infant male circumcisions - 2002

## DETAIL

| CPT Code | Description |
|---|---|
| 54150 | Circumcision, using clamp or other device; newborn |
| 54152 | Circumcision, using clamp or other device; except newborn |
| 54160 | Circumcision, surgical excision other than clamp, device or dorsal slit; newborn |
| 54161 | Circumcision, surgical excision other than clamp, device or dorsal slit; except newborn |

**Per Diane Mueller @ MN DHS**

## FEE FOR SERVICE

| CPT Code | # of Surgeries | Total Avg. Fees | Total Expense |
|---|---|---|---|
| 54150 | 2,677 | $59.81 | $160,120 |
| 54152 | 92 | $314.45 | $28,929 |
| 54160 | 19 | $225.39 | $4,282 |
| 54161 | 282 | $304.28 | $85,806 |
| | 3,070 | | **$279,137** |

## MANAGED CARE ESTIMATE

| CPT Code | # of Surgeries | Total Avg. Fees | Total Expense |
|---|---|---|---|
| 54150 | 5,975 | $59.81 | $357,384 |
| 54152 | 111 | $314.45 | $34,904 |
| 54160 | 59 | $225.39 | $13,298 |
| 54161 | 698 | $304.28 | $212,385 |
| | 6,843 | | **$617,970** |

## TOTAL FFS + MANAGED CARE - PHYSICIAN, MISC. FEES

| CPT Code | # of Surgeries | Total Avg. Fees | Total Expense |
|---|---|---|---|
| 54150 | 8,652 | $59.81 | $517,504 |
| 54152 | 203 | $314.45 | $63,833 |
| 54160 | 78 | $225.39 | $17,580 |
| 54161 | 980 | $304.28 | $298,191 |
| | 9,913 | | **$897,107** |

# MN Medical Assistance (Medicaid) payments for infant male circumcisions - 2002

## OUTPATIENT CIRCUMCISIONS -- FACILITY FEES

**Per Diane Mueller @ MN DHS**

### FEE FOR SERVICE

| CPT Code | Est. # of Surgeries | Est. Facility Fees | Est. Facility Exp. |
|---|---|---|---|
| 54150 | 222 | $677.90 | $150,734 |
| 54152 | 8 | $677.90 | $5,180 |
| 54160 | 2 | $735.40 | $1,161 |
| 54161 | 23 | $735.40 | $17,225 |
| | 255 | | **$174,301** |

### MANAGED CARE ESTIMATE

| CPT Code | Est. # of Surgeries | Est. Facility Fees | Est. Facility Exp. |
|---|---|---|---|
| 54150 | 496 | $677.90 | $336,436 |
| 54152 | 9 | $677.90 | $6,250 |
| 54160 | 5 | $735.40 | $3,604 |
| 54161 | 58 | $735.40 | $42,636 |
| | 568 | | **$388,926** |

### TOTAL FFS + MANAGED CARE -- OUTPATIENT FACILITY FEES

| CPT Code | Est. # of Surgeries | Est. Facility Fees | Est. Facility Exp. |
|---|---|---|---|
| 54150 | 719 | $677.90 | $487,170 |
| 54152 | 17 | $677.90 | $11,430 |
| 54160 | 6 | $735.40 | $4,764 |
| 54161 | 81 | $735.40 | $59,862 |
| | 823 | | **$563,227** |

## GRAND TOTAL BY CPT CODE

| CPT Code | Total Physician, Misc. Fees | Total Outpatient Facility Fees | Grand Total |
|---|---|---|---|
| 54150 | $517,504 | $487,170 | **$1,004,674** |
| 54152 | $63,833 | $11,430 | **$75,263** |
| 54160 | $17,580 | $4,764 | **$22,345** |
| 54161 | $298,191 | $59,862 | **$358,052** |
| | $897,107 | $563,227 | **$1,460,334** |

**Newborn sub-total = $1,027,019**

C. L. TREGILGAS 2/14/2005

> *"Routine circumcision is not a medical issue or a social issue. It is a sexual issue and a human rights issue."*
>
> Frederick Hodges

## How is circumcision done?

Most parents don't know what is actually done to a baby when he is circumcised. The baby is placed spread-eagle on his back on a board and his arms and legs are strapped down so that he can't move. His genitals are scrubbed and covered with antiseptic. His foreskin is torn from his glans and slit lengthwise so that the circumcision instrument can be inserted. Then his foreskin is cut off.

Most parents who see what is done to a baby when he is circumcised and how he reacts decide against circumcision and let their baby keep his foreskin intact.

## Parents have new concerns

More and more parents – including Jewish and Muslim parents – are questioning the wisdom of subjecting their baby to the pain and risks of circumcision and its life-long consequences. More and more parents are wondering if they have the right to consent to the irreversible amputation of a healthy, normal, sensitive, functional part of their baby's penis – an amputation that experts regard not just as unnecessary, but as contra-indicated. More and more parents are becoming truly informed and, as a result, more and more parents are deciding against circumcision and are keeping their baby boys intact.

> *"The best reason to let a baby keep his foreskin intact is that it's almost a certainty he will be glad you did."*
>
> John A. Erickson

> *"Many parents today realize that if they had been given accurate information about circumcision, they would never have let anyone circumcise their baby. I am one of those parents, and that is why I do the work I do and why I have written this pamphlet."*
>
> Marilyn Fayre Milos, R.N.

No national or international medical association recommends circumcision.

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More information can be found at:
**www.nocirc.org** and **www.cirp.org**

**NOCIRC pamphlets:** Ten different pamphlets: 50¢ each or $25/100 (same or mixed) plus $5 S/H.

The **NOCIRC Resource Guide** lists the pamphlets, books, articles, newsletters and videos available from NOCIRC, and other resources as well. Free for SASE.


**National Organization of Circumcision Information Resource Centers**

Post Office Box 2512
San Anselmo, CA 94979-2512 USA

Telephone: 415-488-9883
Fax: 415-488-9660

**www.nocirc.org**

NOCIRC of MN - St. Paul
5865 Neal Ave N. #134
Stillwater, MN 55082-2177
**www.nocircmn.org**
**email: info@nocircmn.org**


*The information in this pamphlet is not meant to replace the care and advice of your pediatrician.*

1/04

**3 NOCIRC Information Series: Infant Circumcision**

# Answers To Your Questions About Infant Circumcision

*from the*

**National Organization of Circumcision Information Resource Centers**

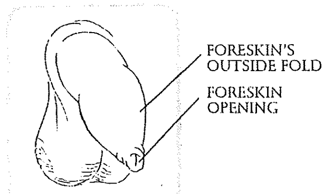
*Educating a New Generation For the Well-Being of All Children*

**www.nocirc.org**

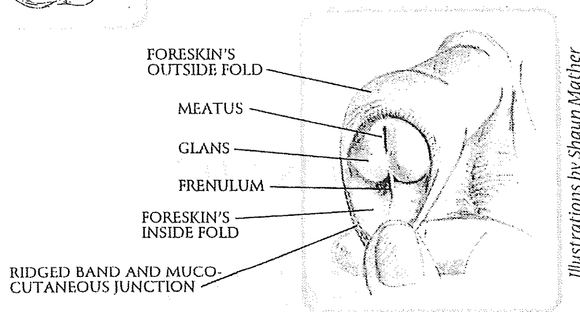
## What is circumcision?

Circumcision is the cutting off of the fold of skin that normally covers the glans of the penis. This double layer of skin, the prepuce, is commonly known as the foreskin.

INFANT PENIS




ADULT PENIS




*Illustrations by Shaun Mather*

## Why is the foreskin there?

The foreskin comprises as much as half or more of the penile skin system and has three known functions: protective, sensory and sexual.

During infancy, the foreskin is attached to the glans and protects it from urine, feces and abrasion from diapers. Throughout life, the foreskin keeps the glans soft and moist and protects it from trauma and injury. Without this protection, the glans becomes dry, calloused and desensitized from exposure and chafing.

Specialized nerve endings in the foreskin enhance sexual pleasure.

The foreskin may have functions not yet recognized or understood.

> *"The foreskin protects the glans throughout life."* American Academy of Pediatrics

## When and why did doctors in the U.S. start circumcising babies?

Doctors in the English-speaking countries started circumcising babies in the mid-1800s to "prevent masturbation," which was blamed for causing many diseases, including epilepsy, tuberculosis, and insanity.

Other reasons have been given since then, but all of them, including the claim that circumcision prevents cancer of the penis, cancer of the cervix, and venereal diseases, have been disproven. We now know that the foreskin is a normal, sensitive, functional part of the body.

## If my son isn't circumcised, won't he be teased?

Raising an intact boy should include empowering him to compassionately respond to anyone who might ever tease him about being normal and whole.

## Is circumcision painful?

Yes. Circumcision is extremely painful – and traumatic – for a baby. Just being strapped down is frightening for a baby. The often repeated statement that babies can't feel pain is not true. Babies are as sensitive to pain as anyone else. Most babies scream frantically when their foreskins are cut off. Some defecate. Some lapse into a coma. The reason some babies don't cry when they are circumcised is that they *can't* cry because they are in a state of shock. Most babies are circumcised without an anesthetic. Anesthetics injected into the penis don't always work. Being stuck with a needle in the penis is itself painful for a baby, just as it would be for anyone else. Babies are rarely given pain medication right after they are circumcised or during the week to ten days it takes for the wound to heal. Pain medication is not always effective and is never 100% effective.

## Does circumcision have risks?

Yes. Like any other surgery, circumcision has risks. They include:

- Excessive bleeding
- Infection
- Complications from anesthetics
- Surgical mistakes, including loss of glans and loss of entire penis
- Death

Many circumcised males suffer from:

- Extensive scarring
- Skin tags and skin bridges
- Tearing and bleeding at the scar
- Curvature of the penis
- Tight, painful erections
- Difficulty ejaculating
- Impotence
- Feelings of having been violated
- Feelings of having been mutilated

*All* circumcised males lose some or most of the sensitivity in their glans and *all* of the sensitivity in their foreskin.

Circumcision may have risks and complications not yet recognized or understood.

> *"Nature is a possessive mistress, and whatever mistakes she makes about the structure of the less essential organs such as the brain and stomach, in which she is not much interested, you can be sure that she knows best of the genital organs."*
>
> Sir James Spence

Chair and Committee Members,

I am Jay Walters and I'm truly honored, enjoy this opportunity and hopefully I've developed a statement you can understand due to my horrible memory and speech.

Consider a normal day but things changed for me at 5:30 am on April 7,1994, when my life was robbed.

I suffered a Traumatic Brain Injury 11 years ago when my work vehicle got hit by a deer crossing the road; basically I'm around 95% with my speech and balance being the obvious problems. Because of one skeleton in my closet, I can't run for public office to serve the public which I would like to do. Its been many years so I hope more can be produced for ones that this will occur to.
I have accomplished many things like a member of the Blue Earth County Human Services Advisory Committee in which I'm involved with the meth problem which does affect your brain that Senator Rosen introduced, assisting school events and helping politicians; one that choose me (volunteer advisor for congressman Gutknecht) which will make important decisions affecting Human Services.

A main purpose is to create an agenda that will provide assistance to those suffering with brain injury and would like you to know that the services provided by the county human services are very helpful and human services needs to continue to provide funding. I am concerned about the impact more cuts to human services programs will have on the disabled. Please continue to invest and support those programs.

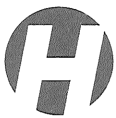
I'm currently affiliated with the Minnesota WORKFORCE CENTER SYSTEM part of (DEED)Department of Employment and Economic Development in which I'm on a [waiting list] since August of 2004 for employment.
A key object I've always had is I'm fortunate and by always having a positive attitude.

I feel comfortable answering public, not private questions you may have.
So please forgive me when I answer, I'll do the best I can.

I appreciate this.

Blue Earth County Human Services Advisory Committee
Jay Walters

311 W Bert St., apt.22 Lake Crystal, MN 56055
Home phone: (507) 726-2213 E-mail address: FMCST@HICKORYTECH.NET



Minnesota Hospital Association

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toll free (800) 462-5393 www.mnhospitals.org

**Testimony of Lawrence Massa**
**Chief Executive Officer, Rice Memorial Hospital, Willmar, Minnesota**
**On behalf of the Minnesota Hospital Association**
**February 16, 2005**

Madame Chair and Members. My name is Lawrence Massa; I am the CEO of Rice Memorial Hospital in Willmar. Owned by the city, Rice Memorial has 136 beds and meets a wide range of community needs for residents in Kandiyohi County and the surrounding area. I've been the CEO at Rice for 11 years. I also had the experience, early in my career, of serving as Secretary of the Department of Health in South Dakota.

I am here today in my capacity as the Chair of the Minnesota Hospital Association's Board of Directors. Thank you for the opportunity to present the concerns of Minnesota's 138 hospitals regarding the administration's budget proposal.

We have very serious concerns about the impact of the administration's proposed budget — from the cuts in MinnesotaCare eligibility, the hospital payment reductions and the abandonment of responsibility for the General Assistance Medical Care program. The policy decisions inherent in the proposed budget represent big steps backward for Minnesota. Two facts about Minnesota demonstrate our values and the benefit of those values. Minnesota has the most citizens with health insurance of any state in the country. Minnesota is also ranked the healthiest of any state in the country.

This proposed budget would abandon those values, threatening vulnerable Minnesotans with loss of coverage and increasing the cost of care for everyone else.

I'll quickly walk through our three main concerns.

***REDUCING MINNESOTACARE ELIGIBILITY***

This budget would eliminate health insurance coverage for at least 27,000 working but low-income Minnesotans who have coverage today. They are covered through MinnesotaCare, a program that helps people help themselves — low-income workers pay a premium based on their income. MinnesotaCare has proven to be a helping hand that has kept people in the work force.

Most of these 27,000 Minnesotans will not be able to purchase private coverage. Each year, many will get sick and require hospital or physician services. Without insurance, most will seek care in the emergency room when their condition demands attention. This is the most expensive care setting and the consequence will be higher health care costs.

We expect that at least $40 million of the estimated $80 million the state expects to save by forcing these folks out of MinnesotaCare will be spent caring for them in hospitals, especially emergency rooms. Remember, 34,000 people lost coverage from the

administration's cuts in 2003. The following year, hospitals experienced a 28 percent increase in the provision of uncompensated care.

### *SHIFTING FUNDING FOR GAMC*

We strongly support the MinnesotaCare program. We believe that coverage should be preserved even if some benefits must be removed to deal with the funding challenge. Minnesota hospitals will continue to support MinnesotaCare including its current funding mechanism, which is a tax on our patients — levied by the state through our charges.

Yet even the most ardent supporter of MinnesotaCare understands that under this taxing mechanism, the sickest pay the most and the poorest pay the largest share of their income. In 2000, the Minnesota Taxpayers Association studied this tax and determined that it was "highly regressive, with low-income taxpayers paying five times more of this tax as a percentage of their income than taxpayers with the highest income."

Now, the administration proposes to abandon funding the General Assistance Medical Care Program through the general fund. Instead, the administration wants the sick to pay for the program through this same regressive tax.

This shift in responsibility is the latest breach of faith related to this tax. When introduced the Legislature and Governor Carlson meant the tax to finance MinnesotaCare. Now, after several years of using the tax funds to support the general fund, the administration proposes to use it to pay for an entitlement program for the poorest of the poor. This is bad policy that will fall hardest on the sick and raise the cost of health care.

### *CUTTING HOSPITAL FUNDING AND LOSING OUT ON FEDERAL MATCHING DOLLARS*

The administration's proposed cuts to hospital Medicaid, MinnesotaCare and GAMC payments are shortsighted. The reason they are shortsighted is the loss of federal matching dollars: When the state proposes to cuts Medicaid payments by $47 million, it would be walking away from an additional $47 million from Washington. The administration speaks about the importance of seizing federal dollars when it comes to other priorities, such as the Northstar Line. That same argument holds here as well.

Altogether, with the loss of state and federal dollars, this proposal would cut hospital payments by $103 million. If these cuts go through, hospitals' base operating rate would be 25 percent below the cost of providing care.[1]

---

[1] The base operating rate DHS pays hospitals for inpatient care for MA and MinnesotaCare patients is already 19 percent below costs. It is worse than that for GAMC Using a mix of state and federal dollars, the state makes DPA and small rural add-on payments that are in addition to the base operating rate and can reduce the payment-to-cost gap. But the typical, mid-size hospital doesn't receive these additional payments.

The administration counts on hospitals shifting this unmet cost to non-government payers. It is a hidden tax that makes everyone else's costs go up. And this has happened already, in both 2002 and 2003, with earlier rounds of cuts.

It is time for all of us to do the hard work of figuring out how to sustain coverage for low-income Minnesotans.

In closing, cutting eligibility and payments is an overly simplistic way of trying to address the state's budget shortfall — one that does more harm than good. We need to develop long-term solutions. For example, we can reduce benefits rather than cutting eligibility. We can improve the Department of Human Services' stewardship of its resources. And we can increase the cigarette tax, which raises revenue and discourages smoking.

Hospitals look forward to working with the Legislature to improve this budget proposal.

MHA

# Administration's Proposed Health Care Budget Jeopardizes Health Care

Minnesota Hospital Association

February 2005

## What's proposed?

*The administration has proposed a budget that would:*

**Cut hospitals $56 million over two years by further reducing the rate the state pays hospitals when we serve patients on government health care programs.**

(The state already pays hospitals an operating rate that is 19 percent below what it costs to provide these services.) The state would be walking away from $47 million in federal matching dollars, *so this change would cost hospitals $103 million.* Losing out on a nearly one-to-one match and leaving our federal tax dollars for another state to spend — **It just doesn't make sense.**

**Kick about 45,000 low-income, working Minnesotans off the MinnesotaCare program.**

While approximately 19,000 individuals would be eligible for coverage in General Assistance Medical Care or Medical Assistance, the remaining 27,000 would be out of luck, with incomes too low to purchase private insurance. These Minnesotans would still need health care services and they would end up in emergency rooms — the most expensive place to receive care. And this is on top of the 34,000 who already lost state coverage in the last round of budget cuts. With the state expecting this change to result in $80 million in savings, these costs will now be shifted to hospitals and clinics that will be providing more uncompensated care. Pushing thousands more Minnesotans into the ranks of the uninsured — **It just doesn't make sense.**

**Play a shell game with state funding, likely leading to an increase in the "Sick Tax."**

The administration would move funding for the General Assistance Medical Care (GAMC) program from the general fund to the Health Care Access Fund (HCAF). The HCAF is supported by the MinnesotaCare tax, a "Sick Tax" paid by those who need health care services. Meeting the basic health care needs of the state's poorest residents would no longer be a statewide obligation — moving instead to a narrow, regressive tax. And with the new demands put on the "Sick Tax" — which would now fund both GAMC and MinnesotaCare — this tax is likely to go up. **It just doesn't make sense.**

## Why is this important to all Minnesotans?

- *The administration's budget proposal would **force all Minnesotans with private insurance to pay higher premiums.*** The administration's proposal would increase the ranks of the uninsured and further lower hospital payments below costs for the government program enrollees who remain. As a result, the state would be forcing hospitals to cover much of those losses by shifting the costs to private insurance payers, where possible. This cost shifting would result in higher costs for businesses and individuals.

- *Thousands of **low-income, working Minnesotans would lose their coverage.*** Republicans and Democrats created MinnesotaCare to give some help to Minnesotans who work in low-paying jobs where employer-sponsored health care coverage is rare or out of reach. This isn't a handout — enrollees contribute to their costs through a sliding-fee scale. Signed into law by former Gov. Arne Carlson, this program has contributed to the fact that more people have health care coverage than in other states. With an increasing number of employers in the state considering dropping health insurance for their employees, this program is needed now more than ever.

- ***Greater Minnesota would feel the impact** of the proposed cuts to MinnesotaCare*. Outstate communities with smaller employers who are less able to sponsor coverage have benefited from this program to a greater degree than other state health care programs. To offer a few examples of the size of MinnesotaCare spending in Greater Minnesota, the 2004 spending was $11.3 million in Crow Wing County, $9 million in Otter Tail County and $4.5 million in Kandiyohi County.

- *The budget would **threaten the ability of hospitals to continue to meet community needs,*** including support for medical education, mental health services and nursing homes — 60 of which are attached to hospitals and subsidized through hospital revenues. One-fifth of hospitals are already operating in the red. Hospitals need to have positive operating margins to be able to fulfill our missions. When state program eligibility was last cut, hospitals saw a 28 percent increase in uncompensated care.

## Why is state funding so important to Minnesota hospitals?

***Minnesota hospitals receive low reimbursements from Medicare.***

This, in effect, penalizes us for having an efficient track record. Medicare paid hospitals approximately 13 percent below our costs in 2003. Given that Medicare represents 41 percent of our patient days, Minnesota hospitals are very dependent on other payers.

***State payments to hospitals already fall well below costs.***

The operating rate that DHS pays hospitals for inpatient care is 19 percent below what it costs hospitals to provide those services to Minnesotans on Medical Assistance (MA) and MinnesotaCare. And the rates are worse for both General Assistance Medical Care (GAMC) and outpatient services. (This is largely due to previous rounds of rate cuts and the fact that nothing has been done to address medical inflation since 2001.) The typical, mid-size hospital is particularly hard-hit. Hospitals are going to take care of Minnesotans on state health care programs, no matter what. But we're interested in seeing the amount we lose kept to a minimum.

***Government program underpayments unfortunately trigger cost shifting to private payers.***

Hospitals' ability to shift these costs is more limited than in other states, given that we have more private insurance patients in managed care plans and fewer with third-party indemnity coverage.

***Minnesota hospitals depend on our ability to cross-subsidize services.***

We subsidize services that operate at a loss — such as emergency rooms and mental health clinics — with those that generate a surplus. Our ability to do so is limited, however. Many other states have regulatory requirements that control the growth of profitable outpatient service providers, such as surgery centers and imaging facilities. With no such controls in Minnesota, these outpatient service providers grow freely, siphoning revenues away from hospitals and undermining our ability to cross-subsidize.

### *What can legislators do to help?*

Legislators can improve the administration's health care budget proposal. Here's how:

- **Spread the pain.** Nearly all of the state cuts are in the Human Services budget. The health care sector alone should not be so disproportionately hit with cuts.
- **Demand more effective use of resources at the Department of Human Services. Everyone else is being asked to do more with less; the state bureaucracy should be no different.** Legislators should keep in mind that every dollar spent on DHS overhead is one less dollar that could be spent for direct health care services. (The DHS budget proposes 71 new positions.)
- **Increase the cigarette tax.** Minnesota has a relatively low cigarette tax, when compared to other states. Increasing the tax would not hurt economic growth, like other taxes. It would also improve public health and raise needed funds, with money to offset the proposed health care cuts. (A $1 increase in the cigarette tax would raise approximately $260 million a year.)
- **Consider reducing benefit levels** in government programs, rather than cutting eligibility.
- **Use some of the state's budget reserve.** The administration's budget restores $350 million to the cash-flow account and $653 million to the rainy day reserve. If you're one of the 27,000 people facing the loss of MinnesotaCare coverage, it's raining right now.
- **Use additional revenues** identified in the February forecast to moderate the administration's proposed health care cuts.

*For more information contact Mary Krinkie or Sue Stout, MHA state government relations.*
*This document is available electronically at www.mnhospitals.org, under "Government Affairs" and State."*

2550 W. University Ave., Suite 350-S., St. Paul, MN 55114-1900 • Tel: (651) 641-1121 • Web: www.mnhospitals.org

## Health and Human Services Testimony
**February 16, 2005**

**by Kristine Schulze and son, Justin Smith**
**1807 Stillwater Street**
**White Bear Township, MN 55110**

My son, Justin, is a smart, happy and determined 6-year old who has cerebral palsy. He is able to speak with a communication device and drives a power wheelchair. He is doing great in 1st grade and gets 0 wrong on his spelling tests. With his physical disability he is unable to walk, cannot sit on his own, cannot feed himself, and cannot use a bathroom or shower by himself. He needs 24-hour care and maximum assistance to do almost everything he wants or needs to do.

Funding to help care for Justin comes from the Consumer Directed Community Supports or CDCS option of the Mental Retardation and Related Conditions or MR/RC waiver. CDCS is a godsend. It pays for staffing and home adaptations along with medical equipment and technology not covered by Medical Assistance or our private health insurance. This program allows us to decide how to best use our available allotted funding to meet our son's needs with approval and oversight by the county. The allotment that we currently receive is at least 20% less than what Justin would be receiving with traditional Personal Care Attendant services and more of the funding goes directly to Justin's needs rather than to a 3rd party agency. With CDCS, not only have we been able to hire a more skilled staff that is paid better wages, but also have been able to purchase adaptive equipment and use funds to help with modifications to our home to make it accessible for Justin.

We have been informed that in January 2006, the Department of Human Services or DHS will decrease Justin's CDCS budget by $30 a day. This is about 23% below his current funding level. This would be the equivalent of about two hours of staffing a day. Two hours less staffing a day may not sound like much, but it is a great hardship for my family. It takes four hours a day simply to feed my son. It takes another three hours a day for other daily living

activities such as bathing, toileting and dressing Justin. These hours don't include the hours that any family would be spending on typical activities with their child such as doing homework or playing. Without staff support, I would have virtually no time to care for the rest of my family. This is a very real cut for our son at the same time that our family is experiencing increases in TEFRA Medical Assistance fees and private health insurance costs. These cuts represent a tremendous disservice to Justin and our family. Is this really how you want to balance the state budget?

The CDCS program has helped Justin to live safely in our home and be able to do more things that "normal" kids do. He is a vibrant member of our community because I have incredible staff to help me bring him to playgrounds, to Tamarack Nature Center or to get ice cream at the Cup and Cone. It is heartbreaking and frustrating to know that it is going to be more and more difficult if not impossible to do the things that have helped Justin to be included in his community. With the proposed reduction in Justin's budget, we won't have adequate staffing or funding for the activities, equipment or home adaptations that he needs. It is one of society's roles to help individuals who are disabled. I strongly urge you to not let this administration continue to balance the state budget at the expense of people with disabilities.

February 14, 2005

SAVE OUR SUPPORTS!!

THE 2003 LEGISLATIVE SESSION PULLED THE RUG OUT FROM UNDER FAMILIES LIKE MINE!

My name is Melody Dochniak. My husband I have two children who both have Autism. Dain is 14 years old and functions at a 2 year old level. Basil is 12 years old and functions at an 8 year old level. Both have been on the waiting list for Waiver Services for over 10 YEARS! When the waiver slots were opened up a few years ago, my boys were on the Consumer Support Exception Grant. As you know during the 2003 session the Exception Grants were eliminated thus their grant was lowered dramatically. At the same time no more waiver slots were to be given out. There was no other option but to stay on the much smaller Consumer Support Grant.

One of my greatest fears is what will happen to my boys if something should happen to my husband our myself. Who would care for my two Autistic children? We need the Waiver to help care for our children!

Today, the Waiver List is growing. Please help families like mine who need help and support to keep their disabled children at home. This help goes along way in helping families keep their disabled kids out of institutions which would be much more expensive for the State of Minnesota.

PLEASE ENSURE THAT MORE WAIVER SLOTS WILL BE AVAILABLE SOON!!

Thank you,

Melody Dochniak

Melody Dochniak
PO Box 296
Hugo, MN 55038

**Testimony before the Senate Health & Human Services & Corrections Budget Division**
**February 16, 2005**
**RE: Governor's Proposed Cuts in Pharmacy Reimbursement**

*Jointly submitted by:*
*Julie K. Johnson, R.Ph., Executive Vice President, MN Pharmacists Association*
*Buzz Anderson, President, MN Retailers Association*

Julie Johnson, R.Ph. – Minnesota Pharmacists Association

Good morning, my name is Julie Johnson. I am the Executive Vice President of the Minnesota Pharmacists Association, and with me today is Buzz Anderson, President of the Minnesota Retailers Association. On behalf of our organizations, thank you for the opportunity to provide information on the pharmacy savings proposals and testify in opposition to pharmacy reimbursement cuts contained in the Governor's budget.

In the interest of time, we are providing committee members with MPhA's comments on the DHS Health Care Services Study that outline pharmacists' concern with the proposals to refer all hemophilia patients and to contract with one pharmacy for the provision of specialty pharmaceuticals. We believe these proposals will have a negative impact on access and will result in fragmentation of patients' prescription drug records.

The administration's proposal to cut pharmacy reimbursement rates has the potential to devastate access to pharmacy services for Medicaid recipients. The proposed reduction appears to be a 2 ½% reduction in reimbursement to pharmacies however the impact of the cut represents approximately 43% of the reimbursement pharmacies receive. This is because the majority of the payment to pharmacies goes to cover the cost of the drug product, which the pharmacy has no control over.

To illustrate the impact of these cuts to pharmacies, we have provided a spreadsheet that shows the break-down of product cost and reimbursement to pharmacies under the current reimbursement set in statute, and the rate proposed in the Governor's budget for 24 drugs covered by Medicaid. In looking at the far right column, you can see the impact of the reduction on the payment to the pharmacies when the drug product cost is separated out. In the 24 drugs we applied the formula to, the impact of the cuts to pharmacies averages 43 percent.

There are several important facts that need to be considered in evaluating the impact this reduction has on pharmacies:

First, according to a 2003 study done by the National Association of Chain Drug Stores, the average cost of dispensing a prescription in Minnesota is $7.38.

Second, in 2002, the Office of Inspector General issued a report that indicated that pharmacies typically can purchase brand drugs at AWP – 17.1%.

Third, in the private sector, pharmacies are allowed to pass the provider tax through to third party payers, but the state does not reimburse for the tax. With the tax having been increased to 2% as of January 1, 2004, this makes the impact of the proposed reduction AWP – 16%.

Taking this into consideration, this means that pharmacies will be making 1.1% on the product component of the formula – less than what the state will be making on the provider tax paid by the pharmacies when they purchase the drugs from their wholesalers. This rate will put pharmacy reimbursement at a level where pharmacies are unable to recover their cost of dispensing.

Reimbursement to pharmacies has been cut continuously for more than ten years, and while it is not a cost-driver in the Medicaid drug budget, they received cuts during the last session and the proposals to further drive down their rates continue to be introduced. Further, there is a lawsuit pending to remove the uncollected debt protections that pharmacies are afforded as it relates to Medical Assistance co-pays. If these protections are removed, this would represent potentially another $3.00 reduction that would push pharmacy reimbursement even further below their cost of dispensing.

MnRA and MPhA have been working in good faith with the legislature, DHS and pharmacy economics experts for the past three years to identify mechanisms that would enable the state to address the cost-drivers in the drug budget. The vast majority of the suggestions that we have made have been implemented and pharmacists willingly accepted the additional administrative burdens that resulted from those changes. DHS commended the pharmacies in a January Provider Update, for assisting them in saving $14 Million dollars per year, yet at the same time cuts in reimbursement have been imposed.

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Buzz Anderson – Minnesota Retailers Association

Minnesota pharmacists are disheartened and frustrated by the continuous introduction of policies that adversely impact their ability to provide care to their patients. With the cuts to Medicaid reimbursement that passed during the 2003 session, the reduction of rates from private third party payers that resulted when payments to health plans participating in PMAP were cut, the administration's drive to sanction the use of Canadian mail-order pharmacies, and continuous reductions in private sector reimbursement rates, the survival of community pharmacies is becoming more and more impossible, particularly in rural areas.

Today, we are providing you with data that was developed by the Minnesota Department of Health's Office of Rural Health and Primary Care. This Profile of Pharmacies provides good information on the environment that pharmacies are operating in and the threats that they are facing. At some point, the State is going to have to recognize that if this trend continues, Minnesotans are going to face a crisis in access to pharmacy services.

To continue this trend undermines the valuable role that pharmacists play in the health care system. While much of their work is done behind the scenes, pharmacists do a great deal to protect and improve the health of their patients. Pharmacists are the experts in the health care system on drug therapy and as more and more drugs become available and the complexity of therapies grows, their role in the health care system is even more important.

When pharmacists are presented with a prescription for a patient, they work behind the scenes to identify whether there are any problems with the patient's complete drug therapy. This includes screening for potential drug interactions, identifying situations where patients may be taking two or more medications that are intended to treat the same condition, checking the dose that was prescribed to ensure that it is appropriate for the patient, working with physicians and other prescribers on necessary changes to drug therapy, and looking for opportunities to substitute generic prescriptions when they are available. Pharmacists also provide necessary

services to their patients to monitor their health conditions and provide advice to their patients on how to take their medications to get the best results and how to minimize side-effects. In interacting with their patients, they are able to identify when the medications aren't working and either work with the doctors to make the necessary change or advise the patient to go back to see their physician when necessary.

The role that pharmacists play in the health care system is very important, and the proposed reductions diminish pharmacists ability to care for their patients. The Minnesota Retailers Association and the Minnesota Pharmacists Association ask that you take these things into consideration as you move forward in the budgeting process, and urge you to not cut pharmacy reimbursement any further.

Thank you for the opportunity to testify this morning.

## Applying the Proposed Medicaid Pharm. Reimbursement Formula

| Drug Product | Average Pharmacy Purchase Price2 | Average Pharmacy Purchase Price + 2% (MN Wholesale Drug Tax)1 | Pharmacy Reimbursement AWP - 11.5% + $3.65 | Pharmacy Gross Margin After Product Cost When Paid AWP - 11.5% + $3.65 | Pharmacy Reimbursement AWP - 14% + $3.65 | Pharmacy Gross Margin After Product Cost When Paid AWP - 14% + $3.65 | Pharmacy Net Margin After Cost of Dispensing[3] | Reduction in Reimbursement to Pharmacy |
|---|---|---|---|---|---|---|---|---|
| Zyprexa 5mg 60ct | $ 356.83 | $ 363.96 | $ 384.58 | $ 20.62 | $ 373.82 | $ 9.86 | $ 2.48 | 52.19% |
| Risperdal 1mg 60 ct | $ 194.23 | $ 198.11 | $ 211.00 | $ 12.89 | $ 205.14 | $ 7.03 | $ (0.35) | 45.46% |
| Seroquel 25mg 100 ct | $ 154.24 | $ 157.33 | $ 168.31 | $ 10.98 | $ 163.66 | $ 6.33 | $ (1.05) | 42.35% |
| Clozaril 100mg 100 ct | $ 378.07 | $ 385.64 | $ 407.26 | $ 21.63 | $ 395.86 | $ 10.23 | $ 2.85 | 52.72% |
| Prozac 90mg 4 ct | $ 82.40 | $ 84.05 | $ 91.62 | $ 7.57 | $ 89.13 | $ 5.08 | $ (2.30) | 32.83% |
| Paxil 40mg 30 ct | $ 86.37 | $ 88.10 | $ 95.86 | $ 7.76 | $ 93.25 | $ 5.15 | $ (2.23) | 33.58% |
| Zoloft 100mg 100 ct | $ 250.11 | $ 255.11 | $ 270.65 | $ 15.54 | $ 263.11 | $ 8.00 | $ 0.62 | 48.53% |
| Effexor XR 75mg 100 ct | $ 282.43 | $ 288.08 | $ 305.16 | $ 17.08 | $ 296.64 | $ 8.56 | $ 1.18 | 49.87% |
| Celexa 20mg 100 ct | $ 236.05 | $ 240.77 | $ 255.64 | $ 14.87 | $ 248.53 | $ 7.76 | $ 0.38 | 47.86% |
| Wellbutrin SR 150mg 60 c | $ 112.41 | $ 114.66 | $ 123.66 | $ 9.00 | $ 120.27 | $ 5.61 | $ (1.77) | 37.69% |
| Remeron 30mg 30 ct | $ 84.40 | $ 86.09 | $ 93.75 | $ 7.66 | $ 91.21 | $ 5.12 | $ (2.26) | 33.21% |
| Prilosec SA 20 mg 30 ct | $ 114.77 | $ 117.06 | $ 126.17 | $ 9.11 | $ 122.71 | $ 5.65 | $ (1.73) | 38.00% |
| Prevacid 30mg 100 ct | $ 411.23 | $ 419.45 | $ 442.65 | $ 23.20 | $ 430.25 | $ 10.80 | $ 3.42 | 53.44% |
| Depakote EC 250mg 100 | $ 112.52 | $ 114.77 | $ 123.77 | $ 9.00 | $ 120.38 | $ 5.61 | $ (1.77) | 37.70% |
| Neurontin Capsules 100m | $ 51.49 | $ 52.52 | $ 58.62 | $ 6.10 | $ 57.06 | $ 4.55 | $ (2.83) | 25.46% |
| Lipitor 10mg 90 ct | $ 202.43 | $ 206.47 | $ 219.75 | $ 13.28 | $ 213.64 | $ 7.17 | $ (0.21) | 45.98% |
| Zocor 20mg 90 ct | $ 293.80 | $ 299.67 | $ 317.29 | $ 17.62 | $ 308.43 | $ 8.76 | $ 1.38 | 50.28% |
| Celebrex 200mg 100 ct | $ 271.07 | $ 276.49 | $ 293.03 | $ 16.54 | $ 284.85 | $ 8.37 | $ 0.99 | 49.42% |
| Glucophage 500mg 500 ct | $ 370.50 | $ 377.92 | $ 399.18 | $ 21.27 | $ 388.01 | $ 10.09 | $ 2.71 | 52.54% |
| OxyContin CR 40mg 100 c | $ 459.07 | $ 468.25 | $ 493.73 | $ 25.48 | $ 479.88 | $ 11.64 | $ 4.26 | 54.33% |
| Norvasc 10mg 90 ct | $ 177.58 | $ 181.13 | $ 193.23 | $ 12.09 | $ 187.87 | $ 6.74 | $ (0.64) | 44.28% |
| Ultram 50mg 100 ct | $ 103.82 | $ 105.89 | $ 114.48 | $ 8.59 | $ 111.35 | $ 5.46 | $ (1.92) | 36.46% |
| Average | | | | | | | | 43.83% |

**Important Points to Consider:**

1. The state does not reimburse pharmacies for the 2% Wholesale Drug Tax. All other managed care providers are required to reimburse for this. In 2003, the legislature changed the law to allow other providers to pass the tax through to the state for these programs, but pass-through of the Minnesota Wholesale Drug Tax was not included in the legislative changes.
2. Pharmacies have no control over the cost of the product. The reimbursement they receive must be sufficient to enable the pharmacy to pay for their inventory, recover their cost of dispensing and remain financially viable.
3. The average cost of dispensing a prescription in Minnesota, according to the 2004 National Association Chain Pharmacy Industry Profile, is approximately $7.38 per prescription.

# Rural Pharmacy In Minnesota

## Rural Pharmacists Provide:

✔Local and convenient access to medications and drug therapy.
✔Needed patient education about health conditions, medication use and side effects.
✔Management of drug safety and drug safety issues.

- *Twenty-five percent of the U.S. population lives in rural areas, many are elderly. With the exponential increase in elderly people taking life-preserving medications for chronic disorders, pharmacists in rural areas provide an essential service.*

✔Drug therapy knowledge to rural hospitals, clinics and long-term care facilities.

- *Many pharmacists in small towns provide nursing home patients with medications. In addition, federal law requires monthly pharmacists' review of residents' medications.*
- *In the hospitals in these small towns, pharmacists oversee distribution of inpatient medications.*
- *Often, rural hospitals and nursing homes count on the local community pharmacist to provide these services.*

✔Pharmacists are one of a limited number of health care providers serving in rural communities.

- *The trusted expertise of pharmacists in medication management for patients cannot be provided through online or mail delivery of medications.*

✔Access to over-the-counter medications, medical equipment and supplies, and flu and pneumococcal immunizations

✔Care for veterinary patients.

## Minnesota Rural Pharmacy Statistics:

There are 1,502 pharmacies in Minnesota; 641 of them (44%) are in rural Minnesota

Rural Minnesota has lost 102 pharmacies since 1996, many of these closures resulted in communities having no access to a local pharmacy.

In Minnesota there are 126 towns with one pharmacy, the total number of residents/patients served by these small town pharmacies is more than 226,000.

In towns that have only one pharmacy, the nearest opportunity to obtain pharmacy services is, on average, at least 22 miles away.

The average age of a pharmacist in rural Minnesota is 50 years.

## Solutions:

Pharmacists in rural areas are facing challenges in reimbursement, competition, covering staffing and meeting increased medication needs of patients.

As more rural pharmacists reach retirement age, the number of pharmacies *closing without replacement is likely to increase.*

**To maintain pharmacy services in rural areas, pharmacists must be:**

- Maintain Medicaid reimbursement at current levels.
- Conform Minnesota pharmacy access standards to match the Medicare standard.
- Assure provider tax relief for losses incurred as a result of the Medicare Part D Benefit.
- Support loan forgiveness for rural pharmacists.


**References**

1. www.nrhrural.org/page.file/different.html "What's Different About Rural Health Care."

2. "Profile of Pharmacies in Rural Minnesota," Office of Rural Health and Primary Care, MN Dept. of Health.

3. Unpublished research from the College of Pharmacy, University of Minnesota, data collected 2003.



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**TO:** **Tom Fields, MN Department of Human Services**
**Michael Bailit, Bailit Consulting**

**FROM:** **Julie Johnson, R.Ph., Executive Vice President/CEO**
**Elizabeth Carpenter, Vice President, Public Affairs**

**DATE:** **January 10, 2005**

**RE:** **DHS Health Care Services Study: Findings and Savings Strategy Options**

The Minnesota Pharmacists Association (MPhA) has reviewed the January 3, 2005 draft of the "DHS Health Care Services Study: Findings and Savings Strategy Options," and submits the following comments for your consideration.

**Retail Pharmacy Reimbursement**

In *Strategy Option 4: Pharmacy Savings,* item number three on page 42 suggests that reimbursement to retail pharmacies be reduced to AWP-14% + $3.65, "allowing retail pharmacies to retain a sizable spread between their acquisition costs and their reimbursement level."

In making the argument that these rates be reduced, a comparison is made between the current rate set in Minnesota Statute (AWP-11.5%+$3.65), and the rates being paid in other Midwestern states whose discounts off of AWP range from 12.0% to 13.5%. This comparison implies that Minnesota pharmacies are retaining a greater spread between their acquisition costs and the reimbursement they receive from their Minnesota Medicaid than their counterparts in other Midwestern states. This is not the case.

In making the comparison, the report references a 2001 study that was done by the US Office of the Inspector General that found that the actual average pharmacy acquisition cost for brand name products to be AWP-17.2%. In Minnesota, pharmacies are also subject to a state-imposed 2% wholesale drug distributor tax that increases their acquisition costs. This tax is not reimbursed by the state Medicaid program. As a result, the spread retained by Minnesota pharmacies (the difference between their actual acquisition cost and the amount reimbursed by Minnesota Medicaid) is actually *the same as, or lower than* the other Midwestern states referenced in the report.

The draft report to the legislature fails to acknowledge the additional cost to Minnesota pharmacies that is incurred as a result of the wholesale drug distributor tax. The Minnesota Pharmacists Association respectfully requests that this section of the report be reexamined, taking this information into consideration, prior to submission to the Minnesota Legislature.

**Bundling Payments of Home IV Infusion Drugs and Related Services**

Pharmacists providing home infusion services have stressed the importance of having per diems set at a level that recognizes and covers the costs of providing these services. In addition to supplying the drug, these pharmacists provide additional services including: kinetics dosing of antibiotics, adjustment of pain management doses, and TPN management (including monitoring electrolytes and adjusting doses). MPhA encourages the DHS in bundling these payments to consider the role of home infusion pharmacists and consider implementing separate per diems for nursing care and pharmacist care.

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**Requiring Hemophilia Patients To Obtain Blood Factor Products Through a 340B Center**

Pharmacists in rural areas have expressed concern regarding adequate and timely access to blood factor products for rural patients. One rural pharmacist indicated that the patient they serve has a central line to infuse the product, making the patient more susceptible to line infections. Since the pharmacist treating him was local, they have been able to treat the patient on the same day that they were diagnosed, avoiding costly hospitalization on two separate occasions. The question of whether rural hemophilia patients will be able to receive the same level of care if their infusion provider is not local, is one that MPhA would urge the Department to consider in making their report to the Legislature.

**Exclusive Providers for Specialty Pharmacy Drugs**

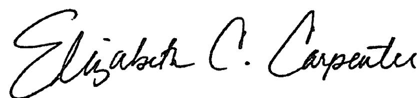
The Minnesota Pharmacists Association opposes the use of exclusive contracting with specialty pharmacy providers for specialty pharmacy drugs. By mandating which pharmacy patients must use for specific pharmaceuticals, the medication profile of Medicaid recipients would be fragmented. With the growing complexity of medication therapies, the maintenance of a complete medication profile is critical in ensuring that pharmacists have the information they need in order to accurately screen for drug interactions and provide appropriate counseling.

**Pilot and Evaluate Disease Management**

The Minnesota Pharmacists Association supports the recommendation made in the report that DHS pursue a pilot project that would evaluate the potential for disease management to improve quality of care and reduce health care costs associated with chronic illness. Many studies have shown that pharmacists are effective in bringing about new efficiencies in health care and, even more importantly, in patient care. Please find enclosed for your consideration a summary of findings that have proven Medication Therapy Management Services (MTMS) by pharmacists to have made a significant difference in both cost and quality outcomes. MPhA would welcome the opportunity to be involved with the development and incorporation of pharmacists in the project.

The Minnesota Pharmacists Association respectfully urges the Department of Human Services to take these comments into consideration. MPhA would welcome the opportunity to meet with you to discuss these issues further and provide clarification on any questions you have.

Respectfully submitted,



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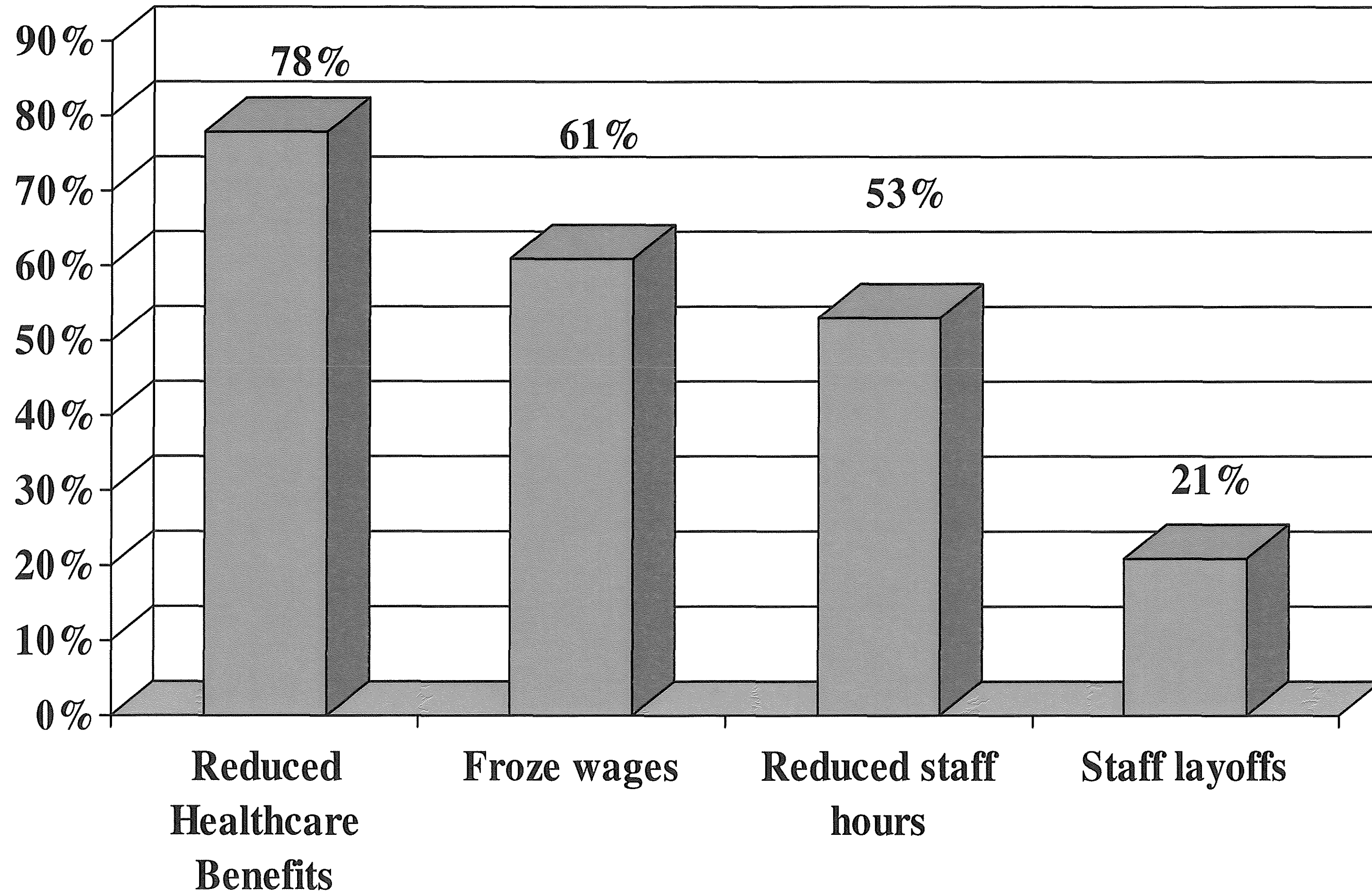
# Nursing Home Staff Hurt by Rate Freeze

Percent of Nursing Homes who Took the following Actions in Response to Frozen MA Rates




*Source: Long Term Care Imperative 2005 Legislative Survey*

# Minnesota Youth Service Association

## Committee on Public Policy and Advocacy

c/o StreetWorks, 2222 Park Avenue, Minneapolis, MN 55404
phone (612) 252-2735 fax (612) 252-2736 * richard.wayman@freeportwest.org

***Pursuing public policy reform to increase opportunities and resources for homeless and runaway youth.***


## MINNESOTA HAS THOUSANDS OF HOMELESS YOUTH EACH YEAR!

In October of 2003 the Wilder Research Center conducted a state-wide survey of homeless youth in Minnesota. Homeless youth are aged 12 to 21 years and have no parental, substitute, foster, or institutional home to which they can safely go. They are unaccompanied by an adult. The Wilder Research Center's survey in 2003 determined the following:

- **Between 500 and 600 youth are homeless** and without shelter on any given night in Minnesota.
- Homeless youth are **disproportionately youth of color** (65% were African American, American Indian, or bicultural).
- Nearly **1 out of 6 had no regular place to live for more than a year** (16%);
- **1 out of 8 had stayed in an abusive situation** because they did not have other housing options (13%);
- **One third have considered suicide** (34%) and one quarter (23%) have attempted suicide;
- Nearly 1 out of 2 homeless youth have been **physically or sexually mistreated** (46%); nearly 3out of 10 have been sexually abused (31% of all girls and 22% of all boys);
- **3 out of 10 had experienced parental neglect** (30%)
- 7 out of 10 homeless youth had experienced a placement in foster home, group home, or corrections facility (71%)

## LOCAL NONPROFIT ORGANIZATIONS HELP YOUTH SUCCEED!

The Twin Cities metropolitan area has seen an enormous amount of homeless and at-risk youth seeking shelter. In 2003 alone, eight nonprofit agencies served 3,659 homeless and runaway youth with 1,992 being under the age of 18 years. (However, please note that this is not an unduplicated count.) However, the crisis of homeless and runaway youth is not just an urban issue. Greater Minnesota also reports an alarming supply of troubled teenagers:

- In Bemidji, outreach workers with Evergreen Shelter saw 145 homeless and at-risk youth on the streets and provided emergency shelter and family reunification services to 600 youth in 2003; 100 pregnant and parenting teens and single homeless youth in Transitional Housing Program.
- In Brainerd, a Lutheran Social Services youth shelter provided emergency shelter to 37 homeless youth in 2001;
- In Duluth, Lutheran Social Services' shelter assisted 554 youth in 2001 with street-based outreach reporting an additional 250 youth needing services each day.

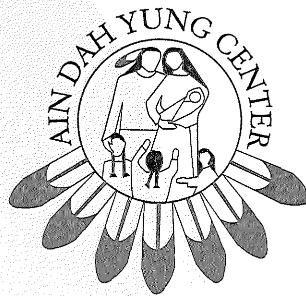
## FUNDING CUTS ARE REDUCING SAFE OPTIONS FOR YOUTH!

Recent losses in federal, state, and local funding have impacted nonprofit organizations ability to serve homeless and runaway youth. Since 2003 we have lost 29emergency shelter beds, 137 units of supportive, transitional housing, and 48 youth case workers. Minnesota must do better to protect and nurture older adolescents!

# Ain Dah Yung Center

OUR HOME

STRENGTHENING AMERICAN INDIAN YOUTH AND FAMILIES



# Mission

TO ASSIST AMERICAN INDIAN YOUTH AND FAMILIES TO THRIVE IN SAFETY, WHOLENESS AND A HEALING PLACE WITHIN THE COMMUNITY.

**American Indian families participate in traditional activities such as the drum group and powwows to help build a sense of community.**

# Promoting strength and pride in American Indian youth and families

The Ain Dah Yung Center — which means "our home" in the Ojibwe language — began in 1983 as an emergency shelter for runaway and homeless American Indian youth.

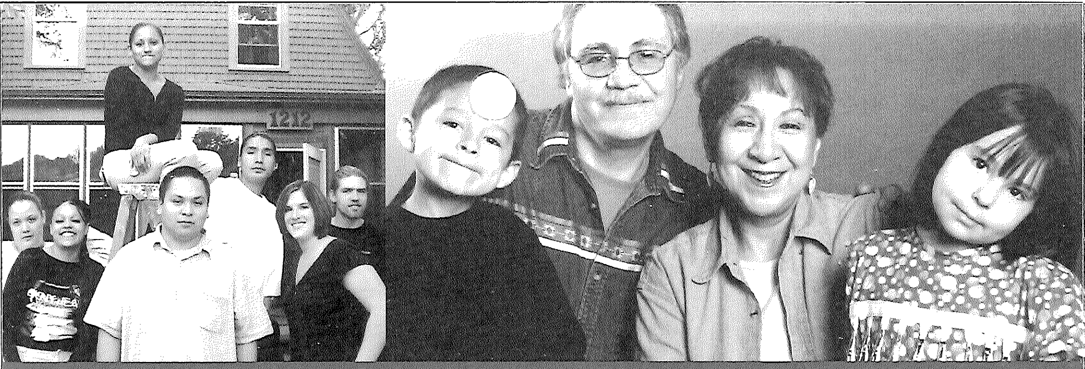
The shelter quickly filled the need for a culturally relevant and safe place in the Twin Cities — one of the most concentrated urban American Indian populations in the United States.

While the shelter remains the backbone for the Ain Dah Yung Center's mission to strengthen American Indian youth and families, it has grown to address a wide variety of issues in the American Indian community.

Today, the Ain Dah Yung Center is a national model for providing a broad spectrum of culturally relevant and cost-effective social services to American Indian youth and their families — a group that has been reluctant to use mainstream government services and programs.

The Ain Dah Yung Center provides a continuum of care and services — recognizing that, in American Indian culture, you can't grow as a person until you have honor, dignity and respect for both yourself and everything around you.

**The Ain Dah Yung Center is a culturally based social services provider whose mission is to strengthen American Indian youth and families. Its main office is at 1089 Portland Ave. St. Paul, MN 55104 (651) 227-4184.**



Each year, the Ain Dah Yung Center provides services to about 500 youth and families, using

# Youth Programs

**OUR HOME EMERGENCY SHELTER • AIN DAH YUNG**

Offers a safe and supportive environment in the short term — and counseling, advocacy and tutoring in the longer term — to assist runaway and homeless children ages 5 to 17 succeed in school and in life.

**PHONE: (651) 227-4184 • FAX: (651) 224-5136 • info@aindahyung.com**

**STREET OUTREACH PROJECT**

Information on health, sexually transmitted diseases, birth control and safe housing is given to runaway and homeless youth who are unable or unwilling to use the emergency shelter.

**PHONE: (651) 227-4184 • FAX: (651) 224-5136 • info@aindahyung.com**

**OUR CHILDREN PROGRAM • NINIJANISAG**

Provides culturally based chemical health education, leadership training and community-building activities to youth to prevent chemical abuse and other destructive behavior.

**PHONE: (651) 227-4184 • FAX: (651) 224-5136 • info@aindahyung.com**

**HONOR COMMUNITY INITIATIVE • NAMADJI**

Drawing on traditional cultural values, provides education to St. Paul middle school students to reduce the risk of suicide among American Indian youth.

**BEVERLEY A. BENJAMIN YOUTH LODGE**

Offers transitional living services — including education and adult living skill instruction — for youth between the ages of 16 and 21 who have no safe home.

**PHONE: (651) 632-8923 • FAX: (651) 224-5136 • info@aindahyung.com**

**INDIAN CHILD WELFARE LEGAL ADVOCACY PROJECT**

Together with Southern Minnesota Regional Legal Services, provides assistance to ensure that the unique interests of American Indian children are represented as required by the federal Indian Child Welfare Act.

**PHONE: (651) 793-8946 • FAX: (651) 771-4929 • info@aindahyung.com**

traditional American Indian beliefs as a starting point for personal and community growth.

# Family Programs

**STAND WITH THE PEOPLE PROGRAMS • OYATE NAWAJIN**

Ain Dah Yung's Stand With the People programs listed below are designed to keep American Indian families together and strong by providing the knowledge, skills and resources needed to provide a safe and stable environment for children.

**PHONE: (651) 776-2230 • FAX: (651) 776-2290 • www.aindahyung.com**

**INTENSIVE IN-HOME PROGRAM**

Offers intensive, short-term parenting and life-skill education, advocacy, case management and resource referral services for families identified by Ramsey County Child Protection.

**FAMILY SUPPORT PROGRAM**

Provides parents with education, support groups, case management and advocacy, and resource referral.

**MY RELATIVES PROGRAM • INDINWAY MUG ENUG**

Offers the same services as the Family Support Program (see above), but for at-risk families that have been identified by Ramsey County Child Protection.

**ALTERNATIVE RESPONSE PROGRAM**

Provides early intervention services — including case management, advocacy and resource referral — for families that have been identified by Ramsey County Child Protection.

**COUNSELING AND SUPPORT PROGRAM**

Provides culturally sensitive counseling and support services for American Indian children and adults, including individual, group, family therapy and assessment.

**PHONE: (651) 495-1075 • FAX: (651) 776-2290**

**YOUTH VIOLENCE REDUCTION PROJECT**

Offers skill-building education, case management and advocacy to reduce violent behavior for American Indian youth in Ramsey County.

**PHONE: (651) 776-2230 • FAX: (651) 776-2290**

**RAMSEY COUNTY CHILDREN'S MENTAL HEALTH CASE MANAGEMENT**

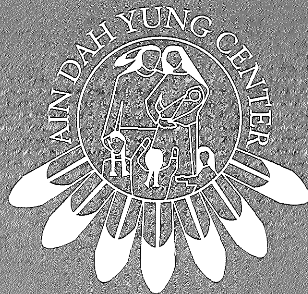
Provides support, case management and assistance in coordinating resources for families with children who have mental health needs.

**PHONE: (651) 495-1081 • FAX: (651) 776-2290**

# Ain Dah Yung Center

A CULTURALLY BASED SOCIAL SERVICES
PROVIDER FOR STRENGTHENING
AMERICAN INDIAN YOUTH AND FAMILIES.

1089 Portland Ave.
St. Paul, MN 55104
(651) 227-4184
**www.aindahyung.com**

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