



OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

EVALUATION REPORT

**Financial Management of
Health Care Programs**

FEBRUARY 2008

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OFFICE OF THE LEGISLATIVE AUDITOR

STATE OF MINNESOTA • James Nobles, Legislative Auditor

February 2008

Members of the Legislative Audit Commission:

In fiscal year 2007, Minnesota spent \$6.5 billion on health care programs serving lower-income people. Payments were made on a fee-for-service basis to health care providers, as well as on a per enrollee basis to a variety of private and county-owned managed care organizations that have contracts with the state.

We found that Minnesota's use of managed care provides several advantages over fee-for-service, but that approach does not automatically control costs. Therefore, we recommend greater scrutiny of costs—as well as health outcomes—in both managed care and fee-for-service. We also discuss alternative service delivery models that the Legislature could consider.

This report was written by Joel Alter (project manager), Valerie Bombach, and Timothy Dykstal. We received the full cooperation of the departments of Human Services, Health, and Commerce, and we also received helpful advice from health plans, counties, and many others.

Sincerely,

A handwritten signature in black ink that reads "Jim Nobles".

James Nobles
Legislative Auditor

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Summary

Minnesota should continue to rely significantly on managed care to serve enrollees in the state's publicly funded health care programs, but with enhanced efforts to contain medical and administrative spending.

Major Findings:

- National research has shown mixed results regarding managed care's impact on health care costs, outcomes, and access. However, providing health care services to low-income Minnesotans through "managed care" has offered several advantages over "fee-for-service" care (pp. 110-119).
- The Department of Human Services (DHS) has paid managed care health plans at rates that have enabled them to remain financially healthy, but more rigorous cost containment efforts will be required by DHS and the Legislature to address rising spending per enrollee (p. 47).
- State agencies have conducted limited review of health plans' administrative spending for public programs, which totaled \$200 million in 2006 (p. 66).
- Minnesota's Medical Assistance program costs more per enrollee than the U.S. average for Medicaid programs, reflecting its more comprehensive benefit set and higher proportions of spending for long-term care and people with disabilities (pp. 8-9).
- County-based health plans have made significant efforts to improve services in rural parts of Minnesota, but it is still unclear whether their services are better or less expensive than those of other health plans (pp. 98-99, 105).

- The Legislature and DHS have not adequately updated fee-for-service reimbursement rates in publicly funded health care programs (p. 53).

Recommendations:

- DHS should report to the 2009 Legislature on (1) progress to implement its cost containment strategies in publicly funded health care programs (p. 33), and (2) reasons for differences between DHS's targets for health plans' net income and the plans' actual net income (p. 48).
- DHS should increase its scrutiny of administrative spending by health plans serving Minnesota's public programs (p. 74). The Legislature should require the departments of Health and Commerce to develop procedures for more detailed reviews of the "reasonableness" of health plan expenditures (p. 74).
- The Legislature should retain the option of using both private and county-based health plans to administer managed care for public programs, but it should restrict expenditures to health-related purposes (p. 104). It should also authorize DHS to periodically reconsider which plans will serve counties that have single-plan purchasing arrangements (p. 108).
- The Legislature should consider a modest increase in certain fee-for-service rates (p. 54).

The Department of Human Services administered \$6.5 billion in health care services in 2007, using a combination of managed care and fee-for-service care.

Report Summary

Minnesota has three main health care programs for lower income people: Medical Assistance (which is Minnesota's version of the federal Medicaid program), MinnesotaCare, and General Assistance Medical Care. Together, these programs cost \$6.5 billion in fiscal year 2007.

Managed care offers several advantages over fee-for-service, although definitive evidence on cost-effectiveness is lacking.

Minnesota pays for publicly funded health care programs in two ways. Under a "fee-for-service" approach, the state reimburses health care providers for services already delivered to program enrollees. Under a "managed care" approach, the state contracts with health plans and pays them a predetermined rate for services to enrollees, and the health plans bear the risk for any costs above this rate. A majority of the enrollees in Minnesota's public programs are served by managed care, but most spending occurs through fee-for-service care.

In Minnesota, managed care has been implemented in a way that offers several advantages over fee-for-service. For example, state contracts with health plans provide a mechanism for leveraging improvements in access, accountability, and quality that has been lacking in fee-for-service. Also, managed care (in contrast to fee-for-service) limits the state's financial risk to predetermined payment levels. In addition, managed care enrollees generally have more recourse when problems arise than do enrollees in fee-for-

service care. This is one reason that our report recommends that the Legislature consider expanding the duties of the state's managed care ombudsman to encompass fee-for-service enrollees. Finally, health plans' efforts to engage enrollees in health improvement activities contrast with the more passive and uncoordinated approaches that have characterized fee-for-service care.

Nationally, studies have reached mixed conclusions about whether managed care leads to better outcomes, lower costs, and greater access to services than fee-for-service care. Minnesota set out to determine in the 1980s whether managed care programs were more cost-effective than fee-for-service programs, but it never produced definitive, statewide evidence. In general, Minnesota health plans have performed fairly well on measures of service quality compared with national averages, while there has been little measurement of quality in fee-for-service care.¹

Minnesota needs stronger efforts to contain health care costs, especially in managed care.

Research has indicated that Minnesota's Medicaid costs per enrollee are well above the national average—probably reflecting Minnesota's more comprehensive benefit package and its higher proportion of costs for long-term care and people with disabilities. Also, Minnesota's payments per enrollee to health plans for public

¹ We recommend that the departments of Human Services and Health agree on a single way to compute and publicly report on health plan performance; currently, these two departments use different methods.

DHS proposed a variety of health care cost savings strategies in 2005, but containing health care costs remains unfinished business.

managed care programs are higher than those in most states.

There has been significant growth in Minnesota's managed care spending in recent years. Medical spending per managed care enrollee grew 12 percent annually between 2000 and 2006. Also, among non-disabled enrollees under age 65, Minnesota's growth in managed care spending per enrollee exceeded the nation's growth rate.

Minnesota's health plans have typically made money from their participation in public programs. In recent years, the plans' overall net income from these programs ranged from 0.7 percent of total revenues (2006) to 4.9 percent (2004). States must set managed care rates that are "actuarially sound," but this does not ensure cost containment (and might even contribute to cost inflation). Health plans' net returns have often exceeded the levels targeted by DHS during its rate-setting process, although plans have consistently experienced losses in the General Assistance Medical Care program. Health plans' reserves grew significantly in recent years, but there is no authoritative benchmark regarding the maximum level of reserves plans should have.

In fee-for-service care, the Legislature and DHS have not adequately updated Minnesota's fee-for-service reimbursement rates for physician services. For example, the Legislature has authorized only one general increase in physician reimbursement since 1992, and DHS has not implemented a legislatively-mandated change intended to make reimbursement rates fairer.

In 2005, DHS proposed a wide range of strategies to contain costs in Minnesota's health care programs. In some cases, there has been important progress—for example, DHS has started to implement "evidence-based" practices to determine when to cover certain medical services, and the Legislature and Department of Health have initiated an ambitious project to foster the use of electronic medical records. In other cases, there has been little progress—for example, in fostering multi-county service consolidation and improving case management services for people in home and community-based services. DHS should present the 2009 Legislature with a status report on its strategies to contain health care costs.

There has been limited state oversight of health plans' administrative spending.

The costs to administer Minnesota's health care programs are significant. At the state level, DHS spent an estimated \$119 million to administer managed care and fee-for-service health care in 2006, with increases in these expenses averaging 10 percent annually since 2000.

Health plans' administrative spending totaled \$200 million in 2006, and their administrative spending per enrollee grew by about 8 percent annually between 2000 and 2006. In aggregate, health plans' administrative spending for public programs was about 7 percent of their total spending in 2006 (excluding premium taxes and surcharges), and these expenditures ranged from 6 percent to 20 percent among individual health plans.

With some modification, county-based purchasing deserves more time to demonstrate its value.

State rules require the departments of Health or Commerce to periodically review the “reasonableness” of health plans’ spending, but these reviews have not been program-specific, nor have they focused on administrative costs in detail. Officials in these departments say they lack the directives, resources, and clear standards to conduct in-depth reviews.

For the state’s public programs, DHS rarely reviews health plans’ subcontracts for services, does not review detailed information on subcategories of administrative expenditures, and does not set caps or incentives to ensure that health plans’ spending for administrative services aligns with the department’s assumptions during the managed care rate-setting process. DHS’s rate-setting methods and contract requirements should address administrative spending more closely, and the Department of Health should develop guidelines to help plans consistently allocate costs among their lines of business.

The Legislature should retain county-based purchasing but change some laws that govern it.

The 1997 Legislature authorized groups of counties to purchase or provide health care on behalf of enrollees in Minnesota’s public programs. Three “county-based purchasing” organizations now administer services in all or parts of 27 counties.

These organizations have made significant efforts to respond to local priorities and work with county agencies. But their administrative costs, in aggregate, have been higher than those of private health plans,

and it is unclear whether county-based plans’ efforts to integrate health care and social services have contained costs. Also, county-based plans have had mixed performance on measures of program quality and compliance with regulations.

County-based purchasing deserves more time to demonstrate its value, but the Legislature should make several changes in the laws governing it. For example, county-based purchasing organizations can now choose whether to allocate surplus revenues to their member counties, and state law should require that public program revenues (whether for county-based or other health plans) be used to serve health-related purposes. Also, state law has designated some county-based organizations to be the sole health plan in certain counties. To help ensure that services are cost-effective, the Legislature should authorize DHS to periodically reconsider which plans will serve these counties. In addition, the Legislature should require county-based plans to meet statutory reserve requirements *without* relying primarily on county taxing authority as a guaranty of these revenues.

Introduction

Health care spending is a large and growing part of the nation's economy and states' budgets. Health care programs are the largest area of expenditure in Minnesota's largest state agency (the Department of Human Services, or DHS), and state contracts with managed care organizations account for some of Minnesota's largest payments to private organizations.

Legislators have asked questions about whether existing state health care programs are well managed and cost-effective. In April 2007, the Legislative Audit Commission directed our office to evaluate the financial management of publicly funded health care programs in Minnesota. Our evaluation addressed the following questions:

- **To what extent has there been progress toward the implementation of health care cost containment strategies previously identified by DHS?**
- **Does the state have appropriate practices for setting payment rates, contracting for services, and monitoring quality in its health care programs for low-income Minnesotans?**
- **Is there adequate state oversight of health plan spending for administrative activities? What are the costs for DHS and the health plans to administer health care services?**
- **What has been Minnesota's experience with administration of publicly funded health care programs through managed care organizations? Should Minnesota consider alternatives to its existing service delivery approaches for these programs?**

The focus of this evaluation was the state's financial management and oversight of publicly funded health care programs for low-income Minnesotans. These programs include Medical Assistance, MinnesotaCare, and General Assistance Medical Care. We did not examine the federally-administered Medicare program, except to better understand how it relates to some of the state-administered health care programs. Our study focused largely on the state's role as a purchaser of health care services, including its roles in contracting, rate setting, quality assurance, and accountability.

We did not examine all aspects of the state's administrative activities in health care programs, nor did we examine the operations of health care programs in detail. For example, we did not evaluate the state's processes for enrolling clients and providers, and we did not evaluate the adequacy of the state's fraud control and prevention activities. We examined the state's oversight of managed

care organizations' administrative spending, but we did not conduct financial audits of reported expenditures. Also, we did not examine issues regarding access to publicly funded health care programs, except as part of our general literature reviews and our examination of state agencies' activities to ensure compliance with current regulations. In addition, we did not evaluate the State of Minnesota's health care programs for its own employees.

To conduct this evaluation, we obtained documents and data about Minnesota's health care programs from the state departments of Human Services, Health, and Commerce, and we interviewed officials in each of these agencies. We interviewed a variety of other people with perspectives on Minnesota's health care programs, including officials from the managed care organizations that administer services on behalf of DHS, county staff, health care providers, health care researchers, and advocacy groups. We reviewed research literature on topics related to state health care purchasing, oversight of public programs, and the cost-effectiveness of alternative service delivery approaches.

Chapter 1 provides background on Minnesota's public programs and the roles played by state agencies. Chapter 2 summarizes the extent to which there has been progress on health care cost-related strategies suggested by DHS in 2005. Chapter 3 examines the state's rates for managed care and fee-for-service care, and Chapter 4 discusses managed care administrative spending. Chapter 5 examines quality assurance mechanisms in the managed care and fee-for-service systems, and Chapter 6 evaluates Minnesota's experience with "county-based purchasing." Finally, Chapter 7 reviews managed care's impact and value, and it discusses other service delivery options the state could consider.

Background

SUMMARY

Minnesota has several publicly funded health care programs that serve lower-income Minnesotans. Most enrollees are in “managed care” programs, but most of the expenditures occur through “fee-for-service” arrangements. Minnesota’s Medicaid program (called “Medical Assistance”) costs significantly more per enrollee than the U.S. average for Medicaid programs, probably due to Minnesota’s more comprehensive benefit package and its relatively large shares of spending for long-term care and enrollees with disabilities. Three state agencies—the departments of Health, Human Services, and Commerce—play key roles in the financial management of Minnesota’s health care programs.

Recently, the director of the U.S. Congressional Budget Office testified to Congress that “[t]he nation’s long-term fiscal balance will be determined primarily by the future rate of health care cost growth.”¹ He noted that, over the past four decades, the costs per beneficiary of Medicare and Medicaid have increased about 2.5 percentage points faster annually than the nation’s per capita gross domestic product.² Health care programs for people with low incomes are also a major factor affecting state governments’ spending levels, and this chapter addresses the following questions:

- **What are Minnesota’s main publicly funded health care programs, and what role do they play in Minnesota’s health care system?**
- **How much do these programs cost, and how do Minnesota’s costs per enrollee compare with those in other states?**
- **What is “managed care” and “fee-for-service” health care? To what extent are the state’s health care programs delivered through each?**
- **What are the key responsibilities of Minnesota state agencies in the financial management of health care programs?**

¹ Peter R. Orszag, *Health Care and the Budget: Issues and Challenges for Reform: Testimony Before the Committee on the Budget, U.S. Senate* (Washington, D.C.: Congressional Budget Office, June 21, 2007), 1.

² *Ibid.*

OVERVIEW OF MINNESOTA'S PUBLICLY FUNDED HEALTH CARE SERVICES

Programs

Minnesota has three comprehensive health care programs for lower-income people: Medical Assistance, General Assistance Medical Care, and MinnesotaCare (see Table 1.1). Together, these programs provide health care to about 11 percent of Minnesota's population. In addition,

- **Minnesota's health care programs for lower-income people cost \$6.5 billion (from all funding sources) in fiscal year 2007, or about one-fourth of total health care spending in the state.**

The \$6.5 billion does not include spending for the Medicare program, which provides health insurance to thousands of seniors and people with disabilities in

Minnesota has three main health care programs for lower-income people.

Table 1.1: Key Characteristics of Minnesota's Health Care Programs for Lower-Income People

| | Medical Assistance | General Assistance Medical Care | MinnesotaCare |
|-------------------------------------|--|---|--|
| Administered mainly by: | Counties | Counties | State |
| Funding responsibility | 50% federal 49% state 1% county | 0% federal 97% state 3% county | 34% federal 58% state 8% enrollees |
| Total spending, FY 2007 | \$5.8 billion | \$281 million | \$434 million |
| Average monthly enrollment, FY 2007 | 507,332 | 33,516 | 117,912 |
| Populations typically served | Low-income families, pregnant women, seniors, and people with disabilities | Low-income individuals who are ineligible for MA, such as able-bodied adults without children | Low- and moderate-income individuals and families who (1) do not have access to employer-provided insurance, and (2) have incomes above the limits for MA and GAMC |

SOURCES: Minnesota Department of Human Services; Office of the Legislative Auditor, *Follow-up Review: MinnesotaCare Eligibility Determination* (St. Paul, 2007).

Medical Assistance is Minnesota's largest health care program.

Minnesota.³ Medicare is administered and funded mostly by the federal government. We excluded Medicare from our review, except for the purpose of understanding how Minnesota's state health care programs have been designed to integrate Medicare services.

Medical Assistance (MA) is Minnesota's version of the federal Medicaid program. It is Minnesota's largest health care program in terms of enrollment and spending, and costs are split about equally between the federal and state governments. In general, individuals qualify for MA if they (1) are a member of a population subgroup covered by federal or state Medicaid law, and (2) have household income and assets within the program's limits.⁴ Table 1.2 shows the incomes that qualify for MA in Minnesota for various groups; Minnesota's income limits are higher than the Medicaid limits in many states. Federal law requires states to provide certain services to MA recipients, such as physician, laboratory, inpatient hospital, outpatient hospital, and nursing facility services. In addition, Minnesota law specifies that some services deemed "optional" under federal law will be provided in Minnesota—such as audiology, chiropractic, dental, hospice, mental health, physical therapy, and vision-related services. Minnesota has also obtained various "waivers" from the federal government that authorize MA coverage for community-based care that would not otherwise be covered by MA.⁵ Enrollees in MA (and the other public programs discussed below) are subject to co-payments or co-insurance for certain services.

General Assistance Medical Care (GAMC) is a state-funded program for people not eligible for MA. Most of the enrollees are adults between ages 21 and 64 without dependent children. To qualify for the full range of GAMC health benefits, persons must have household incomes at or below 75 percent of the federal poverty guidelines. GAMC does not cover some services covered by MA, such as home health care and nursing facility services. Persons with incomes between 75 and 175 percent of the federal poverty guidelines are currently eligible for GAMC hospital-only coverage.

MinnesotaCare is a state health care program that covers low- and moderate-income persons without access to other types of health care coverage. It covers children under age 21, pregnant women, and adults caring for children under 21 if their household incomes are no greater than 275 percent of the federal poverty guidelines. It also covers adults without children if their incomes do not exceed 175 percent of the federal guidelines. Enrollees pay premiums based on a sliding scale. MinnesotaCare covers children and pregnant women for all health care

³ In 2005 (the most recent year for which data on all funding sources was available), Medicare accounted for 15 percent of Minnesota's \$29.4 billion in total public and private health care spending.

⁴ People with incomes over the MA income limits may still qualify for coverage through MA "spenddown" provisions—that is, if they spend a specified portion of their income on medical bills.

⁵ Minnesota's waivers include the Elderly Waiver, the Home and Community-Based Waiver for Persons with Mental Retardation or Related Conditions, the Community Alternative Care Waiver, the Community Alternatives for Disabled Individuals Waiver, and the Traumatic Brain Injury Waiver. States must demonstrate that the average annual spending per waiver recipient is not greater than the average cost of persons in institutional care.

Table 1.2: Health Care Program Income and Asset Limits, FY 2008

| Health Care Program | Eligibility Group | Net Household Income Limits, as a Percentage of Federal Poverty Guidelines | Asset Limits |
|---------------------------------|---|--|---|
| Medical Assistance | • Pregnant women | 275% | None |
| | • Children under 2 | 280 | None |
| | • Children ages 2-18 | 150 | None |
| | • Children ages 19-20 | 100 | None |
| | • Elderly, blind, and people with disabilities | 100 | \$3,000 for household of one; \$6,000 for two, plus \$200 per additional person |
| | • Parents with children under 19 | 100 | \$10,000 for household of one; \$20,000 for household of two or more |
| MinnesotaCare | • Families | 275 | \$10,000 for household of one; \$20,000 for household of two or more |
| | • Single adults and households without children | 175 | \$10,000 for household of one; \$20,000 for household of two or more |
| General Assistance Medical Care | • Full-coverage | 75 | \$1,000 per household |
| | • Hospital-only coverage | 175 | \$10,000 for household of one; \$20,000 for household of two or more |

SOURCE: Minnesota Department of Human Services.

services covered by MA; parents and adults without children qualify for many but not all MA services.

The Medical Assistance program described earlier includes two specialized programs for enrollees over age 65. The **Minnesota Senior Health Options (MSHO)** program is a voluntary program for MA-eligible seniors that is intended to integrate health care and related support services. Under MSHO, the Department of Human Services (DHS) contracts with managed care

MinnesotaCare covers many lower-income families and individuals not covered by other programs.

Within Medical Assistance, there are several specialized health care programs for seniors and people with disabilities.

organizations to provide primary, acute, and long-term care services. MSHO serves many individuals who are eligible for both MA and Medicare, and the state's contracts consolidate the requirements for these programs. A centerpiece of MSHO is its requirement for managed care organizations to arrange for a care coordinator for each enrollee. Seniors in MA who choose not to enroll in MSHO must enroll in the **Minnesota Senior Care (MSC)** program. MSC offers mostly similar coverage to MSHO, but with less coordination of care.⁶ As of November 2007, MSHO had 36,009 enrollees, and MSC had 10,936 enrollees.

Minnesota's Medical Assistance program also includes two voluntary programs for people with disabilities. The 2006 Legislature authorized the Department of Human Services to establish the **Special Needs Basic Care (SNBC)** program, and enrollment started in January 2008.⁷ This program is intended to give disabled MA enrollees the option of enrolling in a single managed care organization that will administer their Medicaid and Medicare services. Under this program, the managed care organization is responsible for the first 100 days of nursing home care, but enrollees receive other long-term care services on a fee-for-service basis. In the seven-county Twin Cities area, people with disabilities may enroll in the **Minnesota Disability Health Options (MnDHO)** program, which is similar to SNBC but requires the enrollee's managed care organization to cover (1) 180 days of nursing home care, and (2) certain services under Minnesota's home and community-based waivers.⁸

Some of the programs discussed above include a combination of "basic" health care services and long-term care services. Most of our evaluation focused on "basic" health care services, and spending for these services totaled about \$4.0 billion in fiscal year 2007. Between 1998 and 2007, the average annual rate of increase in spending for "basic" health care in Minnesota's public programs was 10.7 percent.⁹

Cost Comparisons with Other States

It is difficult to find good information for comparing states' aggregate expenditures and overall benefit levels for publicly funded health care programs. As noted in the previous section, two of Minnesota's three health care programs were state-initiated, and many states do not have comparable programs. However, all 50 states operate Medicaid programs, which comprise a large share of the nation's health care expenditures for low-income people. For Medicaid, it

⁶ Under the "MSC Plus" program—which operates in all outstate counties—managed care organizations must cover 180 days of nursing facility and elderly waiver services, which is identical to MSHO's coverage. In contrast, MSC coverage in the Twin Cities metropolitan area counties is presently 90 days of nursing facility and elderly waiver services; these counties will be required to transition to the "MSC Plus" coverage by 2009.

⁷ *Laws of Minnesota* 2006, chapter 282, art. 20, sec. 30.

⁸ As of November 2007, MnDHO had 917 enrollees.

⁹ Based on an analysis of "basic health care grants" and "health care management" in Minnesota biennial budget documents.

Minnesota's higher Medicaid costs reflect its broader coverage and its larger share of spending for long-term care and people with disabilities.

is possible to draw some comparisons between Minnesota and other states. Prior analyses have indicated that:

- **Minnesota's Medical Assistance program costs significantly more per enrollee than the national average.**

An analysis by staff at the U.S. Center for Medicare and Medicaid Services found that Minnesota's average calendar year 2004 Medicaid spending per enrollee was 50 percent higher than the U.S. average (\$9,191 vs. \$6,119).¹⁰ Similarly, an analysis by the Kaiser Family Foundation that used a somewhat different measure found that Minnesota's average Medicaid payment per enrollee in fiscal year 2004 was 41 percent higher than the U.S. average.¹¹

Minnesota's higher cost per enrollee is probably due to several factors. First, Minnesota's Medicaid program has a more comprehensive set of health care benefits for its recipients than many states. We used a national database to compare the breadth of Minnesota's coverage in 31 acute care service categories. Minnesota's MA program covered each of these services. However, at least one-third of the states did not cover seven of these services—chiropractor services, occupational therapy, psychologist services, dentures, physical therapy, hearing aids, and services for speech, hearing, and language disorders.¹² Also, Minnesota is 1 of more than 30 states with a supplemental Medicaid program for "medically needy" individuals who would not otherwise be eligible for Medicaid.¹³

Second, a high percentage of Minnesota's Medicaid spending is for long-term care services, which often have relatively high costs per recipient compared with other Medicaid services. According to a national analysis of Medicaid spending, about 50 percent of Minnesota's fiscal year 2006 Medicaid spending was for long-term care, compared with 37 percent nationally.¹⁴ Minnesota's percentage was third highest among states (behind North Dakota and Connecticut).

¹⁰ Anne B. Martin, Lehka Whittle, Stephen Heffler, Mary Carol Barron, Andrea Sisko, and Benjamin Washington, "Health Spending by State of Residence, 1991-2004," *Health Affairs*, Web Exclusive, <http://content.healthaffairs.org/cgi/reprint/hlthaff.26.6.w651v1>, published online September 18, 2007, accessed October 3, 2007.

¹¹ Kaiser Family Foundation, "Medicaid Payments per Enrollee, FY 2004," <http://statehealthfacts.org/comparetable.jsp?ind=183&cat=4>, accessed September 27, 2007. This estimate is based on a simple calculation of costs divided by total enrollees; in contrast, the estimate by the CMS staff was based on costs divided by "person-years" (that is, total months eligible divided by 12).

¹² Based on an analysis of Kaiser Family Foundation, "Medicaid Benefits: Online Database," <http://www.kff.org/medicaid/benefits/index.jsp?CFID=18497928&CFTOKEN=96308275>, accessed September 16, 2007.

¹³ Jeff Crowley, "Medicaid Medically Needy Programs: An Important Source of Medicaid Coverage" (January 2003), <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14325>, accessed October 3, 2007.

¹⁴ Kaiser Family Foundation, "Distribution of Medicaid Spending by Service, FY 2006," <http://www.statehealthfacts.org/comparetable.jsp?ind=178&cat=4>, accessed September 27, 2007.

Third, compared with other states, Minnesota spends a higher proportion of its total Medicaid dollars on people with disabilities. In fiscal year 2004, Minnesota spent 48 percent of its Medicaid payments on people with disabilities—higher than any other state.¹⁵ States' Medicaid spending per enrollee is typically higher for people with disabilities than for other eligible Medicaid recipients, so this is likely a factor in Minnesota's relatively high overall spending per enrollee.

State Approaches to Purchasing Health Care

States use a combination of “fee-for-service” and “managed care” approaches to purchase health care services for their residents. Most states initially implemented their Medicaid programs on a fee-for-service basis. Under this approach, health care providers serving Medicaid-eligible people submit bills for state reimbursement. States pay for services authorized for reimbursement, and there are no caps on the state's overall financial obligations.

Like other states, Minnesota purchases health care using a combination of fee-for-service and managed care.

States have also used a “managed care” approach to purchase many health care services for lower-income persons. Under this approach, states contract with managed care organizations—often called “health maintenance organizations” or “health plans”—to provide health care services at a predetermined, fixed rate. This “capitated” rate is an amount that will be paid to the health plan on a “per member per month” basis. Unlike the fee-for-service approach, the managed care approach typically transfers financial risk from the state to the health plans.¹⁶ In other words, the health plan bears responsibility to pay for enrollee costs, even if these costs are greater than the state's predetermined payment amounts set in the state contracts. Such an approach enables states to limit their financial obligations while creating incentives for health plans to control their spending. The use of the term “managed care” for this approach is a bit misleading, as many states have also implemented strategies in recent years intended to foster better management of the care (and the costs of care) provided to enrollees through a fee-for-service approach. However, we use the term “managed care” in this report to refer to the state's purchase of services from health plans based on capitated rates.

The Minnesota Department of Human Services contracts with nine managed care organizations (shown in Table 1.3) for the state's publicly funded programs. These organizations vary greatly in the number of counties and enrollees they

¹⁵ Kaiser Family Foundation, “Distribution of Medicaid Payments by Enrollment Group, FY 2004,” <http://www.statehealthfacts.org/comparetable.jsp?ind=182&cat=4>, accessed September 27, 2007.

¹⁶ In “full-risk” managed care, health plans assume the risk for any costs that exceed the capitation payments. Some states also have “partial risk” managed care programs in which the states pay providers a set rate per enrollee to coordinate patient care.

Minnesota contracts with six health maintenance organizations and three county-based purchasing organizations.

Table 1.3: Health Plans Administering Minnesota's State Health Care Programs, November 2007

| Health Plan | Type of Organization ^a | Number of Enrollees, All Public Programs | Counties Served in the MA or MinnesotaCare Programs ^b |
|---------------------|-----------------------------------|--|--|
| BluePlus | HMO | 106,704 | 81 |
| UCare | HMO | 87,638 | 77 |
| Medica | HMO | 125,806 | 33 |
| HealthPartners | HMO | 50,821 | 15 |
| South Country | CBP | 24,780 | 14 |
| PrimeWest | CBP | 10,397 | 10 |
| Metropolitan | HMO | 16,597 | 6 |
| FirstPlan | HMO | 9,506 | 5 |
| Itasca Medical Care | CBP | <u>5,317</u> | 3 |
| Total | 6 HMOs, 3 CBPs | 437,566 | 87 |

^a HMO = health maintenance organization; CBP = county-based purchasing organization.

^b This is the unduplicated number of counties where health plans administered services in either of two programs: MinnesotaCare or the Prepaid Medical Assistance Program for persons under age 65. Some plans only administer one of these two programs in a given county.

SOURCE: Office of the Legislative Auditor, analysis of data from Minnesota Department of Human Services.

serve. Six of these organizations are health maintenance organizations. State law defines a health maintenance organization as:

[A] nonprofit corporation ... which provides, either directly or through arrangements with providers or other persons, comprehensive health maintenance services, or arranges for the provision of these services, to enrollees on the basis of a fixed prepaid sum without regard to the frequency or extent of services furnished to any particular enrollee.¹⁷

Minnesota law also authorizes DHS to contract with another type of managed care health plan, called a “county-based purchasing” organization. These organizations are publicly owned health plans, established by counties, that “purchase all covered services for a fixed payment from the state.”¹⁸ DHS presently contracts with three county-based purchasing organizations that,

¹⁷ *Minnesota Statutes* 2007, 62D.02, subd. 4. To our knowledge, the requirement for health maintenance organizations to be nonprofit corporations is unique among states. Another unique requirement is that health maintenance organizations must “participate” in Minnesota’s publicly funded programs as a condition of their licensure (*Minnesota Statutes* 2007, 62D.04, subd. 5).

¹⁸ *Minnesota Statutes* 2007, 256B.692, subd. 3. In addition to the three county-based purchasing organizations shown in Table 1.3, one health plan (Metropolitan) is licensed as a health maintenance organization but owned by Hennepin County.

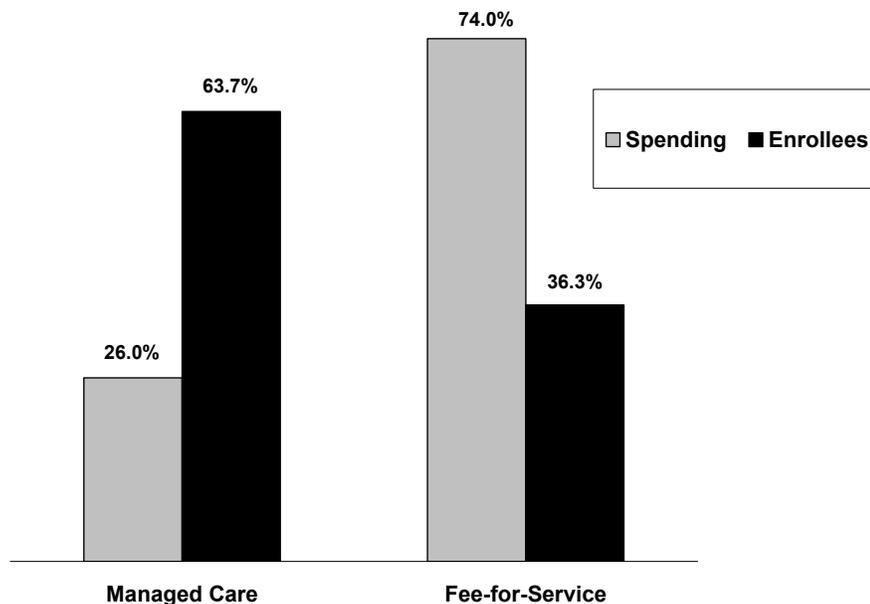
together, serve a total of 27 counties. Chapter 6 addresses county-based purchasing in greater detail.

Fee-for-service and managed care both comprise significant elements of Minnesota’s service delivery structure for publicly funded health care programs. As shown in Figure 1.1, we found that:

- **A majority of the enrollees in Minnesota’s publicly funded health care programs are served by managed care organizations, but most of the spending occurs through fee-for-service care.**

Figure 1.1 focuses on spending and enrollment in Minnesota’s Medicaid program, which is by far the largest of Minnesota’s health care programs. The figure includes Medicaid spending and enrollment for both “basic” health care (such as services provided by physicians) and long-term care services (such as nursing services provided in institutional or community-based settings). As of June 2006, 64 percent of Minnesota’s Medicaid enrollees were in managed

Figure 1.1: Percentages of Minnesota’s Medicaid Spending and Enrollees in Managed Care and Fee-for-Service Care, 2006



SOURCES: Office of the Legislative Auditor, analysis of spending data reported by the Kaiser Family Foundation, <http://www.statehealthfacts.org>, “Total Medicaid Spending, FY 2006” and “Distribution of Medicaid Spending on Acute Care, FY 2006,” accessed November 26, 2007; U.S. Center for Medicare and Medicaid Services, *Medicaid Managed Care Enrollment Report, Summary Statistics as of June 30, 2006* (Washington, D.C., 2006), 4.

Managed care expenditures represent a large share of the state's payments to nonprofit organizations.

care.¹⁹ Minnesota's percentage was 35th highest among the 50 states. Nationally, and in Minnesota, the percentage of Medicaid recipients served through managed care increased significantly in the past ten years.²⁰

Although most Medicaid enrollees are in managed care, spending for managed care services represents a minority of Medicaid costs. Figure 1.1 shows that managed care accounted for 26 percent of Minnesota's overall Medicaid spending in fiscal year 2006, which was the 12th highest percentage among the states.²¹ Managed care's modest share of Medicaid costs reflects the fact that higher cost enrollees—particularly people with disabilities and people in long-term care—are served primarily by fee-for-service health care.

Like most states, Minnesota initially used managed care primarily to serve a relatively able-bodied subgroup of its lower-income population: families on welfare. Later, Minnesota began requiring low-income seniors to enroll in managed care, and recently Minnesota has offered people with disabilities the option of enrolling in managed care. Individuals with disabilities tend to have higher health care costs than individuals on welfare because they are more likely to have chronic health conditions, use expensive health care services (such as hospital and pharmacy services), and remain eligible for public programs for long periods of time.²² The potential for improved management of costs and services for people with disabilities is one reason that a health care consulting firm concluded that, nationally, "capitation is least used for the subgroup that it seems best-suited to serve."²³

Managed care does not represent the majority of spending in Minnesota's health care programs, but the amount of funding the state grants to individual managed care organizations is enormous. Minnesota state government made payments totaling \$4.7 billion to about 3,800 nonprofit organizations in 2005 for a wide variety of programs and purposes.²⁴ Of this total, the state made payments of about \$2 billion to the nine managed care organizations with which it contracts.

¹⁹ U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, *Medicaid Managed Care Enrollment Report, Summary Statistics as of June 30, 2006*, <http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer06.pdf>, accessed November 26, 2007.

²⁰ Minnesota's percentage of Medicaid enrollees served in managed care increased from 33 percent in 1996 to 64 percent in 2006. The U.S. percentage of Medicaid enrollees served in managed care increased from 40 percent to 65 percent during this period.

²¹ For acute care services only, managed care accounted for 53 percent of Medicaid spending in Minnesota, which ranked ninth among the states.

²² According to one recent analysis, the average Medicaid expenditure for a nondisabled adult enrollee under age 65 was about 16 percent of the average expenditure for a disabled enrollee—see Kaiser Family Foundation, "Medicaid Payments Per Enrollee, FY 2004," <http://www.statehealthfacts.org/comparetable.jsp?ind=183&cat=4>, accessed November 2, 2007.

²³ The Lewin Group, *Medicaid Capitation Expansion's Potential Cost Savings* (Washington, D.C., April 2006), 10.

²⁴ Office of the Legislative Auditor, *State Grants to Nonprofit Organizations* (St. Paul, 2007), 13-14.

Minnesota's Health Care System

Enrollees in Minnesota's publicly funded health care programs can use many of the same health plans and health care providers as Minnesotans with private health care insurance. It is worth noting that:

- **Minnesota's publicly financed health care programs operate within the context of a statewide health care system that compares favorably with other states on many key measures.**

Minnesota has fared well on rankings of states' health care systems.

The Commonwealth Fund—a foundation that focuses on health care issues—recently ranked states on more than 30 measures of health system performance.²⁵ The foundation ranked Minnesota among the top states on measures of access (ninth), quality (twelfth), efficiency (tenth), and health outcomes (seventh).²⁶ For example, the foundation listed Minnesota as the top ranked state on the percentage of adults over age 49 who receive recommended screening and preventive care. Similarly, the United Health Foundation ranked Minnesota “at the top of the list of healthiest states” in 2006, a position held by Minnesota in this analysis in 11 of the last 17 years.²⁷ This foundation based its rankings on analyses of personal behaviors (such as smoking prevalence), community environments (such as infectious disease rates), health policies (such as immunization coverage), and health outcomes (such as mortality rates). While Minnesota has a reputation for providing residents with relatively good access to high quality health care services, data also indicate that the average health care spending per capita in Minnesota has consistently been below the national average (\$5,742 vs. \$6,276 in 2005).²⁸

STATE AGENCY ROLES

Three state agencies—the departments of Health, Commerce, and Human Services—play key roles in the financial management of Minnesota's health care programs. In the following sections, we provide a brief overview of their duties.

²⁵ The Commonwealth Fund, *Aiming Higher: Results from a State Scorecard on Health System Performance* (New York, June 2007). The report by the Commonwealth Fund also gave Minnesota a relatively low ranking on a fifth dimension of performance (equity) due to variation in the system's performance among population subgroups.

²⁶ Most of the report's measures of efficiency and costs focused on states' rates of “potentially avoidable” hospitalizations.

²⁷ United Health Foundation, *America's Health Rankings: A Call to Action for People and Their Communities* (Minnetonka, MN, 2006).

²⁸ Minnesota Department of Health, “Key Facts About Minnesota Health Care Markets,” www.health.state.mn.us/divs/hpsc/hep/transform/resourcebook/resourcebookmarkettrendsfinaltab1.ppt, slide 8, accessed September 26, 2007.

The Department of Health enforces statutes and rules governing health plans.

Minnesota Department of Health

The Department of Health has statutory authority to regulate various types of managed care organizations that operate in Minnesota. This includes nine health maintenance organizations and three county-based purchasing organizations based in Minnesota.²⁹ The department has authority to enforce statutes and rules governing these organizations' public and private lines of business, including authority to levy administrative penalties up to \$25,000 per violation.³⁰ For all health maintenance organizations and county-based purchasing organizations, the department conducts quality assurance examinations at least every three years and contracts with the Minnesota Department of Commerce to conduct financial examinations. The department also approves "small group" and "individual market" premium rates for health maintenance organizations.³¹

The department also makes information available to the public about all health maintenance organizations and county-based purchasing organizations. This includes annual financial statements, quality assurance reviews, financial examination reports, and data on enrollment, quality indicators, executive compensation, and department enforcement actions. In addition, the department's website has information on consumer complaints regarding health maintenance organizations but not county-based purchasing organizations. The department also periodically collects and reports information on the administrative costs of group health care purchasers that conduct business in Minnesota, including health maintenance organizations and county-based purchasing organizations.³²

Minnesota Department of Commerce

The Department of Commerce conducts financial examinations of health plans.

The Commissioner of Commerce has statutory authority to enforce Minnesota's insurance laws.³³ The departments of Commerce and Health have established an interagency agreement to help clarify the respective duties of these departments related to health maintenance organizations and county-based purchasing organizations. Under this agreement, the Department of Commerce conducts financial examinations of each health plan to ensure compliance with Minnesota laws and insurance industry standards. The interagency agreement also specifies,

²⁹ In addition, the department's Managed Care Systems Section regulates over 100 "essential community providers," which are health care providers serving high-risk, special needs, and underserved individuals (*Minnesota Statutes* 2007, 62Q.19). The department is also authorized to license "community integrated services networks" and "accountable provider networks," but none are currently licensed in Minnesota.

³⁰ The department issues "certificates of authority" to health maintenance organizations. In contrast, county-based purchasing organizations are not licensed by the department, although they are subject to its regulation and enforcement.

³¹ *Minnesota Statutes* 2007, 62A.021, subd. 1(c).

³² For several years, the department did not obtain data on administrative spending from two county-based purchasing organizations (South Country Health Alliance and Itasca Medical Care).

³³ *Minnesota Statutes* 2007, 60A.03, subd. 2.

among other duties, that the Department of Commerce will (1) review and analyze health plans' periodic financial reports, (2) recommend enforcement or remedial actions to the Department of Health, (3) provide actuarial services to ensure that health plans (or applicants for licensure) comply with all financial and rate-filing requirements, (4) recommend to the Department of Health whether health plans' rate filings should be approved, and (5) provide advice to the Department of Health regarding investigations of consumer complaints. In addition, the Department of Commerce has statutory authority to monitor and regulate health plans' risk-based capital,³⁴ and the Health-Commerce interagency agreement assigns responsibility to the Department of Commerce for certain duties related to oversight of health plans' financial solvency. State rules also require that either the Department of Health or Department of Commerce review the reasonableness of health maintenance organization expenditures at least once every three years.³⁵

Minnesota Department of Human Services

The Department of Human Services administers Minnesota's publicly financed health care programs.

The Department of Human Services supervises the statewide administration of Minnesota's publicly funded health care programs. Statutes require DHS to "plan and implement a unified, accountable, comprehensive health services system" that accomplishes the duties shown in Table 1.4. County agencies play various administrative roles under DHS's supervision, such as determining the eligibility of individuals for health care programs.³⁶

Table 1.4: Department of Human Services' Duties Regarding Minnesota's Health Care System

- Promote accessible and quality health care for all Minnesotans
- Assure provision of adequate health care within limited state and county resources
- Avoid shifting funding burdens to county tax resources
- Provide statewide eligibility, benefit, and service expectations
- Manage care, develop risk management strategies, and contain cost in all health and human services
- Support effective implementation of publicly funded health and human services for all areas of the state

SOURCE: [Minnesota Statutes](#) 2007, 256B.04, subd. 1a.

³⁴ [Minnesota Statutes](#) 2007, 60A.50-60A.57.

³⁵ [Minnesota Rules](#) 2007, 2730.0500-2730.0700. These rules were developed by the Department of Commerce.

³⁶ [Minnesota Statutes](#) 2007, 256B.05.

State law requires DHS to operate a statewide, centralized system for making payments to vendors.³⁷ DHS can limit the types and frequency of services covered by state health care programs, and it determines the state's reimbursement amounts for authorized services.³⁸ DHS does not license managed care organizations, but it decides which plans to contract with and negotiates the terms of these contracts (including payment rates). State law also requires DHS to implement a "utilization review" program to safeguard against excessive payments, unnecessary or inappropriate service use, and underutilization of services in services provided for fixed rates.³⁹ In addition, DHS is required to have procedures to identify fraud, theft, and abuse.⁴⁰

DHS administers a process for enlisting the participation of health care providers in Minnesota's publicly funded health care programs.⁴¹ DHS also operates a help desk to answer provider and consumer questions about coverage, benefits, and billing.

³⁷ *Minnesota Statutes* 2007, 256B.041.

³⁸ *Minnesota Statutes* 2007, 256B.04, subd. 12.

³⁹ *Minnesota Statutes* 2007, 256B.04, subd. 15.

⁴⁰ *Minnesota Statutes* 2007, 256B.04, subd. 11.

⁴¹ *Minnesota Rules* 2007, 9505.0195.

Progress on DHS Cost Containment Strategies

SUMMARY

State agencies and the Legislature have made mixed progress in implementing strategies identified in a 2005 Department of Human Services (DHS) report on ways to contain publicly funded health care costs and improve services. The state has taken important first steps to implement evidence-based medicine, electronic medical records, and care management in fee-for-service health care, for example. But a number of key DHS suggestions have not been implemented, and the report's net impact on health care costs is unclear. DHS should provide a status report on its 2005 recommendations to the 2009 Legislature.

State law requires the Commissioner of Human Services to administer a “comprehensive health services system.”¹ In addition to promoting health care access and quality, the law requires the commissioner to implement a system that “manages care, . . . contains cost in all health and human services[,]” and supports effective services throughout the state.² This chapter addresses the following questions:

- **To what extent has the state made progress toward implementation of strategies suggested by the Department of Human Services in 2005 to control the cost of state health care programs?**
- **Have these strategies resulted in documented cost savings so far?**

2005 DHS COST SAVINGS REPORT

The 2003 Legislature directed DHS to “determine the appropriateness of eliminating reimbursement for certain payment codes under medical assistance, general assistance medical care, or MinnesotaCare” and suggest possible modifications of services covered under these programs.³ After consulting with legislative leadership, DHS expanded the scope of this study “to identify strategies that could produce long-term positive impacts on both the budget and program enrollees’ health status.”⁴ Over the course of 14 months, DHS received advice from a consultant (Bailit Health Purchasing), an “expert panel,” a

¹ *Minnesota Statutes* 2007, 256B.04, subd. 1a.

² *Ibid.*

³ *Laws of Minnesota* First Special Session 2003, chapter 14, art. 13C, sec. 2, subd. 7.

⁴ DHS, *Health Care Services Study: Findings and Strategies for Savings* (St. Paul, January 2005), 4.

A 2005 DHS report identified strategies for containing health care costs.

“stakeholder work group,” and others. In January 2005, DHS issued its final report, titled *Health Care Services Study: Findings and Strategies for Savings*. (We will refer to it throughout this chapter as the *Strategies for Savings* report.)

Table 2.1 summarizes the key strategies suggested by DHS. The report represented an ambitious effort by DHS to identify strategies for managing costs and improving services across a wide range of public health care activities. It recommended strategies addressing both the fee-for-service and managed care components of Minnesota’s health care programs, and it addressed basic health care services as well as “continuing care” services (such as services provided in nursing facilities). DHS concluded that the strategies shown in Table 2.1 “hold significant promise for savings,” although it did not have implementation plans or savings estimates for all of them.

PROGRESS ON THE STRATEGIES SUGGESTED BY DHS

Overview

Through interviews and document reviews, we examined what progress has occurred in the three years since DHS issued its *Strategies for Savings* report. We recognize that some of the strategies suggested by DHS would require longer than three years to fully implement. However, the 2005 report represented a strategic plan on the topic of health care cost savings, highlighting areas that DHS judged to be of the highest priority. Thus, we think it is reasonable to assess the status of state-level actions on these issues during the past three years. We found that:

- **There has been mixed progress on DHS’s 2005 suggestions for containing health care spending.**
- **Currently, there is limited information on what cost savings may have resulted from these strategies, even in some areas where important progress has occurred.**

Table 2.2 summarizes our assessment of the progress that has occurred in each of the areas targeted by DHS’s report. The following sections provide overviews of each area, including brief discussions of actions taken since the report was issued.

Table 2.1: Strategies Identified in DHS's 2005 *Strategies for Savings* Report
Use Evidence-Based Decision Making for Benefits Coverage Policy

- Hire a DHS medical director
- Create an advisory council to DHS on medical policy issues
- Participate in a multi-state evidence-based research collaborative

Increase Pharmacy Savings

- Require beneficiaries with hemophilia to obtain blood factor products through a "340B" hemophilia treatment center
- Contract with specialty pharmacies to be exclusive providers of certain specialty pharmacy drugs
- Reduce the reimbursement rates for retail pharmacies

Implement Intensive Medical Care Management for the Chronically Ill in Fee-For-Service Medical Assistance

- Contract with an experienced vendor for these services
- Customize the program to meet enrollees' needs

Pilot and Evaluate Disease Management (DM)

- Implement a DM pilot tailored to the fee-for-service Medicaid population
- Evaluate managed care organizations' DM practices

Expand Managed Care for People with Disabilities

- Begin transitioning enrollees with disabilities from fee-for-service into managed care

Improve Training and Oversight in the Personal Care Attendant (PCA) Program

- Increase training opportunities for public health nurses, PCAs, and enrollees using PCA services
- Develop performance-based contracts for PCAs and monitor performance
- Provide better information to physicians who prescribe PCA services
- Institute a registry of individual PCAs
- Require PCA agencies to hold a DHS license
- Strengthen DHS's capacity to investigate PCA fraud and abuse

Help Counties to Collaborate on Health and Human Services Issues

- Facilitate the development of regional service delivery and other forms of county collaboration
- Help counties develop core performance indicators and standards

Improve DHS's Managed Care Contract Management

- Annually identify DHS's purchasing priorities and negotiate several managed care performance goals aligned with these priorities
- Apply financial and non-financial incentives to these priorities
- Review health plan performance regularly and collaborate on opportunities for performance improvement

Improve DHS's Management of County Performance

- Annually identify DHS's purchasing priorities and negotiate performance goals with county organizations aligned with these priorities
- Apply financial and non-financial incentives to these priorities
- Review county performance regularly and collaborate on opportunities for performance improvement

Divert and Reduce the Length of Nursing Facility Stays

- Place long-term care consultants in hospitals and geriatric clinics to advise families and consumers on long-term care alternatives
- Fund assessment workers and independent care planning to help consumers admitted to nursing facilities plan for their discharge
- Improve relocation services case management

Improve County Case Management for the Home and Community-Based Waivers

- Define case management and establish its goals
- Eliminate duplication of the various types of case management services
- Establish and enforce statewide case management standards

Expand the Use and Connectivity of Electronic Medical Records (EMRs)

- Increase EMR accessibility for rural practices and clinics
- Promote connectivity and interoperability among Minnesota providers
- Involve providers of continuing care services in efforts to expand EMR use

SOURCE: Department of Human Services, *Health Care Services Study: Findings and Strategies for Savings* (St. Paul, January 2005).

Table 2.2: OLA Assessment of Progress on DHS's 2005 Cost Containment Strategies

| Areas DHS Targeted for Improvements | OLA Summary of Progress Since 2005 |
|--|------------------------------------|
| Implement evidence-based decision making | Significant progress |
| Increase pharmacy savings | Significant progress |
| Implement intensive medical care management | Moderate progress |
| Assess disease management programs | Limited progress |
| Expand managed care for people with disabilities | Moderate progress |
| Improve the personal care attendant program | Moderate progress |
| Help county programs collaborate | Limited progress |
| Improve DHS's managed care contract management | Limited progress |
| Improve DHS's management of county performance | Moderate progress |
| Divert and reduce the length of nursing home stays | Limited progress |
| Improve county case management for home and community-based waivers | Limited progress |
| Support efforts to expand the use and connectivity of electronic medical records | Significant progress |

DHS has had mixed progress implementing its cost savings strategies.

SOURCE: Office of the Legislative Auditor, based on interviews and document reviews.

Evidence-Based Decision Making

DHS's 2005 report said that "many health care services [in the state's public programs] are delivered when not needed and produce no benefit to the patient."⁵ A consultant to DHS reviewed national expenditures and research in 12 fee-for-service health care areas and extrapolated that \$37 million in Minnesota's 2003 Medical Assistance payments for these services might provide no benefits to the enrollees.⁶

Federal and state laws significantly affect the scope of services covered by Minnesota's health care programs. Federal regulations specify, for example, that states must pay for inpatient hospital services to qualify for federal Medicaid funding. Minnesota law also mandates coverage of inpatient care, but it adds restrictions—such as requiring a second medical opinion prior to reimbursement for certain elective surgeries, or prohibiting reimbursement for sex reassignment surgery.⁷ Nevertheless, DHS has considerable latitude to make coverage decisions. State law grants DHS general authority to limit the types and quantity

⁵ DHS, *Strategies for Savings*, 19.

⁶ The consultant used national research and data to estimate overuse of emergency room visits, coronary angiography, cardiac catheterization, upper gastrointestinal endoscopy, knee surgery for osteoarthritis, magnetic resonance imaging for back pain, and hysterectomies, among other services.

⁷ *Minnesota Statutes* 2007, 256B.0625, subd. 1 and 3a.

DHS has recently implemented a more formal process for making benefits coverage decisions based on medical evidence.

of services covered by publicly funded health care programs, within the parameters set by federal and state requirements.⁸

The 2005 *Strategies for Savings* report recommended that DHS implement a more rigorous approach to setting benefits coverage policy. Consistent with the report's recommendations, DHS hired a physician as its medical director in 2006, following several years in which this position was not filled. Also, consistent with the 2005 report, the Legislature created a Health Services Advisory Committee to help DHS set coverage policies for the Medical Assistance, MinnesotaCare, and General Assistance Medical Care programs. This committee has met regularly since mid-2006. The DHS medical director and Health Services Advisory Committee have reviewed existing research evidence on various medical procedures, such as bariatric surgery, medical imaging, and spinal fusion. For several health care procedures, DHS has adopted policies specifying circumstances requiring special authorization before the procedures can be paid for by public programs. Also, consistent with the 2005 report's recommendations, Minnesota joined a multi-state collaborative that provides member states with research summaries on various health care procedures.⁹

Overall, we think that the state's actions since 2005 have created a foundation for more cost-effective, evidence-based benefits coverage decisions. DHS officials acknowledge that there are many additional areas that should be subjected to evidence-based reviews, so the actions of the past two years represent the first part of an ongoing process. Also, DHS plans to implement a more efficient method for administering "prior authorizations" of health care procedures, one that is less dependent on providers submitting paper documentation for large numbers of cases.¹⁰ However, DHS now has a more formal process for making coverage decisions based on medical evidence, and the hiring of a medical director has enhanced the department's internal expertise.

The 2005 *Strategies for Savings* report estimated that, in fee-for-service care alone, implementation of evidence-based decision making would yield net state savings of \$832,000 in fiscal year 2006, \$1.9 million in 2007, and \$2.8 million in 2008. At this time, however, DHS officials have not estimated actual net savings that have resulted from this strategy. It is doubtful that there were savings in

⁸ *Minnesota Statutes* 2007, 256B.04, subd. 12. *Minnesota Rules* 2007, 9505.0210 establishes general criteria for services that can be covered. Specifically, services must be (1) medically necessary, (2) appropriate and effective for the medical needs of the recipient, (3) high quality and timely, and (4) the most cost-effective service available to meet the recipient's needs.

⁹ Minnesota is 1 of 11 states that participate in a Medicaid Evidence-Based Decisions project, sponsored by the Oregon Health and Science University.

¹⁰ *Minnesota Statutes* 2007, 256B.0625 requires DHS to publish a list of health services for which prior authorization is required, plus the criteria for determining these services.

fiscal year 2006, since the medical director was hired late in that fiscal year, and the Health Services Advisory Committee started its work in fiscal year 2007.¹¹

Pharmacy Services

Pharmacy costs are a large part of Minnesota's publicly funded health care programs. For example, managed care organizations reported that pharmacy spending accounted for 12 percent of their 2006 expenditures in Minnesota's public programs. These organizations reported that pharmacy spending grew 210 percent between 2000 and 2005, compared with 132 percent growth in their overall spending for the publicly funded health care programs.¹²

The 2005 *Strategies for Savings* report proposed three new strategies to limit pharmacy costs, which it estimated would save an average of about \$5 million in state funds annually. So far, progress to implement these new strategies has been limited. First, DHS recommended requiring enrollees with hemophilia to obtain "blood factor products"—drugs that help blood to clot—through federally recognized "340B" hemophilia treatment centers. There are three such centers in Minnesota, and they are able to obtain blood factor products at rates substantially below wholesale prices. The 2005 Legislature did not approve this proposal, preferring to allow hemophiliacs to purchase blood factor products from any willing provider. However, DHS subsequently reduced state reimbursement rates for many of these products, thus realizing some savings.

Second, DHS recommended that the state contract with specialty pharmacies to be exclusive providers for certain drugs. DHS said that specialty pharmacies had better prices for these drugs, due to competition among Minnesota's growing number of specialty pharmacies. Again, the 2005 Legislature rejected DHS's proposal, preferring to allow the purchase of these drugs from any willing provider. DHS subsequently reduced the reimbursement for these products, from 88 percent of average wholesale price to 83 or 84.5 percent of average wholesale price, depending on the product.

Third, DHS recommended a reduction in the state's reimbursement rate for retail pharmacies—from 88.5 percent of the average wholesale price to 86 percent of the average wholesale price (plus a \$3.65 dispensing fee). To justify this reduction, DHS cited a federal study that recommended that states reduce their reimbursement rates to more closely match the actual average pharmacy acquisition cost of 82.8 percent of average wholesale price. The Legislature subsequently authorized only a small reduction in reimbursement, to 88 percent of the average wholesale price.

The Legislature only partially implemented DHS's recommendations for pharmacy cost containment, but DHS has taken other actions on its own.

¹¹ Future estimates of any new cost savings should also consider new costs to implement this strategy. For example, Minnesota's annual cost of participating in the multi-state collaborative on evidence-based health care procedures is \$158,000, plus DHS has hired staff to help implement the evidence-based decision making strategy.

¹² Based on Office of the Legislative Auditor analysis of data from Health Plan Financial and Statistical Reports, as reported to the Minnesota Department of Health.

Although the recommendations for legislative action in the *Strategies for Savings* report were only partially implemented, DHS deserves credit for significantly expanding cost savings initiatives that were in place (or were in the planning stages) when the *Strategies for Savings* report was issued. For example, DHS has increased the number of drugs on its “maximum allowable cost” list, which sets the maximum price the state will reimburse pharmacies for medications that have generic equivalents. Between 2003 and 2007, the number of drugs on this list grew from about 300 to about 1,500. DHS claims that this list saved the state’s Medicaid program \$66 million in fiscal year 2007, with a majority of these savings due to program changes in the past two years.¹³ Also, DHS expanded its “preferred drug list” from 35 categories in 2004 to 72 categories by 2007. By steering Medicaid enrollees toward drugs on the “preferred” list, DHS has been able to get rebates on a higher percentage of Medicaid pharmacy expenditures. Overall, the state’s savings from DHS’s recent actions appear to be larger than the savings that would have been realized from the *Strategies for Savings* report’s legislative proposals.

Intensive Care Management for Chronically Ill Fee-for-Service Enrollees

People with chronic illnesses account for a disproportionately large share of medical expenditures.

In recent years, there has been increased focus on managing services for certain public program enrollees who account for a disproportionately high share of health care costs. These enrollees often have chronic, medically complex health conditions involving mental or physical disabilities. Traditionally, they have been ill-served under a fee-for-service system, receiving minimal help in managing their conditions and limited coordination of primary and specialty care services. As such, they are more likely to experience deteriorating health conditions that require costly emergency and acute care services. The 2005 *Strategy for Savings* report estimated that these highest risk individuals might account for only 1 to 3 percent of the population but 25 percent of acute care health costs.¹⁴

The *Strategy for Savings* report suggested that DHS (1) procure services from a health care vendor experienced with managing high-risk individuals, and (2) develop approaches customized to meet these enrollees’ unique needs.¹⁵ With the support of legislative funding, DHS has since initiated two care models to

¹³ For example, in 2006 DHS began placing products on the maximum allowable cost list when one generic equivalent was available; previously, DHS placed products on the list only when two generics were available. Also, DHS now requires prior authorization when a “dispense as written” prescription for a drug on this list requests a brand name drug rather than its generic version, and DHS officials said this requirement has significantly limited the use of brand name drugs.

¹⁴ DHS, *Strategies for Savings*, 28.

¹⁵ The report also recommended that DHS collaborate with managed care organizations to learn from their experience with similar programs and promote performance improvement across these organizations; we discuss this strategy in the next section on disease management.

help manage this high-risk population: (1) Intensive Care Coordination (ICC) services and (2) provider-directed care services.¹⁶

The department's ICC program aims to provide comprehensive care while avoiding unnecessary inpatient hospitalizations, emergency room visits, and redundant services. Specifically, ICC brings services to the individual by providing disability services care coordination combined with intensive support by clinical staff to help with health care, housing, social services, provider relationships, and other needs. In this regard, ICC services go well beyond traditional disease management—which typically focuses on a single disease—and encompass a broader range of interventions specific to individual circumstances. Participation in ICC services is voluntary and, initially, available to a limited number of enrollees.

An important component of improving health care for the chronically ill involves recruiting and paying primary care clinics to help coordinate high-risk patients' care. The *Strategy for Savings* report did not directly recommend this initiative, but DHS recognized the need for these clinic resources. Thus, in 2007, DHS requested and received state funding to implement a provider-directed care coordination program for all fee-for-service enrollees who have complex and chronic medical conditions (not just persons receiving ICC services), starting in January 2008.¹⁷

With funding from the Legislature, DHS has started implementing projects to help manage care for fee-for-service enrollees.

Overall, progress on the department's intensive care management strategies has been slower than DHS anticipated in its 2005 report, partly because DHS decided to pursue a more comprehensive care model than it originally proposed. After issuing a request-for-proposals for the Intensive Care Coordination program in 2006, DHS selected a vendor in May 2007. As of November 2007, DHS was in the midst of identifying individuals who would be best served by the program and had not yet implemented the ICC services. DHS anticipates that the provider-directed care coordination program will serve more enrollees than the ICC program and have a larger provider network. The department is in the early stages of developing and recruiting clinic services.

Funding constraints have limited the ICC program enrollment to 300 individuals with the most complex health care needs—less than the 500 suggested in the *Strategies for Savings* report.¹⁸ The *Strategies for Savings* report estimated that improved care coordination of the chronically ill could yield \$413,000 in savings over a four-year period, starting in 2006. The savings DHS projected for 2006 and 2007 did not occur, and it is too early to estimate savings for 2008.

¹⁶ In response to the report's recommendations, the 2005 Legislature required DHS to develop an "intensive care management program" for certain child enrollees in fee-for-service care (*Laws of Minnesota* 2005 First Special Session, chapter 4, art. 8, sec. 44).

¹⁷ *Minnesota Laws* 2007, chapter 147, art. 15 and 16.

¹⁸ Initially, most of the enrollees served by ICC will be from the Twin Cities area.

Disease Management

“Disease management” is closely related to the care management approach discussed in the previous section. Disease management programs target people with a particular set of chronic conditions—such as diabetics—and help them comply with treatment guidelines and good self-care practices. Disease management programs sometimes also aim to educate health care providers about cost-effective treatment approaches.

The 2005 *Strategy for Savings* report suggested that DHS follow a two-pronged disease management strategy: (1) implementing a pilot project of disease management with the fee-for-service population, including rigorous, independent evaluation, and (2) reviewing whether managed care organizations’ disease management programs are cost-effective and comply with “best practices.” The report did not estimate the cost savings that might result from these recommendations.

DHS’s efforts to implement the first part of this strategy—for fee-for-service care—were incorporated into the comprehensive care coordination efforts that we described in the previous section. DHS officials decided that a comprehensive approach would address fee-for-service enrollee needs better than an approach focused on specific diseases, so DHS decided not to implement a separate disease management project.

Thus, we focused our attention on DHS’s proposed strategy to evaluate disease management activities in managed care. We found that DHS has not initiated a systematic evaluation of managed care organizations’ disease management efforts, contrary to what it proposed in 2005. For example, DHS has not identified “lessons learned” from managed care organizations’ implementation or self-evaluations of their disease management programs.¹⁹

We think there is a need for close scrutiny of disease management programs. The disease management concept is appealing because a relatively small share of enrollees account for a large share of health care spending. But disease management programs can take many forms, and research has raised questions about their cost-effectiveness. In 2004, the U.S. Congressional Budget Office said that “while disease management programs improve adherence to practice care guidelines and lead to better control of the disease, their net effects on health costs are not clear.”²⁰ A 2005 review of previous research said that disease management programs for people with congestive heart failure “may save more money than they cost,” but it cited “mixed results” for programs aimed at asthma,

DHS has not yet examined “lessons learned” from health plans’ disease management programs.

¹⁹ The *Strategies for Savings* report also suggested that DHS compare health plan disease management programs with “best practice standards.” For several years—predating the *Strategies for Savings* report—DHS has monitored health plan compliance with a state contract provision that requires the plans to meet industry standards for disease management programs.

²⁰ U.S. Congressional Budget Office, *An Analysis of the Literature on Disease Management Programs* (Washington, D.C., October 13, 2004).

diabetes, and depression.²¹ Recently, the federal government started a pilot program to evaluate care coordination and management for chronically ill Medicare patients; an initial report found that fees paid to the participating programs far exceeded savings produced in the program's first six months.²² In addition, Mathematica Policy Research staff concluded that prior trials of disease management in the Medicare program have had very limited positive impacts, although it suggested further testing of a few approaches that seemed promising.²³ In our view, these findings reinforce the need for DHS to critically examine disease management activities in Minnesota's public programs.

Managed Care for People with Disabilities

The 2005 *Strategies for Savings* report said that people with disabilities were the "only large group that Minnesota exempts from managed care enrollment."²⁴ DHS said that its fee-for-service system was perceived by enrollees as "bureaucratic" and "fragmented," and this system had not provided enough preventive care and care coordination. DHS recommended that, starting in January 2007, the state should begin transitioning enrollees with disabilities into managed care—initially offering "basic" health care only, with continuing care services (such as home care and personal care attendants) still provided through fee-for-service. The report offered no recommendation about whether enrollment in managed care should be mandatory or voluntary, although DHS's consultant estimated that a voluntary approach "may not yield significant savings."²⁵ DHS estimated that a managed care approach would cost more than fee-for-service in its initial year, with any savings in subsequent years dependent on the ability of health plans to manage medical expenses.

The 2005 Legislature required DHS to establish a planning process for implementing a new managed care program by January 2007.²⁶ The 2006 Legislature then authorized DHS to implement a voluntary "special needs basic care" program for people with disabilities, with full implementation pushed back to January 2008.²⁷ This program does not cover long-term care services. A broader program—integrating primary, acute, and long-term care services funded by Medicare and Medicaid in a single program—is offered to disabled enrollees

Minnesota has expanded managed care for people with disabilities, but the implementation of these services should be closely monitored.

²¹ Ron Z. Goetzel, Ronald J. Ozminkowski, Victor G. Villagra, and Jennifer Duffy, "Return on Investment in Disease Management: A Review," *Health Care Financing Review* 26, no. 4 (Summer 2005): 1-19.

²² Nancy McCall, Jerry Cromwell, and Shulamit Bernard, *Evaluation of Phase I of Medicare Health Support Pilot Program Under Traditional Fee-for-Service Medicare: Report to Congress* (Washington, D.C., RTI International, June 2007).

²³ Randall Brown, Arnold Chen, Deborah Peikes, Jennifer Schore, and Dominick Esposito, "Does Disease Management/Care Coordination Work for Medicare?" <http://www.academyhealth.org/2007/monday/asia1/brownr.pdf>, accessed November 5, 2007.

²⁴ DHS, *Strategies for Savings*, 31.

²⁵ *Ibid.*, 33.

²⁶ *Laws of Minnesota* First Special Session 2005, chapter 4, art. 8, sec. 85.

²⁷ *Laws of Minnesota* 2006, chapter 282, art. 20, sec. 30.

in the Twin Cities metropolitan area, but state law prohibits expansion of this program beyond its current boundaries before July 1, 2009.²⁸

In our view, there has been moderate progress toward the implementation of DHS's recommendations in this area. As proposed in the 2005 *Strategies for Savings* report, the state is implementing the first step of a phased effort to transition people with disabilities into managed care. The program began enrolling eligible people one year later than the 2005 report proposed. Disability advocates told us they support this program, but they have unresolved questions about the ability of managed care organizations to adequately serve enrollees. Also, they are waiting to see whether managed care organizations and DHS can provide data that demonstrate cost savings and improved care coordination. Their concerns echoed questions that have been raised by some county staff regarding the ability of health plans to meet the needs of populations that are new to managed care. Overall, the Legislature and DHS have taken important initial steps, but the cost-effectiveness of these efforts and the skillfulness of health plan implementation merit continued attention.

Personal Care Attendant (PCA) Program

Personal care attendants (PCAs) are individuals paid by publicly funded health care programs to help disabled enrollees live independently in the community. Over 40,000 PCAs provide services to enrollees in Minnesota's public managed care and fee-for-service programs. There is general recognition of the need for high-quality services to help keep people out of institutional settings, but there have also been many concerns about training and oversight in Minnesota's PCA program.²⁹ DHS's 2005 *Strategies for Savings* report said that "virtually anyone can be a PCA" because the state lacked training and certification requirements, and it cited evidence of fraud and abuse in the program.³⁰

We found that there has been moderate progress on the PCA recommendations that DHS made in its 2005 report. Consistent with the report's recommendations, DHS implemented a statewide registry of individual PCAs to help identify fraud or inappropriate billing practices, and it added staff to investigate fraud and abuse. Also, DHS now periodically audits organizations that employ PCAs, reviewing selected compliance issues.

The *Strategies for Savings* report also recommended improvements in training for public health nurses (who assess whether individuals need PCA services), PCA enrollees, and PCAs themselves. DHS has implemented a new three-day assessment training course targeted to public health nurses who are new to the

Many people with disabilities need some assistance to live in the community.

²⁸ *Minnesota Statutes* 2007, 256B.69, subd. 23(f). This is the Minnesota Disability Health Options (MnDHO) program.

²⁹ For example, the *Strategies for Savings* report noted concerns that had been expressed about Minnesota's PCA services by the U.S. Department of Health and Human Services Inspector General, Minnesota Office of the Legislative Auditor, Minnesota Attorney General, county public health nurses, and health plans.

³⁰ DHS, *Strategies for Savings*, 39-42.

DHS has taken several steps to improve the personal care attendant program, but more oversight and accountability are needed.

PCA program, and DHS also offers one-day training for experienced public health nurses. It is unclear whether these training opportunities—which are not explicitly mandated by the state—will adequately address concerns that have been expressed about inconsistencies among assessors, but they are a useful starting point.³¹ The *Strategies for Savings* report also suggested that DHS hire nurses to provide training for individuals using PCA services; DHS has not done so. DHS has, however, distributed a PCA enrollee “guidebook” in five languages that was developed by public health nurses.³² In addition, the *Strategies for Savings* report said that PCAs may lack proper training to determine which services should be provided to an individual, and DHS is now in the early stages of implementing improved training for them. DHS began piloting a voluntary PCA training curriculum in January 2008, and DHS officials told us they intend to seek authority in 2009 to make this training mandatory.

Finally, the *Strategies for Savings* report suggested that organizations that employ PCAs be required to obtain state home care licenses and undergo a certification process based on performance standards. However, the Department of Health has not yet pursued licensure requirements for organizations that employ PCAs.³³ Also, DHS has not implemented performance standards for these organizations, although DHS officials said they intend to propose legislation regarding standards in 2009.

Overall, DHS has taken positive first steps, but they are not sufficient. There continue to be questions about financial accountability within PCA services, and DHS officials expressed a desire to seek changes in PCA-related policy and authority from the 2009 Legislature.³⁴

County Collaboration

DHS delegates many health care-related duties to counties, including eligibility determination, case management, and delivery of certain continuing care services, among others. The 2005 *Strategies for Savings* report said DHS lacks sufficient staff to monitor 87 counties and the leverage to influence changes in county performance. Consequently, “the state is currently able to exercise only limited oversight and control over services and administrative functions that significantly impact consumer outcomes and agency expenditures.”³⁵ The report suggested that DHS foster the development of regional administrative agencies to

³¹ DHS staff told us they intend to seek legislative authorization in 2009 to mandate use of the public health nurse training. However, DHS said that counties throughout the state already view the DHS training course for new public health nurses as a prerequisite to doing PCA assessments.

³² DHS has distributed over 15,000 copies of the guidebook since 2003. DHS officials also said they are now testing training to help enrollees make their own decisions about hiring PCAs, and these tests will provide the basis for expanded enrollee training in the future.

³³ DHS officials said that PCA licensure could improve PCA management and compliance, but they said that other DHS initiatives are also necessary to improve program integrity.

³⁴ The *Strategies for Savings* report did not estimate the amount of savings that might result from implementing its PCA recommendations, and DHS has not made subsequent estimates.

³⁵ DHS, *Strategies for Savings*, 45.

There has been little progress toward consolidation of small counties' human services agencies.

deliver local services, as well as other forms of county collaboration.³⁶ The report did not estimate cost savings that might result from implementing these recommendations.

We have seen little evidence of progress in this area, by either DHS or the Legislature. A 2007 report by our office recommended that the Legislature enact provisions to more strongly encourage consolidation of small counties' human services agencies.³⁷ There was no legislation in 2007 that did this explicitly. Also, DHS has many ongoing state-county working groups that foster collaboration among counties, but DHS has not made significant efforts to encourage development of the regional administrative units envisioned in its own 2005 report. Today, only 5 of Minnesota's 87 counties participate in multi-county human services agencies.

DHS Management of Health Plan Contracts

A health care consultant hired by DHS concluded in 2005 that "DHS does not engage in sufficiently active strategic management of its [managed care] contractors."³⁸ The consultant also said that DHS's relationship with the health plans has been too confrontational. In response, the 2005 *Strategies for Savings* report recommended that DHS negotiate performance improvement goals with health plans in a limited number of strategically important areas. The report said that DHS should meet regularly with health plans to discuss their performance, and that it should develop incentives aligned with DHS priorities.

Our interviews did not indicate that the relationship between DHS and the health plans is fundamentally dysfunctional. There are some ongoing tensions and frustrations between DHS and the health plans, but this is not uncommon in a contractual relationship. In fact, officials from several health plans complimented DHS staff for their fairness and professionalism.

However, we concluded that DHS has made limited progress toward a more strategically focused performance improvement process, such as that recommended in the *Strategies for Savings* report. In Chapter 5, we note that the state's performance-related financial incentives in its contracts with health plans have been useful but could be improved. We also discuss the uneven impact of "performance improvement projects" that have been mandated in health plans' state contracts. Health plan officials said that, in prior years, they found it difficult to implement and gain physician acceptance of performance improvement projects that covered a wide variety of clinical areas. They wanted to focus health plan performance improvement efforts on a limited number of important areas of health care. However, discussions between DHS and the health plans during 2007 resulted in limited progress toward a more focused,

³⁶ *Ibid.*, 47-49.

³⁷ Office of the Legislative Auditor, *Human Services Administration* (St. Paul, 2007), 64-76.

³⁸ DHS, *Strategies for Savings*, 50.

collaborative, and coordinated quality improvement program in the plans' 2008 contracts.

DHS Management of County Performance

The 2005 *Strategy for Savings* report said that DHS should work with counties using a “strategically focused contract management approach,” particularly regarding long-term care services for seniors and people with disabilities.³⁹ The report said that DHS should negotiate performance improvement goals with counties, based on DHS’s “purchasing priorities.” It also said that DHS should regularly review county performance levels and establish incentives for counties to achieve DHS goals. DHS made no estimate of cost savings that might occur as a result of these recommendations.

The *Strategies for Savings* report said successful implementation of this approach would require some consolidation of county human services activities, “otherwise there are simply too many counties and too few [DHS] staff.”⁴⁰ As noted earlier, this consolidation has not occurred.

However, DHS initiated reviews of individual counties’ home and community-based services in 2006, and it expects to complete reviews of the remaining counties (as well as health plans and American Indian tribes) by 2011. DHS told us that it decided to pursue this approach—rather than adopting the specific recommendations of the *Strategies for Savings* report—in response to federal pressures on states to improve their compliance and quality assurance monitoring. Each county review results in a report that identifies strengths, areas needing improvement, and required corrective actions.

In our view, these reports provide improved oversight of county delivery of home and community-based services, although the reports seem to focus more on procedural compliance than service outcomes or costs.⁴¹ DHS officials told us that they intend to refine their performance measures in this area, based on their experience with these reviews. Overall, we give DHS credit for moderate progress to implement its proposals in the *Strategies for Savings* report. Although DHS has not set county-specific performance improvement goals based on its “purchasing priorities,” it has enhanced accountability for this service area.

DHS has improved the oversight of county home and community-based services, but the impact on costs and service outcomes is unclear.

³⁹ DHS, *Strategies for Savings*, 51-52.

⁴⁰ DHS, *Strategies for Savings*, 51.

⁴¹ For example, the reports often required counties to ensure that documents were signed, client files contained all necessary items, and services were provided in a timely manner.

The length of nursing facility stays has declined in recent years, but this was not due to the suggestions in DHS's 2005 report.

Nursing Facility Stays

Minnesota has an above-average rate of nursing home residents per 1,000 state residents over age 85, compared with the nation as a whole.⁴² The 2005 *Strategies for Savings* report said that Minnesota should implement strategies to divert and reduce the length of avoidable stays in nursing facilities, although it offered no estimates of potential cost savings.⁴³

Specifically, the 2005 DHS report said that Minnesota should, on a pilot basis: (1) place county-based long-term care consultants in hospitals and geriatric clinics for the purpose of better informing consumers and families about long-term care alternatives, and (2) provide people who are newly admitted to nursing homes with immediate assistance in planning for post-discharge services, potentially hastening the discharge process. The report also said that Minnesota should ensure that new nursing facility residents receive information about how to obtain “relocation case management” services.

The pilot projects have not been implemented, and DHS officials told us they probably will not pursue them. For example, DHS officials said that the option of placing staff in facilities to help inform clients and their families would be very expensive. DHS staff said they rely instead on several other mechanisms to provide consumers and their families with information on long-term care options.⁴⁴ Also, DHS staff said that there is less urgency today to reduce the length of nursing home stays because the average length-of-stay has declined in recent years. This trend toward reduced use of nursing facilities appears to be a long-term trend, not a result of the strategies proposed in 2005.⁴⁵

County Case Management

The 2005 *Strategies for Savings* report cited a variety of concerns about county case management for people eligible to receive home and community-based services provided through federal Medicaid waivers. It described problems such as the lack of statewide service standards, duplication of services, large caseloads, fragmented administration, and lack of coordination between health

⁴² National Center for Health Statistics, *Health, United States, 2007* (Hyattsville, MD, 2007), 371. In 2003, Minnesota had 322 nursing home residents per 1,000 residents age 85 and older, compared with a national rate of 271.

⁴³ The 2005 report said Minnesota faced a particular challenge from Minnesotans whose nursing facility stays are publicly funded but who initially entered the facilities as “private pay” residents. It said this group represented a majority of Medical Assistance-funded nursing facility residents.

⁴⁴ Information sources cited by DHS include an online service directory (minnesotahelp.com), county long-term care consultants, and the Minnesota Board on Aging’s “Senior LinkAge Line.” DHS staff told us there is variation in how county long-term care consultants approach this task, and DHS has considered the possibility of reassigning some duties now performed by these staff to the Senior LinkAge Line.

⁴⁵ According to data we obtained from DHS, Minnesota’s number of nursing facility “resident-days” funded by Medicaid declined by 3 percent between federal fiscal years 2005 and 2006. In the prior three years, annual reductions ranged from 3.3 to 4.7 percent.

Past reports have offered ideas for improving local case management services, but there has been limited progress to implement them.

care and continuing care services, among others.⁴⁶ The report said that improvements in case management could save money by helping to direct clients to more cost-effective and preventive services, although it did not present an estimate of possible savings. Legislatively-mandated reports issued in 2003, 2005, and 2007 have each addressed the need for case management redesign, referencing some of the same issues mentioned in DHS's 2005 *Strategies for Savings* report.⁴⁷

DHS has taken some initial steps to address past concerns about county administration of waived service programs. For example, DHS has been developing and testing a standardized tool for counties to use when assessing the service needs of people with disabilities. Also, in the past two years, DHS staff have started conducting on-site reviews to evaluate county waived services programs and how they are administered. DHS officials also told us they are in the early stages of developing a training program for local case managers. But disability advocates told us that most of the case management issues raised in the previous reports continue to be problems today. In addition, advocates said that counties have been increasingly subcontracting for case management services, and they expressed concern that (1) counties lack expertise in contract management and (2) DHS has not exercised much oversight of the county subcontracting process. Overall, recent reports have provided significant guidance for ways to improve case management, but DHS has made limited progress in implementing these recommendations.

Electronic Medical Records

The 2005 *Strategies for Savings* report said that expanded use of electronic medical records holds significant promise for increasing the efficiency of medical practice. However, the report said that the high cost of electronic systems could impede their adoption, especially in small, rural, or inner-city practices. Also, existing electronic systems do not all have the ability to share information with each other. The report recommended ongoing state efforts to address these problems.⁴⁸

Since that report was issued, the Legislature set forth a timeline in statute for implementation of electronic medical records:

By January 1, 2015, all hospitals and health care providers must have in place an interoperable electronic health records system within their hospital system or clinical practice setting. The commissioner of health, in consultation with the Health Information Technology and Infrastructure Advisory Committee, shall develop a statewide plan to meet this goal, including uniform standards to be used for the

⁴⁶ DHS, *Strategies for Savings*, 55-58.

⁴⁷ The most recent of these reports is Institute on Community Integration, *Redesigning Case Management Services for People with Disabilities in Minnesota* (Minneapolis: University of Minnesota, March 8, 2007).

⁴⁸ DHS, *Strategies for Savings*, 59-60.

It will take time to fully implement electronic medical records, but the state has established a framework for doing so.

interoperable system for sharing and synchronizing patient data across systems. The standards must be compatible with federal efforts. The uniform standards must be developed by January 1, 2009, with a status report on the development of these standards submitted to the legislature by January 15, 2008.⁴⁹

The extended timeframe adopted by the Legislature indicates the challenges of developing a statewide network of exchangeable health care information. However, the Department of Health has established several work groups that have been meeting regularly to address specific issues, such as data security and technology standards. Also, the Legislature has appropriated funding for grants and loans to foster more widespread use of electronic records by private and public organizations.

In our view, there appears to be considerable momentum behind the electronic medical record initiative. The Legislature has provided a framework for the effort, and people from a variety of state, local, and private organizations are participating in its implementation. While there is no assurance that the legislative timelines will be met, we think there has been important progress in the early stages of this project.

Recommendation

Health care cost containment is a topic of ongoing discussion in the executive and legislative branches of Minnesota government. The *Strategies for Savings* report presented DHS's highest priority strategies in 2005 for containing costs in Minnesota's publicly funded health care programs. We recognize that it will take time to implement some of these strategies and analyze their net costs. Also, DHS's priorities and strategies may change over time. For this reason, it will be important for DHS to give the Legislature periodic updates on these and other cost containment strategies.

RECOMMENDATION

The Legislature should require the Department of Human Services to present the 2009 Legislature with a status report on its 2005 report that identified strategies for cost containment. When appropriate, the status report should identify new or alternative strategies for containing the costs of Minnesota's publicly funded health care programs.

⁴⁹ [Minnesota Statutes](#) 2007, 62J.495, subd. 1.

State Payment Rates for Health Care Programs

SUMMARY

The Department of Human Services (DHS) annually sets rates that determine the amounts it will pay to managed care organizations to serve enrollees in public programs. In recent years, payment rates have usually exceeded the managed care organizations' medical and administrative costs, contributing to program stability and growth in the organizations' reserves. But the use of a managed care approach does not guarantee cost containment, and Minnesota's managed care spending per enrollee rose faster than the national increase between 2000 and 2005. The Legislature and DHS should continue to pursue strategies to contain costs. In fee-for-service care, there have been few changes in the state's physician reimbursement rates over the past 15 years. This has helped contain costs, but questions about the adequacy and equity of fee-for-service payment rates deserve the attention of policy makers.

Minnesota's aggregate spending levels for publicly funded health care programs are determined partly by the rates the state sets to pay for health care services. In the case of managed care, the Department of Human Services (DHS) annually sets rates for monthly "capitation" payments—that is, a prepaid amount per enrollee to compensate health plans for the services they are required to provide. In the case of fee-for-service care, DHS reimburses health care providers for services they have already delivered, based on a state-determined schedule of rates for various medical procedures. This chapter addresses the following questions:

- **How do Minnesota's rates for paying health plans and fee-for-service providers compare with rates in other states?**
- **Has DHS set managed care capitation rates that contain costs while allowing for reasonable returns to the health plans?**
- **Have Minnesota's fee-for-service payment rates contained costs while providing reasonable reimbursement levels for health care providers?**

Federal law requires that states establish methods of paying for Medicaid services that (1) "are consistent with efficiency, economy, and quality of care" and (2) "are sufficient to enlist enough providers so that care and services are available [under the state's Medicaid program] at least to the extent that such care and services are available to the general population in the geographic area."¹

¹ 42 U.S. Code, 1396a.

However, federal law does not require states to demonstrate their compliance with these provisions, and state officials told us that there is no specific federal monitoring of state compliance with these requirements.

This chapter focuses on broad issues related to Minnesota's rate-setting practices; it does not provide a complete description or critique of the methods DHS uses to set rates for managed care or fee-for-service care. Also, this chapter does not specifically discuss the portion of capitation payments intended to cover administrative costs, which we address separately in Chapter 4.

MANAGED CARE CAPITATION RATES

Background

Capitation payments are specified amounts that a state pays to the managed care organizations with which it contracts. DHS makes capitation payments to cover the cost of enrollees' medical care and health plans' administrative costs. The health plan is responsible for any costs it incurs above the level of the capitation payment, and the plan can keep any portion of the payment that remains after paying for expenses. Capitation payments are intended to limit the state's financial liability while giving health plans an incentive to hold down spending.

Until 2003, states were supposed to set managed care rates at levels that yielded cost savings over a fee-for-service approach.

Until 2003, the federal government required states to set capitation rates for Medicaid programs so that the cost of serving managed care enrollees would not exceed the cost of serving this same population through the traditional fee-for-service approach. Thus, the rate-setting process was supposed to ensure that a managed care approach yielded cost savings over a fee-for-service approach.²

Eventually, it became difficult for states to accurately compare the costs of fee-for-service and managed care approaches. In some states, the size of the fee-for-service population decreased considerably, or its characteristics differed markedly from those of the managed care population. Consequently, the federal government replaced the requirement for a comparison of managed care and fee-for-service costs with a requirement that capitated rates be "actuarially sound."³

It is not entirely clear what constitutes an "actuarially sound" rate. There are no "actuarial standards of practice" that govern certification of rates for Medicaid programs. A work group of the American Academy of Actuaries has issued guidance suggesting that Medicaid managed care rates are actuarially sound if

² For example, Minnesota law required that calendar year 1988 capitated rates paid to health plans not exceed 90 percent of the average monthly per capita fee-for-service payments under Medical Assistance projected for fiscal year 1988 (*Minnesota Statutes* 2007, 256B.031, subd. 4).

³ 42 *CFR* sec. 438.6(c) (2007).

The federal government now requires states to set managed care rates that are “actuarially sound.”

they “provide for all reasonable, appropriate, and attainable costs” of a program.⁴ However, this guidance does not carry the binding authority that actuarial standards of practice would carry. Furthermore, actuaries typically have considerable latitude to determine the methods they use, leading a major health care consulting firm to conclude that “the concept of actuarial soundness can be stretched to fit almost any rate range.”⁵

Each year, the federal government certifies that Minnesota’s Medical Assistance and MinnesotaCare programs comply with the requirement for actuarially sound rates.⁶ There is no requirement for health plans to be paid actuarially sound rates under the state-funded General Assistance Medical Care program.

DHS’s annual managed care rate-setting process is complicated and time-consuming, both for DHS and the health plans. Minnesota’s managed care rates for calendar year 2008 are based on costs and utilization for calendar year 2006, adjusted by DHS’s actuary for various DHS-designated factors. For example, rates are adjusted to reflect cost trends from three prior years, with greater weight given to the most recent year’s trend. In addition, 50 percent of each payment rate is adjusted to reflect enrollees’ health care risk levels, based on past diagnoses; the other 50 percent is based on enrollees’ demographic characteristics, such as age, gender, and region of residence. The rates also reflect DHS’s assumptions regarding health plans’ levels of administrative expenditures and surplus revenues. Health plans expressed various concerns to us about DHS’s rate-setting practices and procedures, but several complimented DHS’s administration of this process as fair, open, and professional.⁷

Cost Containment

In Chapter 1, we noted that Minnesota’s overall Medicaid costs per enrollee are significantly larger than the costs per enrollee nationally. In addition,

- **Previous studies have indicated that Minnesota’s Medicaid capitation payments are relatively high, compared with other states.**

⁴ Medicaid Rate Certification Work Group of the American Academy of Actuaries, *Health Practice Council Practice Note: Actuarial Certification of Rates for Medicaid Managed Care Programs*, (Washington, D.C.: American Academy of Actuaries, August 2005), 8. The work group said that rates would usually include “appropriate risk/profit margins” but offered no further guidance on this issue (p. 12).

⁵ Grady Catterall, Lisa Chimento, Rachel Sethi, and Brandon Maughan, *Rate Setting and Actuarial Soundness in Medicaid Managed Care* (Falls Church, VA: The Lewin Group, January 23, 2006), 17.

⁶ MinnesotaCare is funded partly with federal Medicaid funds, so it is required to comply with the federal requirements for actuarial soundness. Also, *Minnesota Statutes* 2007, 256L.11, subd. 1, requires that providers under the MinnesotaCare program be paid “at the same rates and conditions established for medical assistance.”

⁷ Health plans expressed various concerns about the rate-setting process, although they were not unanimous in their views. For example, some officials expressed concerns that: (1) DHS’s software for making risk adjustments is not up-to-date, (2) a larger portion of the rates should be risk-adjusted, or (3) a biennial rate-setting process would be preferable to an annual one.

Minnesota's managed care capitation rates for public programs are relatively high, compared with other states.

Perhaps the most comprehensive comparisons have been two Urban Institute studies that examined rates for non-elderly and non-disabled enrollees. The most recent of these studies reported that Minnesota's Medicaid managed care rates in 2001 were 34 percent higher than the national median.⁸ The study also characterized Minnesota's Medicaid rates as "relatively high" because Minnesota was one of few states with Medicaid rates above the national Medicaid median while its Medicare rates were below the national Medicare median.⁹ In addition to the Urban Institute studies, an analysis conducted by a consulting firm for the U.S. Department of Health and Human Services concluded that Minnesota had relatively high capitation rates for managed care services to children from low-income families. The analysis reported that Minnesota's average 2003 Medicaid capitation rate for children ages 1, 6, and 14 was 58 percent higher than the national average for children of comparable ages.¹⁰

These studies discuss possible reasons for variation in states' rates but do not explain why any particular state is relatively high or low. In part, Minnesota's relatively high capitation rates probably reflect the state's more generous Medicaid benefit package compared with other states (discussed in Chapter 1). But Minnesota's rates could also reflect other factors, such as the state's historical spending levels for fee-for-service Medicaid (which used to serve as a basis for determining Medicaid capitation payments), or DHS's success in constraining costs in its annual rate-setting processes.

Spending for medical care accounts for a large majority of the payments Minnesota makes to managed care organizations. The level of managed care spending for medical care is affected by legislative appropriations, the capitation rates set by DHS, the health of the enrollees, and the cost containment activities of the health plans. To assess recent changes in medical spending under managed care, we examined financial data reported annually by health plans. We found that:

- **Medical expenditures per enrollee in Minnesota's managed care programs increased significantly in recent years.**

Table 3.1 shows trends in health plans' reported medical expenditures (including hospital costs) between 2000 and 2006. Health plans report expenses separately for the Medical Assistance (MA), MinnesotaCare, General Assistance Medical Care (GAMC), and Minnesota Seniors Health Options (MSHO) programs. The table shows the 2000-06 trend in aggregate spending per member-month, based

⁸ John Holahan and Shinobu Suzuki, "Medicaid Managed Care Payment Methods and Capitation Rates in 2001," *Health Affairs* 22, no. 1 (January/February 2003): 204-218. The authors identified Minnesota's rates as among the highest of the 36 states included in the analysis. The previous Urban Institute analysis of capitation rates—for 1998—showed that Minnesota's rates were 12 percent above the national median.

⁹ *Ibid.*, 214.

¹⁰ Harriette B. Fox, Stephanie J. Limb, Margaret A. McManus, and Ruti G. Levtov, *An Analysis of States' Capitation Methods and Pediatric Rates, 1997-2003* (Washington, D.C.: U.S. Department of Health and Human Services, February 2005). The comparison of Minnesota with other states focused on children eligible for the Temporary Assistance for Needy Families program.

Table 3.1: Health Plan Expenditures for Medical and Hospital Costs, 2000-06

| | Contract Year 2000 | Contract Year 2006 | Average Annual Growth Rate |
|---|-----------------------|-----------------------|----------------------------------|
| Medical and Hospital Expenses (in billions) | | | |
| All Programs | \$0.816 | \$2.303 | 18.9% |
| PMAP, GAMC, MinnesotaCare | 0.765 | 1.568 | 12.7 |
| MSHO | 0.051 | 0.735 | 56.0 |
| Total Member-Months (in thousands) | | | |
| All programs | \$3,844 | \$5,368 | 5.7% |
| PMAP, GAMC, MinnesotaCare | 3,802 | 4,950 | 4.5 |
| MSHO | 43 | 418 | 46.2 |
| Health Care Expenses per Member-Month | | | |
| All Programs | \$212 | \$429 | 12.4% |
| PMAP, GAMC, MinnesotaCare | 201 | 317 | 7.8 |
| MSHO | 1,191 | 1,759 | 6.7 |

NOTE: Health plans' medical and hospital expenses represent net expenses after deductions for reinsurance recoveries. "All Programs" includes data for the Prepaid Medical Assistance Program (PMAP), General Assistance Medical Care (GAMC), MinnesotaCare, and Minnesota Senior Health Options (MSHO) program. The spending data reported by health plans reflects all revenue sources for each program, including federal Medicare payments in the case of MSHO. In addition, the increase in medical expenses partly reflects an influx of Medicare funds due to the statewide expansion of MSHO in 2006.

SOURCE: Office of the Legislative Auditor, analysis of health plans' statements of revenue, expenses, and net income, 2000 and 2006.

on (1) all four of these programs (with an average annual increase of about 12 percent) and (2) the three programs other than MSHO (with an average annual increase of about 8 percent). DHS staff told us that some spending increases might be attributable to increases that have occurred in the average health risks among public program enrollees over recent years.¹¹ Also, the expansion of MSHO statewide in late 2005 appears to have contributed to increased medical costs per member-month as some enrollees moved from the Minnesota Senior Care program to more comprehensive services under the MSHO program.¹²

We also examined Minnesota spending trends using data we extracted from one of the federal government's main Medicaid databases, which contains data on all

¹¹ DHS uses estimates of enrollees' health care "risk factors" to help set capitation rates.

¹² In addition, the spending data reported by health plans reflect all revenue sources for each program, including federal Medicare payments in the case of MSHO. Thus, the increase in spending partly reflects an influx of Medicare funds into MSHO in 2006.

Minnesota's managed care spending per enrollee grew faster than the national rate in recent years.

states through 2005.¹³ We found that Minnesota's capitated Medicaid spending per eligible person grew at a rate faster than the nation as a whole between 2000 and 2005. Specifically, we examined spending for all non-disabled managed care enrollees under age 65. Minnesota's spending grew at an annual rate of 5.9 percent during this period; the national growth rate was 4.5 percent.¹⁴

The federal requirement for states to develop "actuarially sound" payment rates does not guarantee cost containment. In fact,

- **Complying with the federal requirement for states to have "actuarially sound" managed care rates might foster continued increases in these rates.**

Typically, actuaries rely considerably on historical cost increases to adjust capitated rates for future years. However, as one state Medicaid agency commented in a waiver application to the federal government:

[States' limited regulatory flexibility] is compounded by the inherent inflationary nature of actuarial soundness. The concept is built on formulaic methodologies that assume that historic health care cost increases will be repeated in the future[,] making inflation a self-fulfilling prophecy. States are left with no ability to break this cycle and are simply captive to future cost increases.¹⁵

A recent article said that five states have terminated their Medicaid "full-risk" managed care programs since the federal requirement for actuarial soundness was implemented. The author commented that "actuarial soundness provides incentives for managed care organizations to *increase their costs* to maximize their future revenues—a rather perverse incentive for a capitated industry, particularly when the original appeal of HMOs was that they would control Medicaid costs."¹⁶

Health Plans' Net Income

Generally, states aim for a balance in the managed care rate-setting process: setting rates high enough to ensure the financial viability of health plans (and a stable service system for enrollees), but low enough so that plans do not make

¹³ See an overview of the Medicaid Statistical Information System at: <http://www.cms.hhs.gov/MSIS/>.

¹⁴ Increases in spending may partly have reflected expansions of managed care to plans or enrollees with above-average costs—for example, through the implementation of county-based purchasing in some outstate counties or the development of managed care for certain people with disabilities.

¹⁵ Michigan Department of Community Health, Medical Services Administration, *Modernizing Michigan Medicaid, 1115 Demonstration Application*, June 1, 2005. Michigan officials told us that the federal government has not yet acted on their waiver application, which included a request for suspension of the requirement for actuarially sound rates.

¹⁶ Bruce Spitz, "Medicaid Agencies as Managed Care Organizations: An "Actuarially Sound" Solution?" *Journal of Health Politics, Policy and Law* 32, no. 3 (June 2007): 379-413. Some states have gone to "partial risk" (also called "primary care case management") programs, in which the states make care coordination payments to physicians.

Minnesota's health plans are nonprofit agencies, but they are allowed to keep their surplus revenues from state programs.

unreasonably large returns. In Minnesota, all of the health plans that administer state health care programs are nonprofit organizations, but they are still allowed to retain surplus revenues that remain after covering their expenditures.

Some states have seen significant turnover in the health plans choosing to administer public programs. One study said that “[c]ommercial managed care organizations have not found Medicaid to be a profitable venture,” noting that the number of states with health plans bearing full financial risk (as Minnesota has) dropped from 45 in 1997 to 35 in 2004.¹⁷ In Colorado, health plans sued the state over concerns about the adequacy of capitated Medicaid rates, and most plans discontinued their participation in Medicaid by 2007. We found that:

- **Compared with some other states, Minnesota has had stability in the participation of health plans in its publicly funded programs.**

No health plan has discontinued its participation in Minnesota’s publicly funded health care programs during the past several years. In fact, the passage of legislation in 1997 authorizing the establishment of county-based purchasing organizations has increased the number of health plans with which DHS contracts. It is noteworthy that Minnesota law, unlike the laws in other states, requires Minnesota’s nonprofit, tax-exempt health maintenance organizations to “participate” in the state’s publicly funded health care programs as a condition of their state licensure.¹⁸ Specifically, the law identifies circumstances in which these organizations must submit good faith proposals to administer the state’s health care programs.¹⁹ Health plan officials told us that the plans view participation in the public programs as a part of their mission, although they want to receive fair returns for their participation.

To assess the financial status of the health plans administering Minnesota’s public programs, we examined annual financial statements for these plans. We found that:

- **Health plans, in aggregate, have typically made money from their participation in publicly funded health care programs.**

Table 3.2 shows the health plans’ annual “net returns” for each of the major public programs. (“Net return” in this table is defined as net income (or losses) divided by total revenues.) Some plan officials told us to be cautious when drawing conclusions about the gains or losses reported for individual programs, noting that their allocation of expenses and interest earnings among the programs is sometimes imprecise. However, we think it is instructive to look at trends for

¹⁷ Fox and others, *An Analysis of States’ Capitation Methods and Pediatric Rates*, 1.

¹⁸ *Minnesota Statutes* 2007, 62D.04, subd. 5.

¹⁹ The law says that plans must submit proposals to serve a region of the state “if, at the time of publication of a request for proposal, the percentage of recipients in the public programs in the region who are enrolled in the health maintenance organization is less than the health maintenance organization’s percentage of the total number of individuals enrolled in health maintenance organizations in the same region.”

Table 3.2: Health Plans' Net Return on Revenues in Various Managed Care Programs, 2000-06

| Year | Health Plans' Net Income (Gained or Lost) as a Percentage of Total Revenue, by Program | | | | | |
|--|---|----------------|---------------------------------|--|--------------------------|--------------|
| | Medical Assistance | Minnesota-Care | General Assistance Medical Care | Minnesota Senior Health Options ^a | All Programs Except MSHO | All Programs |
| 2000 | 8.8% | -0.6% | -20.6% | 9.0% | 4.0% | 4.3% |
| 2001 | 4.7 | 3.5 | -20.1 | 10.0 | 2.3 | 2.8 |
| 2002 | 0.8 | 6.4 | -11.3 | 6.9 | 1.4 | 1.8 |
| 2003 | 5.1 | 5.7 | -10.2 | 7.7 | 3.7 | 4.0 |
| 2004 | 4.8 | 11.2 | -11.0 | 5.3 | 4.9 | 4.9 |
| 2005 | 1.2 | 7.1 | -9.2 | 7.7 | 1.4 | 2.0 |
| 2006 | -6.5 | 2.7 | -9.6 | 10.8 | -4.7 | 0.7 |
| Program's percentage of total revenues, 2006 | 40.0% | 16.0% | 9.4% | 34.6% | 65.4% | 100% |

NOTE: "Net return on revenues" is the health plans' net income (or losses) divided by their total revenues in these programs. Net income includes net underwriting gains (or losses), net investment income, and net capital gains.

^a Includes revenues from both Medicare and Medicaid.

SOURCE: Office of the Legislative Auditor, analysis of health plans' annual financial statements, 2000-06.

In recent years, health plans have not reported aggregate losses from public programs.

individual programs, even if aggregate net income across all programs is a better measure of the plans' overall financial well-being.

During the seven-year period shown, the overall annual net return rate ranged from a low of 0.7 percent in 2006 to a high of 4.9 percent in 2004. While net returns varied, there were no years in which the plans reported net losses from the public programs *in aggregate*.

Health plans have reported some money-losing years for individual health care programs. In the largest managed care program (Medical Assistance), health plans reported aggregate losses of more than \$64 million in 2006, representing 6.5 percent of total revenues. In 2000-05, however, health plans consistently reported net gains in the Medical Assistance program. The 2006 losses in Medical Assistance were offset by aggregate 2006 net income in the Minnesota Senior Health Options (MSHO) program exceeding \$92 million, which represented a return of 10.8 percent on total MSHO revenues in MSHO's first full year as a statewide program. Health plans reported net gains from MSHO in each of the years shown in Table 3.2, and plans reported net gains from MinnesotaCare in each year except for 2000. MSHO is a combination of Medicaid and Medicare services, and it is unclear which of these programs accounted for most of MSHO's net gains.

However, health plans have consistently reported losses for the General Assistance Medical Care program.

In contrast, health plans reported losses every year on General Assistance Medical Care, a state-funded program that accounts for about 9 percent of the public programs' revenues. As noted earlier, this is the only program that DHS is not required to demonstrate to be "actuarially sound." DHS staff acknowledged that they have regularly set GAMC's rates at levels lower than the program's anticipated costs, with the expectation that the health plans will negotiate lower rates with providers, help clients transition from GAMC to MinnesotaCare, or cover their losses with surpluses from other programs.

Table 3.2 shows net returns for Minnesota's health care programs in aggregate, but the net returns reported by individual health plans in these programs are more variable. For example, among individual plans, 2006 net returns on the Medical Assistance managed care program ranged from a loss of more than 13 percent (BluePlus) to a gain of more than 6 percent (PrimeWest). Also, while most plans have reported positive net income from the Medical Assistance program over the years, HealthPartners has usually reported annual net losses in this program. It is worth noting, however, that each state sets rates that are intended to cover costs (that is, be "actuarially sound") for the state's managed care system *in aggregate*. There is no federal requirement for states to set rates that are actuarially sound for any individual health plan.²⁰

We also observed that:

- **The aggregate net returns reported by health plans for Medical Assistance and MinnesotaCare have often exceeded the levels targeted by DHS.**

As part of the rate-setting process, DHS sets targets for the health plans' "contribution to surplus," and DHS's actuary calculates capitation rates intended to allow plans to achieve these targets. For the most part, DHS tries to set rates at levels that allow plans to take in more revenues than they spend on services, thus allowing the plans to accumulate or maintain their reserve funds. Table 3.3 shows the DHS targets for "contribution to surplus" in various programs in recent years. DHS's targeted gains for the plans have been very modest, ranging from 0 to 1 percent of total revenues. Actual returns in the Medical Assistance and MinnesotaCare programs—shown earlier—have often differed from these targets, typically exceeding them.²¹

Health Plans' Reserves

In addition to looking at health plans' net returns, we looked at the plans' levels of reserves (sometimes called "net worth") to help us assess their financial status. Minnesota law requires health maintenance organizations to file annual reports

²⁰ Medicaid Rate Certification Work Group, *Health Practice Council Practice Note*, 9. DHS sets statewide capitated rates based on data from five of the health plans with which it contracts.

²¹ DHS has excluded investment income when setting the targets shown in Table 3.3, and health plans' net income shown in Table 3.2 would have been somewhat lower if, similarly, the table had excluded investment income. Still, health plans' net income for MA and MinnesotaCare often exceeded DHS's 0 to 1 percent targets in recent years, even after excluding investment income.

Table 3.3: Department of Human Services' Targets for Health Plans' "Contributions to Surplus," 2003-07

| | Medical Assistance: Families and Children Subgroup | Medical Assistance: Aged Subgroup | Minnesota-Care: Medicaid Subgroup | Minnesota-Care: Non-Medicaid Subgroup | General Assistance Medical Care ^a |
|------|--|-----------------------------------|-----------------------------------|---------------------------------------|--|
| 2003 | 1.0% | 1.0% | 1.0% | 1.0% | -- |
| 2004 | 1.0 | 1.0 | 1.0 | 1.0 | -- |
| 2005 | 0.5 | 0.5 | 0.5 | 0.5 | -- |
| 2006 | 0.5 | 0.5 | 0.5 | 0.0 | -- |
| 2007 | 0.0 | 0.5 | 0.5 | 0.5 | -- |

NOTE: "Contribution to surplus" is the excess of revenues over expenses, which is sometimes called the "contribution to reserves" or "retained earnings." DHS sets targets as part of its annual process for setting rates for public managed care programs.

^a The Department of Human Services does not set targets for "contributions to surplus" when developing GAMC capitation rates.

SOURCE: Minnesota Department of Human Services.

on their levels of "risk-based capital."²² If an insurer's risk-based capital drops below 200 percent of its "authorized control level" of risk-based capital, the insurer must, at a minimum, prepare a corrective action plan for the Department of Commerce.²³ Minimum reserve requirements are intended to help ensure the financial solvency of the health plans. State law requires county-based purchasing organizations to satisfy the fiscal solvency requirements that apply to health maintenance organizations or community integrated service networks.²⁴ As discussed in Chapter 6, state law allows counties (with their taxing authority) to guarantee the solvency of county-based plans.

Table 3.4 shows information on health plans' net worth and risk-based capital ratios. It is worth noting that several of these plans (shaded in gray) do a combination of public and private business, while the others administer only public programs. We found that:

- **The reserves of most Minnesota health plans have grown to amounts several times larger than the minimum required in state law for health maintenance organizations.**

²² *Minnesota Statutes* 2007, 60A.61. An organization's minimum level of "risk-based capital" is determined by considering the nature of the organization's business, its credit-worthiness, and its asset portfolio.

²³ *Minnesota Statutes* 2007, 60A.50-60A.55.

²⁴ *Minnesota Statutes* 2007, 256B.692, subd. 2.

Table 3.4: Health Plan Net Worth and Risk-Based Capital Ratios, Selected Years

| | 2006 Net Worth (in millions) | 2001 Risk-Based Capital Ratio | 2005 Risk-Based Capital Ratio | 2006 Risk-Based Capital Ratio |
|----------------|---------------------------------|----------------------------------|----------------------------------|----------------------------------|
| BluePlus | \$210.2 | 418% | 758% | 729% |
| HealthPartners | 297.0 | 535 | 623 | 580 |
| Medica | 281.7 | 506 | 715 | 706 |
| UCare | 169.9 | 244 | 553 | 545 |
| FirstPlan | 18.1 | 261 | 850 | 650 |
| Metropolitan | 10.4 | 465 | 313 | 214 |
| Itasca | 3.4 | NA | 291 | 195 |
| PrimeWest | 14.0 | NA | 383 | 376 |
| South Country | 18.4 | NA | 578 | 493 |

NOTE: Plans shaded in gray have both commercial and publicly funded lines of business; the others have only public enrollees.

SOURCES: Allan Baumgarten, Minnesota Managed Care Review (Minneapolis, 2006 and 2007); Office of the Legislative Auditor, review of health plan financial statements.

Altogether, the health plans that contract with the state had about \$1 billion in reserves in 2006.

Statewide, the health maintenance organizations that contract with the state had nearly \$1 billion in reserves in 2006, and county-based purchasing organizations reported another \$36 million in reserves. Most health plans' risk-based capital levels were much higher than they were in 2001, although one plan (Metropolitan Health Plan) saw a significant decline in its reserves. The statewide increase in reserves suggests that most health plans are healthier financially than they were a few years ago, whether due to their public or private lines of business.

Some people have questioned whether the health plans' reserves are excessive. For example, the Minnesota Attorney General disputed the accuracy of the reserves reported by one private health insurer, claiming that this company's actual reserves were much larger than reported.²⁵ We did not evaluate whether health plans have accurately reported their reserves, although Department of Commerce officials told us that the Attorney General's assessment was flawed. We did consider, however, whether there is a basis for concluding that health plans' reported levels of reserves are too high. We found that:

- **States have adopted few statutory benchmarks for maximum levels of reserves, and expert judgments about the "right" levels of reserves vary.**

²⁵ Minnesota Office of the Attorney General, *Volume I: [Blue Cross Blue Shield Minnesota] Reserves and Surplus* (St. Paul, 2006), 2. Blue Cross Blue Shield Minnesota is not a health maintenance organization, but it is the parent company of BluePlus and FirstPlan.

Minnesota law no longer caps health plans' maximum net worth.

Minnesota law no longer sets a maximum net worth for health maintenance organizations. The law used to specify that net worth could not exceed 25 percent of the total expenses incurred by a health maintenance organization in the previous year, but the 2004 Legislature repealed this limitation.²⁶ In fact, only a few states have imposed caps on health plans' reserves. Michigan caps the surplus of Blue Cross Blue Shield of Michigan at a risk-based capital ratio of 1,000 percent. Hawaii requires nonprofit health plans to refund money to clients if the plans' net worth exceeds 50 percent of the previous year's health care expenditures plus operating costs. In Pennsylvania, a 2005 order from the state insurance commissioner defined acceptable ranges for Blue Cross Blue Shield plans' reserve levels (two were limited to a surplus ratio of 950 percent, and two were limited to 750 percent).²⁷ A leading health care consulting firm examined health plan reserves for the Pennsylvania Legislature and found "no consensus" among experts regarding the "right" amount of surplus to maintain. It concluded that, in Pennsylvania, risk-based capital ratios "in the range of 500% to 900% can be justified to protect against underwriting swings" that could jeopardize a Blue Cross Blue Shield plan's standing with its parent organization and state insurance regulators.²⁸ In addition, companies may need relatively higher amounts of reserves to acquire other companies, to avoid being acquired, or to endure "worst case scenarios," and the appropriate amount of reserves might depend on a company's size and the nature of its business.²⁹

Some health plans told us that much of their increase in reserves has been due to interest earnings from the reserves. However,

- **DHS has not included health plans' interest earnings as revenues when setting capitation rates.**

During the capitation rate-setting process, DHS's actuary includes health plans' spending for investment-related expenses as one category of plans' administrative expenditures.³⁰ But, for purposes of determining health plans revenues during the rate-setting process, the actuary historically has not counted the plans' "investment income earned." In our view, it seems inconsistent to include investment-related expenditures while excluding revenues that result from these costs, and later we offer a recommendation to address this.

As health plans' reserves have grown, health care providers have complained that the plans have benefited at the expense of the providers they use. Managed care

²⁶ *Laws of Minnesota* 2004, chapter 285, art. 3, sec. 6.

²⁷ The Lewin Group, *Considerations for Regulating Surplus Accumulation and Community Benefit Activities of Pennsylvania's Blue Cross and Blue Shield Plans: Final Report* (Falls Church, VA: Report prepared for the Pennsylvania General Assembly, June 13, 2005), ii-v.

²⁸ *Ibid.*, iv, 14.

²⁹ James E. Drennan, Proceedings of Spring Meeting, Society of Actuaries, June 23-25, 2003, "Session 20 PD: How Much is Enough? Capital and Surplus Management for Health Entities," *Record*, 29, no. 2.

³⁰ The state pays for the portion of financial/investment management expenses that the health plans have allocated to the public programs in their reporting on administrative costs.

is supposed to help the state contain the growth of health care costs, but some health care providers expressed concerns to us that their payment rates from health plans did not change much in recent years.³¹ Providers suggested that health plans should have given them comparable rate increases to the plans' own increases in capitation rates. We asked DHS for information about health plans' payment rates for providers, but:

- **DHS officials said they rarely obtain information regarding health plans' subcontracts or provider payment rates for the public programs, citing concerns about their ability to protect the data from public disclosure.**

According to state law, contract-related information provided by the health plans to the Department of Health is not public.³² However, there is no comparable provision for contract information provided by the health plans to the Department of Human Services. DHS officials told us they generally do not obtain copies of this data because of the possibility that the department might then be asked to publicly disclose it. However, as we recommend below, we think it is important for DHS to have more complete information on the expenditures of health plans, including information on the plans' contracts for serving public program enrollees.

Conclusions and Recommendations

Overall, we concluded that:

- **DHS has set managed care rates that have enabled health plans to remain financially healthy, but rising spending per enrollee suggests a need for continued state efforts to contain managed care costs.**

The state's use of managed care will not by itself ensure cost containment.

The health plans administering Minnesota's public programs have been financially healthy—as indicated by (1) positive net income, in aggregate, (2) increased levels of capital reserves, and (3) the stability of the plans participating in Minnesota's public programs.

However, the use of managed care will not, by itself, ensure containment of the state's public health care costs. Minnesota has relatively high capitation rates, and its managed care spending per enrollee grew significantly in recent years. Federal requirements for "actuarially sound" capitation payments in the largest health care programs may create continued pressure for growth in managed care spending. In general, the state's options for improved cost containment include: (1) negotiation by DHS of capitation rates that provide health plans with less net income than they have received in some previous years, (2) continued implementation by DHS and the Legislature of cost containment strategies, such

³¹ Some health care providers gave us information on the rates they have been paid by health plans in recent years for certain services. For the most part, these data showed limited change in payment rates, but we do not know whether these rates were representative of payment trends for the broader range of services that providers offer.

³² *Minnesota Statutes* 2007, 62D.03, subd. 4. Contract information is classified as a trade secret "upon the request" of the health plan.

as those discussed in Chapter 2, (3) improving the health of enrollees in public programs, leading to reductions in health care costs over time, or (4) reductions in enrollee benefits or eligibility.

Earlier, we noted that there have been some differences between DHS's targets for health plans' net returns from public programs and the plans' actual returns. We did not—nor did DHS—identify the reasons for these differences between DHS's net income targets and the health plans' actual net income. Some differences are expected, given the imprecision involved when setting future rates based on past experience. However, such differences might also be caused by flaws in the rate-setting process, possibly involving DHS assumptions, data integrity, or actuary calculations.

RECOMMENDATION

DHS should report to the 2009 Legislature on recent differences between targeted and actual health plan net income in various programs, providing explanations for these differences to the extent possible.

Also, we observed earlier that it seems inconsistent for DHS to include investment-related expenditures in the rate-setting process while excluding the revenues that result from this spending. We recommend that DHS modify its rate-setting process to include, at a minimum, the interest earned by health plans on the capitation payments they receive from the state.³³

RECOMMENDATION

DHS should include at least a portion of health plans' interest earnings in its calculations of revenues for rate-setting purposes.

DHS should collect more information on health plans' subcontracts and provider payment rates.

Finally, we think that DHS should have information about health plans' subcontracts and provider payment rates. First, it is important for DHS to periodically review detailed information about how health plans spend their money, given the magnitude of the state's managed care contracts. Second, information on subcontracts and provider payment rates might help DHS set capitation rates. Third, having this information would help DHS evaluate the merit of complaints by health care providers about the fairness of health plans' payment rates. In our view, the Legislature should classify contract-related information given to DHS as not public upon the request of the health plan—just as the statutes provide when this information is given to the Department of Health—so that DHS will not hesitate to collect and use this information.

³³ This recommendation is consistent with one made in Office of the Inspector General, U.S. Department of Health and Human Services, *Results of the Audit of Investment Income Earned by Managed Care Organizations with Risk-Based Contracts* (Washington, D.C., August 2000). Health plans can vary in the methods they use to allocate interest earnings among their business lines. Thus, if DHS counted interest earnings as revenue for rate-setting purposes, it would need to ensure that health plans used reasonably consistent allocation methods.

RECOMMENDATION

The Legislature should classify information provided to the Department of Human Services on a health plan's contracts and contract-related payment rates as "not public" data.

FEE-FOR-SERVICE PAYMENT RATES

In the previous section, we noted that Minnesota's managed care Medicaid spending per enrollee is higher than the national average—partly reflecting Minnesota's more comprehensive package of Medicaid benefits—and has grown faster than the national average in recent years. We also analyzed Minnesota's fee-for-service Medicaid spending per enrollee, using data we extracted from the federal Medicaid Statistical Information System.³⁴ We found that:

- **Minnesota spends more per enrollee for fee-for-service Medicaid enrollees than other states, but its fee-for-service spending growth in recent years was less than the national average.**

Our analysis indicated that Minnesota's 2005 Medicaid spending per eligible fee-for-service recipient was 76 percent greater than the national average. As with managed care spending, this partly reflected the more comprehensive benefit package that Minnesota offers its Medicaid enrollees compared with other states. It also probably reflected differences in the types of enrollees served in states' fee-for-service systems. Compared with other states, Minnesota has covered a small portion of its welfare families (who tend to have relatively low health care costs) through fee-for-service care, while it has covered most disabled residents (who tend to have relatively high health care costs) through fee-for-service.³⁵

Using federal data, we also found that Minnesota's fee-for-service Medicaid spending per eligible enrollee grew by an average of 1 percent annually between 2000 and 2005, compared with 3 percent annually for the nation as a whole. One reason might be the gradual, ongoing transition of some higher-cost Minnesota enrollees (such as seniors and people with disabilities) from fee-for-service care to managed care.³⁶ Also, as we discuss in the remainder of this section, the small increase in fee-for-service cost per enrollee could partly reflect the limited changes that have occurred in some fee-for-service provider payment rates.

³⁴ See an overview of this database at: <http://www.cms.hhs.gov/MSIS/>. We did not have detailed information on the types of costs that states included (or excluded) in their reported fee-for-service expenditures, which could affect the spending trends over time.

³⁵ The Lewin Group, *Medicaid Capitation Expansion's Potential Cost Savings* (Falls Church, VA, April 2006), 6-7.

³⁶ For example, the voluntary Minnesota Disabilities Health Options (MnDHO) program started in 2001 in four counties in the Twin Cities area. Also, managed care expanded into many rural areas during this period with the start-up of two new county-based purchasing organizations.

In fee-for-service health care, states typically pay for health-related services using state-determined rate schedules. Health care providers submit claims to the state for services they have provided to enrollees, and the state pays providers for authorized services based on a schedule of rates that covers hundreds of individual medical procedures.

We examined Minnesota's fee-for-service payment rates, focusing mostly on physician services. Minnesota pays for a majority of physician services at amounts that are the lower of (1) the provider's submitted charge, or (2) 80 percent of the 50th percentile of the charges submitted by all providers of this service in 1989.³⁷ We found that:

- **Minnesota's Medicaid fee-for-service reimbursement rates for physicians have eroded and are low relative to physicians' actual charges and Medicare reimbursement rates.**

In 2005, the state paid physicians 35 percent of the physicians' submitted charges for their services.

In 2005, payments to physicians for public health care program services represented 35 percent of the physicians' charges for these services. Table 3.5 shows the state's "payment-to-charge" ratios for various health care services. In

Table 3.5: Ratios of State Payments to Submitted Charges for Selected Types of Providers, 2005

| Type of Provider | Total State Payments (in millions) | Total Charges Claimed (in millions) | Payment-to-Charge Ratio |
|---|---------------------------------------|--|-------------------------|
| Hospitals | \$490.2 | \$1,460.5 | 0.34 |
| Physicians | 124.0 | 352.7 | 0.35 |
| Nursing facilities | 153.3 | 327.3 | 0.47 |
| Pharmacies | 462.8 | 776.6 | 0.60 |
| Home health agencies | 136.6 | 177.3 | 0.77 |
| Personal care providers | 283.4 | 304.6 | 0.93 |
| County reservations services | 221.7 | 231.6 | 0.96 |
| Home and community-based services providers | 821.3 | 846.0 | 0.97 |
| Day training and habilitation providers | 173.3 | 176.1 | 0.98 |

NOTE: Includes only the provider types for which there were more than \$100 million in state payments in calendar year 2005.

SOURCE: Minnesota Department of Human Services.

³⁷ The best description of Minnesota's rate-setting method is in the state's federally-approved Medicaid plan. For example, the state statute on rate setting for physician services (*Minnesota Statutes* 2007, 256B.76) does not specifically address how DHS shall compute rates that relate to prevailing charges. Also, DHS staff told us that the state rule on fee-for-service payment rates (*Minnesota Rules* 2007, 9505.0445) is obsolete.

There has been only one across-the-board increase in physician fee-for-service payment rates since 1992.

contrast to the relatively low payment-to-charge ratios for services such as physician and hospital services, some health care activities such as home and community-based services were reimbursed at close to 100 percent of charges.

Over time, there have been few changes in the state's payment rates for fee-for-service care by physicians. In 1992, DHS changed the base year for determining prevailing charges (from 1982 to 1989), in response to a legislative increase in appropriations for fee-for-service rates. There has been no subsequent change in the base year; 1989 rates are still used to determine provider payments. The 1999 Legislature authorized a 3 percent increase in physician rates (effective in 2000), and this has been the only across-the-board physician rate increase since 1992.³⁸ Without periodic increases in rates, the state has been reimbursing an increasingly lower portion of physicians' submitted charges. For example, office visits, maternity-related care, and preventive medicine are being paid in fiscal year 2008 at 33 percent of charges, compared with 62 percent for these services in fiscal year 1993. Other types of physician services are paid at 31 percent of charges in fiscal year 2008, compared with 58 percent in fiscal year 1993.

To better understand how Minnesota's fee-for-service rates compare with those in other states, we reviewed a variety of previous studies. Studies have used somewhat different methods and examined different services, but they have generally shown that Minnesota's Medicaid fee-for-service rates are near the national average. A health care consulting firm computed a weighted average of all 50 states' 2000 rates for 31 types of services, and it reported that Minnesota's Medicaid rates for physician services ranked 22nd highest among the states.³⁹ An analysis of 2003 rates by researchers from the Urban Institute and Center for Studying Health System Change reported that a composite index of Minnesota's Medicaid fee-for-service rates ranked 27th highest among the 50 states.⁴⁰ This study said that Minnesota's rates were at the national average for primary care, slightly below the national average for obstetric care, and well over the national average for other physician services examined.⁴¹ In addition, an actuarial firm analyzed Medicaid fee-for-service rates in 2006 for North Dakota, South Dakota,

³⁸ *Laws of Minnesota* 1999, chapter 245, art. 4, sec. 78.

³⁹ Joel Menges, Chris Park, Jennifer Babcock, Lisa Chimento, Randall Haught, and Silver Ho, *Comparing Physician and Dentist Fees Among Medicaid Programs* (Falls Church, VA: The Lewin Group for the Medi-Cal Policy Institute, June 2001).

⁴⁰ Stephen Zuckerman, Joshua McFeeters, Peter Cunningham, and Len Nichols, "Changes in Medicaid Physician Fees, 1998-2003: Implications for Physician Participation," *Health Affairs Web Exclusive*, June 23, 2004, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.374v1>, accessed May 17, 2007. Overall, Minnesota's Medicaid rates (as measured with the composite index) were lower than those in Iowa, Wisconsin, and North Dakota but slightly higher than those in South Dakota.

⁴¹ The report said that the "other services" examined included hospital visits, surgery, radiology, psychotherapy, and lab tests.

Minnesota, and Montana, and it found that Minnesota's payment rates for physicians were the lowest of the four states examined.⁴²

Most states, including Minnesota, pay lower fee-for-service rates for Medicaid services than for comparable services under Medicare. Nationally, Medicaid fee-for-service rates were 69 percent of the Medicare rates for comparable services; Minnesota's Medicaid rates were 79 percent of its Medicare rates. In primary care, Minnesota's Medicaid fee-for-service rates were only 64 percent of the comparable rates for Medicare.⁴³

It is possible that increases in providers' payment rates might help to improve public program enrollees' access to services—for example, by encouraging more physicians to serve these clients. However, a 2005 review of previous research by researchers Yu-Chu Shen and Stephen Zuckerman reported “no clear consensus” about the relationship between payment generosity and enrollees' service access and use.⁴⁴ Shen and Zuckerman's own research, based on national data, led them to conclude that Medicaid payment rates had “small and limited [positive] effects on access and use for both adults and children,” and they found some indication that higher provider payments might be related to better care.⁴⁵ Other studies have found that a variety of factors, including payment rates, may influence whether providers will serve clients in publicly funded health care programs.⁴⁶ There is some evidence that, compared with other states, Minnesota already has relatively high physician participation in its public programs.⁴⁷

Finally, we examined the status of a “resource-based relative value scale” (RBRVS) method of setting fee-for-service rates. An RBRVS system is intended to rationalize reimbursement rates in a budget-neutral way, by linking payment rates to the resource costs for providing particular services. Medicare rates nationwide have been based on RBRVS since 1992, and many states use an RBRVS approach to set their Medicaid rates. The Legislature required DHS to

⁴² Leigh Wachenheim, Rob Damler, and Kent Roepke, *Analysis of Medicaid Fee for Service Payment Rates* (Milliman, for the North Dakota Department of Human Services, August 31, 2006). In a majority of the other categories examined—such as radiology, speech therapy, physical therapy, and mental health—Minnesota's payment rates were higher than those in the other states.

⁴³ Zuckerman and others, *Changes in Medicaid Physician Fees*, Exhibit 2.

⁴⁴ Yu-Chu Shen and Stephen Zuckerman, “The Effect of Medicaid Payment Generosity on Access and Use Among Beneficiaries,” *Health Services Research* 40, no. 3 (June 2005): 723-744.

⁴⁵ *Ibid.*

⁴⁶ For example, see Peter J. Cunningham and Len M. Nichols, “The Effects of Medicaid Reimbursement on the Access to Care of Medicaid Enrollees: A Community Perspective,” *Medical Care Research and Review* 62, no. 6 (December 2005): 676-696, and Jessie L. Tucker III, “Factors Influencing Physician Participation in Medicaid in the USA,” *International Journal of Social Economics* 29, no. 9 (2002): 753-762.

⁴⁷ A national study found that Minnesota had one of the highest rates of Medicaid participation among pediatricians—see Steve Berman, Judith Dolins, Suk-fong Tang, and Beth Yudlowsky, “Factors That Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients,” *Pediatrics* 110, no. 2 (2002): 239-248.

make payments for physician and other medical professional services based on such a system, beginning in January 2007.⁴⁸ However,

- **Contrary to statutory requirements, DHS has not implemented a Medicaid fee-for-service reimbursement system based on “relative value units.”**

DHS hired a staff person in 2006 to begin working on an RBRVS-type system, but this person subsequently left the agency. As of late 2007, DHS did not have an estimate regarding when such a system might be implemented. Provider representatives expressed concern to us regarding these delays, and they commented that the existing method of setting rates is outdated and inconsistent with industry standards.

Conclusions and Recommendations

Overall, we think that fee-for-service rates need greater attention from policy makers. The lack of regular increases in some types of fee-for-service payment rates have undoubtedly helped to contain costs in Minnesota’s publicly funded health care programs. However, the continuing erosion of the state’s payment rates for certain types of providers has the potential to adversely affect service access and quality. It is difficult to know whether, as federal law requires, Minnesota offers its Medicaid enrollees access to providers that is comparable to the general population’s access to providers; neither DHS nor the federal government systematically collect information on this. However, some people expressed concerns to us about shortages of certain types of providers willing to serve public clients.⁴⁹ In our view,

- **The Legislature and DHS have not taken sufficient steps to address concerns about the adequacy and equity of Minnesota’s fee-for-service rates.**

The Legislature has increased rates for certain categories of providers, such as “critical access” dentists and mental health professionals. Also, there have been annual increases for outpatient hospitals and Medicaid waived services. But the Legislature has not approved general increases in physician fee-for-service rates for 9 years, and there has been no update of the base year of the rates for 16 years. *Minnesota Statutes* 256B.038 requires the executive branch to request inflation increases in various health care service areas (such as physician services) as part of the biennial budget process, but there have been no such proposals in recent budgets.⁵⁰ In addition, DHS did not implement in a timely manner a statutory mandate to base fee-for-service rates on “relative value units,”

The state’s fee-for-service rates need greater attention from policy makers.

⁴⁸ *Minnesota Statutes* 2007, 256B.76, subd. (e).

⁴⁹ For example, the state’s managed care ombudsman told us about problems with the availability of fee-for-service dentists and mental health professionals in some parts of Minnesota.

⁵⁰ In contrast, DHS officials told us that, due to the federal requirements for actuarial soundness in managed care rates, they have built inflation-related increases into (1) the agency’s forecasts of managed care expenditures and (2) the managed care payments themselves.

an approach that was intended to improve the fairness of existing rates. Implementing a reimbursement system based on relative value units would increase some rates while decreasing others; it would not require a net increase in state expenditures.

However, across-the-board increases in provider payment rates would require additional state spending, and legislators would need to weigh the potential costs and benefits of provider payment increases against other budget proposals. DHS estimated that a 5 percent increase in physician rates in 2008 followed by another 5 percent increase in 2009 would have cost about \$25 million per year when fully implemented.⁵¹ Also, there is no guarantee that increases in fee-for-service payment rates would increase enrollees' access to services or improve health care quality. Still, we think that the Legislature should consider modest, targeted rate increases, at least to address issues of fairness and equity. In particular, we think it is hard to justify paying certain types of providers for only about one-third of their claims when other providers are paid for nearly the full amount of their state claims.

RECOMMENDATIONS

DHS should report to the 2009 Legislature on the adequacy of Minnesota's fee-for-service provider rates. As part of this analysis, DHS should identify service areas or regions of the state in which public program enrollees have had difficulty accessing providers.

The Legislature should consider increasing fee-for-service payment rates for certain types of providers, such as primary care physicians.

As required in Minnesota statutes, DHS should implement a "relative value unit" payment system for Medicaid and related programs, and it should update the 2008 Legislature regarding the expected completion date for this task.

⁵¹ Based on estimates developed by DHS staff prior to development of the Governor's 2008-09 biennial budget; the budget did not include this proposal. Health plans sometimes set their physician payment rates at a set percentage of the state's fee-for-service rates, so it is possible that a fee-for-service rate increase could also affect health plan spending.

Administrative Spending

SUMMARY

Minnesota spent \$318 million in 2006 to administer publicly funded health care programs, including nearly \$200 million in health plan administrative costs and \$119 million in Department of Human Services (DHS) costs. Between 2000 and 2006, health plans' administrative spending levels increased faster than program enrollment but more slowly than medical costs. Three state agencies oversee various aspects of health plans' spending, but the depth of their reviews has been limited. DHS should more closely scrutinize and limit administrative spending for public programs, especially through its rate-setting and contracting processes.

One part of controlling publicly funded health care spending is controlling the costs to administer these programs. Similar to medical care costs, the state has experienced consistent growth in administrative expenditures. Three state agencies—the departments of Human Services, Health, and Commerce—each play a role in overseeing health plan spending. This chapter addresses the following questions:

- **How much does the Minnesota Department of Human Services (DHS) spend to administer its managed care and fee-for-service health care programs? How much do health plans spend to administer public programs on behalf of the state?**
- **Have state agencies taken sufficient steps to ensure that health plans' administrative spending is reasonable and accurately reported?**
- **Has DHS done enough to control the administrative spending of health plans with which it contracts?**

Some people have expressed concern about the accuracy of health plans' reporting of their administrative costs. For example, the Minnesota Office of the Attorney General has questioned the adequacy of federal, state, and insurance industry reporting standards, and it has questioned how some plans have defined their administrative expenses.¹ The Attorney General also concluded that one health plan's 2000 administrative costs were almost twice the level publicly reported by the health plan.² Health plans and Department of Commerce staff have disputed the Attorney General's conclusions, contending that the plans report administrative costs in a manner consistent with accepted standards. Our evaluation did not review in detail whether individual health plans properly categorized expenditures as "administrative" costs, nor did we conduct a

¹ Minnesota Office of the Attorney General, Chapter 6: [Allina] Administrative Expenses (St. Paul, 2001), 1-5.

² *Ibid.*, 8-9.

comprehensive review of the “reasonableness” of health plan expenditures. Rather, we summarized available information about reported administrative expenditures, and we evaluated the level of scrutiny these expenditures receive from state agencies.

In this chapter, we report that DHS and the nine health plans that contract with the state incurred expenditures to administer Minnesota’s publicly funded health care programs totaling \$318 million in 2006.³ It is worth noting that this amount does not reflect the entire cost of administering health care services in Minnesota’s public programs. DHS and health plans make payments to various health care providers (doctors, clinics, hospitals, and others) to deliver services, and a portion of these payments covers the providers’ administrative costs. However, there is no state reporting that could be used to determine the exact amount of the providers’ overhead costs. Thus, the total level of Minnesota’s administrative spending for publicly funded health care programs exceeds the \$318 million figure cited above by an unknown amount.

DEPARTMENT OF HUMAN SERVICES ADMINISTRATIVE COSTS

DHS’s Health Care Division provides oversight and support for health care delivered through both the fee-for-service and managed care approaches. As shown in Table 4.1, the department’s administrative activities include health care policy development, implementation of policy initiatives, managing health care eligibility and access, developing and purchasing managed care services, health care rate setting, performance measurement and quality improvement, and many other functions. According to data from past biennial budgets,

- **Between fiscal years 2000 and 2007, DHS’s spending to administer Minnesota’s publicly funded health care programs increased by an average of 10 percent annually.**

During this seven-year period, the department’s administrative expenditures increased from about \$53 million in 2000 to almost \$103 million in 2007, as shown in Table 4.2.⁴ Meanwhile, the department’s average annual spending to administer all other human services programs increased by only 4.4 percent—less than half the rate of health care administration.⁵

³ We did not request estimates from the departments of Health or Commerce on their costs to perform health care-related administrative activities.

⁴ These totals represent DHS’s actual expenditures for Health Care Management and Policy Administration, as reported in the department’s biennial budgets. The totals do not include the DHS Continuing Care Division’s expenditures related to Medicaid-funded activities for the elderly and disabled populations who require continuing care services.

⁵ Our analysis excluded expenditures to administer the department’s State Operated Services programs. The department’s spending for internal agency management—including financial, legal and regulatory, management, and technology operations—increased at an average annual rate of 9.9 percent, from about \$38 million in 2000 to \$73.5 million in 2007.

DHS’s costs to administer the state’s health care programs exceeded \$100 million in 2007.

Table 4.1: Administrative Services for Publicly Funded Health Care Programs

| Administrator | Administrative Service | |
|---------------|---|---|
| DHS | <ul style="list-style-type: none"> • Develop policy and lead implementation of policy initiatives • Develop payment policies and payment rates • Conduct surveys and research to monitor quality of care • Oversee county and tribal administration of health care services • Plan and develop eligibility and enrollment systems • Work with federal government to ensure compliance with Medicaid laws and rules, and negotiate waivers to enhance services | |
| | Managed Care | Fee-For-Service |
| | <ul style="list-style-type: none"> • Administer managed care contracts • Monitor health plans to ensure contract compliance, value, and access • Provide ombudsman support for managed care enrollees • Conduct MinnesotaCare eligibility determinations | <ul style="list-style-type: none"> • Maintain health care provider agreements • Maintain online system for claims operations, customer services, and eligibility verification for providers • Operate centralized payment system (MMIS) • Identify and recover third-party liability costs • Administer medical surcharge and other funds • Support enrollee communication and outreach efforts |
| Health Plans | <ul style="list-style-type: none"> • Develop and maintain provider networks • Process claims • Manage member enrollment • Provide customer service support • Implement quality assurance programs • Manage costs and service utilization • Promote health and wellness of members • Monitor providers • Comply with reporting and other requirements in state contracts | |

SOURCE: Office of the Legislative Auditor, compilation of Department of Human Services documents.

The department estimated that its total expenses for administering the health care programs were likely higher than what was reported in the budget documents—if a portion of DHS costs for internal operations, (such as technology, regulatory, and financial operations) was allocated to health care. Table 4.3 shows DHS’s estimate of its 2006 costs for various administrative categories, totaling more than \$118 million. The largest share of these health care administrative expenses (\$58.7 million) was for managed care program activities, such as those described in Table 4.1. The department’s fee-for-service administrative costs totaled about \$42.5 million, and the remaining expenditures (\$17.6 million) were for services that benefited all publicly funded health care programming, such as research, fraud control, technology development, and regulatory activities.

Table 4.2: Growth in DHS Administrative Expenditures for Health Care vs. Other Programs, 2000-07

| DHS Program Area | 2000 Expenditures (in thousands) | 2007 Expenditures (in thousands) | Average Annual Growth Rate |
|--|-------------------------------------|-------------------------------------|-------------------------------|
| Health Care Management | \$ 52,803 | \$102,876 | 10.0% |
| Management—Total of All Other Programs | 109,586 | 148,113 | 4.4 |
| Agency Internal Management ^a | 37,927 | 73,522 | 9.9 |
| Total Agency and Program Management | \$200,316 | \$324,511 | 7.1% |

NOTE: Analysis excludes expenditures to administer the State Operated Services program.

^a Analysis includes agency expenditures for financial, legal and regulatory, management, and technology operations.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services biennial budget data.

HEALTH PLANS' REPORTED ADMINISTRATIVE SPENDING

Health plans spent \$200 million in 2006 to administer health care programs on behalf of DHS.

As shown in Table 4.1, the health plans' administrative services for managed care programs include member enrollment, customer service, claims processing, provider network management, health and wellness programs, quality assurance, and utilization management, among other activities. According to expenditure data reported by the nine health plans to the Department of Commerce, the plans spent \$200 million collectively to administer Minnesota's publicly funded health care programs in 2006.⁶ Overall, the plans' expenses represented 77 percent of the combined DHS and health plan costs to administer managed care in the public programs.

One measure of service efficiency is health plans' total administrative expenses relative to total program costs, including medical and hospital benefits,

⁶ Office of the Legislative Auditor, analysis of health plans' statements of revenue, expenses, and net income, 2006, for the Prepaid Medical Assistance, MinnesotaCare, General Assistance Medical Care, and Minnesota Senior Health Options programs. Throughout this report, we use the health plans' data reported to the Department of Commerce, which is the primary source of administrative expense data used by DHS for setting capitation payment rates.

Table 4.3: DHS Health Care Administrative Expenditures (in thousands), 2006

| Category | Fee-for-Service Expenditures | Managed Care Expenditures | General Health Care Expenditures | Total Administrative Expenditures |
|--|------------------------------|---------------------------|----------------------------------|-----------------------------------|
| Billing and enrollment | \$ 676 | \$10,999 | \$14,431 | \$ 26,106 |
| Claims processing | 11,011 | 2,316 | 0 | 13,067 |
| Customer service | 2,231 | 8,456 | 1,077 | 11,731 |
| Product management and marketing | 2,475 | 1,786 | 1,058 | 5,319 |
| Regulatory compliance and government relations | 4,273 | 5,285 | 643 | 10,201 |
| Provider relations and contracting | 437 | 2,230 | 0 | 2,667 |
| Quality assurance/ utilization management | 3,707 | 3,272 | 0 | 6,979 |
| Wellness and health education | 237 | 349 | 335 | 920 |
| Research and product development | 5,564 | 4,741 | 0 | 10,305 |
| General administration | 11,920 | 19,315 | 102 | 31,337 |
| TOTAL | \$42,532 | \$58,747 | \$17,646 | \$118,632 |

NOTE: Estimates exclude administrative costs for the department's Continuing Care and Chemical & Mental Health Services divisions.

SOURCE: Department of Human Services, estimates of health care administrative costs.

prescription drugs, and other professional health care services.⁷ As shown in Figure 4.1,

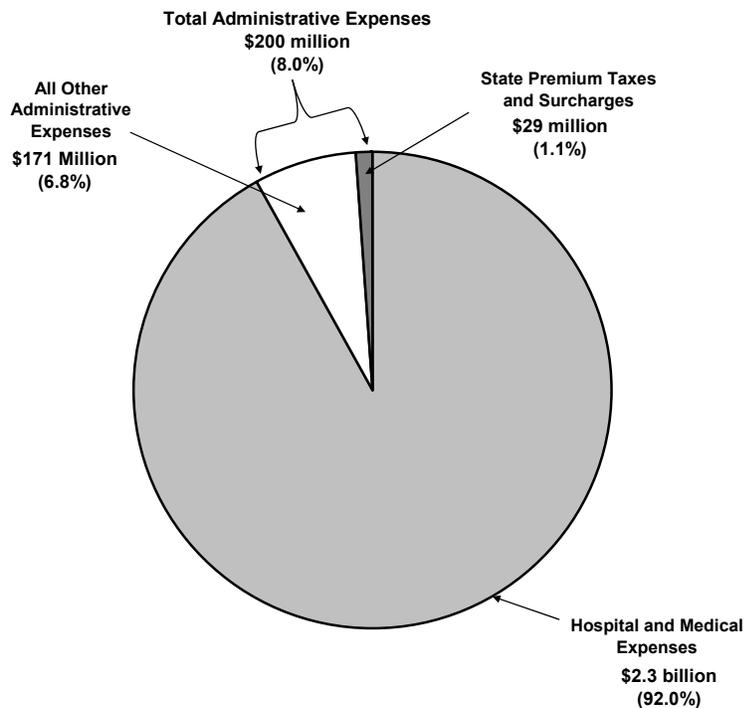
- **Statewide, health plans' administrative costs represented about 8 percent of their total of \$2.5 billion in publicly funded health care program expenditures in 2006.**

About 86 percent of health plans' total administrative expenditures were for salaries, benefits, actuarial and other consulting services, marketing, printing and postage, equipment, rent and other overhead costs. The remaining portion of administrative expenses represented state premium taxes and surcharges paid by the health maintenance organizations.⁸ For example, the five privately-owned

⁷ Health plans' "medical loss ratio" and "administrative loss ratio" are measures used by the insurance industry to indicate value in the purchase of health insurance. For example, *Minnesota Statutes* 2007, 62A.021 requires the departments of Commerce and Health to issue a public report each year listing the medical loss ratios experienced in the individual and small employer markets, by health plan. The medical loss ratio represents the ratio of incurred medical claims to premium revenue—any remaining revenue is presumed to be for administration, marketing, taxes, other expenses, and net income. The "administrative loss ratio" is the ratio of administrative costs to total costs, or the ratio of costs for non-medical care purposes relative to total premium revenues.

⁸ *Minnesota Statutes* 2007, 2971.05, subd. 5, and 256.9657, subd. 3.

Figure 4.1: Health Plans' Publicly Funded Health Care Program Expenditures, 2006



NOTE: Analysis based on estimates of state taxes and surcharges on health maintenance organizations. Totals for the Minnesota Senior Health Options program include Medicaid and Medicare-reimbursed services.

SOURCES: Office of the Legislative Auditor, analysis of Department of Human Services data; health plans' 2006 annual statements and statements of revenues, expenses, and net income for the Prepaid Medical Assistance Program, MinnesotaCare, General Assistance Medical Care, and Minnesota Senior Health Options program.

There are no clear standards for what constitutes an acceptable amount of administrative spending in publicly funded health care programs.

health plans (BluePlus, First Plan, HealthPartners, Medica, and UCare) collectively paid more than \$28 million in state surcharges and taxes imposed on premium revenues—a tax which the four county-owned plans are exempt from paying.

There are no clear standards for what constitutes an acceptable amount of administrative spending in publicly funded health care programs. Measures such as administrative spending as a percentage of total spending have limitations. Health care officials note that administrative cost percentages can be affected by differences among health plans in enrollees' medical needs and how plans are organized.⁹ The Department of Commerce cautions that such measures may be a good indicator of *relative* value if two health plan companies are very similar in the benefits they provide and other factors, but that the measures do not

⁹ For example, Jeff Lemieux, *Perspective: Administrative Costs of Private Health Insurance Plans* (Washington, D.C.: America's Health Insurance Plans, Center for Policy and Research, 2005).

Minnesota health plans' reported administrative expenditures appear to be relatively low compared with those in other states.

guarantee that the product is a *good* value for purchasers.¹⁰ For example, a small health plan's unusually low administrative costs as a percentage of total spending might be due to an unusually large amount of health care claims in a given year.

With these limitations in mind, Minnesota health plans' 2006 administrative expenditures for public programs—as a percentage of total costs—appear to be relatively low (8 percent) when compared with other states.¹¹ A 2007 review of health plan financial statements from 12 states showed that statewide administrative costs for publicly funded health care programs (including premium taxes and surcharges) ranged from a low of about 8 percent (Arizona) to more than 20 percent (Illinois) of premium revenues.¹² Table 4.4 shows that Minnesota's administrative costs were 6.9 percent of total spending when premium taxes and surcharges are excluded.

Economies of scale appear to have some effect on Minnesota's health plans' overall administrative costs, as shown in Table 4.4. Excluding state premium taxes and surcharges on health maintenance organizations, health plans' administrative spending as a share of total expenditures in 2006 ranged from 5.5 percent (Medica) to 19.7 percent (Metropolitan).¹³ The three largest health plans—Medica (5.5 percent), HealthPartners (5.6 percent), and BluePlus (5.9 percent)—had the lowest reported administrative cost ratio of all the plans in 2006, while percentages for the four smallest plans ranged from 7.3 to 9.8 percent.¹⁴ All of the health plans administer the same benefit set and program services for the public programs, and the state allows the health plans considerable latitude in how they organize their administrative services and allocate resources. However, without detailed analysis of each health plan's

¹⁰ Minnesota Department of Commerce, *Report of 2006 Loss Ratio Experience in the Individual and Small Employer Health Plan Markets for Insurance Companies, Nonprofit Health Service Plan Corporations, and Health Maintenance Organizations* (St. Paul, June 2007), 4-5.

¹¹ The administrative cost ratio does not include health plans' "contribution to surplus."

¹² The Lewin Group, *Assessment of HUSKY, Connecticut's Medicaid Managed Care Program* (Falls Church, VA: January 22, 2007), 9. Analysis of other states' administrative cost ratio represents total administrative spending as a percentage of premium revenues. In Minnesota, health plans' administrative percentage of total expenses in 2006 was 7.97 percent, and their administrative percentage of total premiums was 8.02 percent.

¹³ Metropolitan Health Plan officials attributed the higher administrative share partly to the health plan's investment in certain administrative functions following its separation from the Hennepin County Medical Center. Also, Metropolitan staff said that some of these investments are being amortized over a relatively short period. In addition, Metropolitan staff said that their plan lacks the administrative economies of scale of larger plans (as well as county-based purchasing plans that have contracted with large organizations for some administrative tasks).

¹⁴ Analysis represents spending for the Prepaid Medical Assistance, MinnesotaCare, General Assistance Medical Care, and Minnesota Senior Health Options programs, as reported on health plans' 2006 statements of revenues, expenses, and net income, and estimates of state taxes and surcharges on premiums. Totals for the MSHO program include expenditures for Medicaid and Medicare-reimbursed services. UCare's administrative share of total expenses when including spending for the Minnesota Disability Health Options program was slightly lower than the figure shown in Table 4.4 (6.8 percent vs. 7.0 percent).

Table 4.4: Health Plans' Administrative Spending, 2006

| | Total Member- Months (in thousands) | Total Administrative Expenditures (in thousands) ^a | Administrative Spending per Member-Month ^a | Administrative Share of Total Expenses | |
|--------------------------------------|--|--|---|--|--|
| | | | | Excluding Premium Taxes and Surcharges | Including Premium Taxes and Surcharges |
| Health Maintenance Organization | | | | | |
| Medica | 1,614 | \$42,693 | \$26 | 5.5% | 6.7% |
| BluePlus | 1,396 | 35,272 | 25 | 5.9 | 7.1 |
| UCare | 1,065 | 33,737 | 32 | 7.0 | 8.2 |
| HealthPartners | 622 | 14,817 | 24 | 5.6 | 6.9 |
| Metropolitan | 208 | 22,307 | 107 | 19.7 | 20.1 |
| First Plan | 110 | 3,909 | 35 | 7.3 | 8.4 |
| County-Based Purchasing Organization | | | | | |
| South Country Health Alliance | 167 | 8,444 | 51 | 9.8 | 9.8 |
| PrimeWest | 122 | 7,227 | 59 | 9.1 | 9.1 |
| Itasca Medical Care | 64 | 2,463 | 38 | 7.7 | 7.7 |
| Statewide Total | 5,368 | \$170,868 | \$32 | 6.9% | 8.0% |

NOTE: Analysis includes administrative expenditures and member-months for the Prepaid Medical Assistance Program, MinnesotaCare, General Assistance Medical Care, and Minnesota Senior Health Options program. Totals for the Minnesota Senior Health Options program include expenditures for Medicaid and Medicare-reimbursed services.

^a Analysis excludes estimates of state premium taxes and surcharges on health maintenance organizations. Totals are rounded to the nearest dollar.

SOURCES: Office of the Legislative Auditor, analysis of Department of Human Services data and health plans' annual statements and statements of revenue, expenses, and net income, 2006.

Health plans with large enrollments tended to have lower administrative costs per enrollee than smaller plans.

services, populations, and cost-reporting practices, it would be difficult to fully explain variation among the plans' administrative cost levels.

Differences among health plans' administrative spending per member-month are also apparent in Table 4.4, ranging from a low of \$24 per member-month (HealthPartners) to \$107 per member-month (Metropolitan). The larger health plans (HealthPartners—\$24, BluePlus—\$25, Medica—\$26) tended to have lower administrative costs per member-month served, which may be partly due to their ability to allocate fixed costs across their public and commercial lines of business. One plan administering over 1.0 million member-months in 2006 (UCare) showed spending (\$32 per member-month) only somewhat lower than two smaller plans administering 110,000 or fewer member-months (First Plan—\$35, Itasca Medical Care—\$38).¹⁵

¹⁵ Totals exclude state premium taxes and surcharges on health maintenance organizations. Analysis of UCare's per-member-month costs excludes spending for the Minnesota Disability Health Options program.

We also found that:

- **Between 2000 and 2006, health plans' administrative spending for Minnesota's publicly funded health care programs increased faster than program enrollment but slower than medical costs.**

During this seven-year period, health plans' combined spending to administer the four large public programs increased at an average annual rate of 14 percent, or 8 percent per member-month, as shown in Table 4.5. Meanwhile, medical expenses for all four programs increased at a faster annual rate (19 percent), as did medical expenses per member-month (12 percent). Administrative spending per member-month grew at a somewhat slower annual rate for Minnesota Senior Health Options (4 percent) than for the other three programs (5 percent). However, administrative expenses per member-month were four times greater for MSHO in 2006 than for the other three programs (\$107 compared with \$25).

Table 4.5: Average Annual Growth Rates, Health Plan Expenditures, and Program Enrollment, 2000-06

| | Contract Year 2000 | Contract Year 2006 | Average Annual Growth Rate |
|--|-----------------------|-----------------------|-------------------------------------|
| Health Plans' Administrative Expenses (in thousands) | | | |
| All Programs | \$77,352 | \$170,868 | 14.1% |
| PMAP, GAMC, MinnesotaCare | 73,641 | 126,039 | 9.4 |
| MSHO | 3,711 | 44,829 | 51.5 |
| Total Member-Months (in thousands) | | | |
| All Programs | 3,844 | 5,368 | 5.7% |
| PMAP, GAMC, MinnesotaCare | 3,802 | 4,950 | 4.5 |
| MSHO | 43 | 418 | 46.2 |
| Administrative Expenses per Member-Month | | | |
| All Programs | \$20 | \$32 | 7.9% |
| PMAP, GAMC, MinnesotaCare | 19 | 25 | 4.7 |
| MSHO | 87 | 107 | 3.6 |
| Medical Expenses (in thousands) | | | |
| All Programs | \$816,463 | \$2,302,851 | 18.9% |
| Medical Expenses per Member-Month | \$212 | \$429 | 12.4% |

NOTE: "All Programs" includes data for the Prepaid Medical Assistance, General Assistance Medical Care, MinnesotaCare, and Minnesota Senior Health Options programs. Administrative spending totals exclude estimated state premium taxes and surcharges on health maintenance organizations. MSHO totals include expenditures for Medicaid and Medicare-reimbursed services.

SOURCES: Office of the Legislative Auditor, analysis of Department of Human Services data and health plans' statements of revenue, expenses, and net income, 2000 and 2006.

Expansions of managed care, a new premium tax, and accounting changes contributed to growth in health plans' reported spending for health care administration.

Some people have questioned why health plans' total amount of administrative spending for the public programs increased in recent years. This spending growth partly reflects spending decisions by the health plans, and it partly reflects events outside the plans' control. Figure 4.2 illustrates recent trends in plans' administrative spending, and it notes several factors that may have affected aggregate spending. For example, in 2001 and 2003, the state expanded the use of managed care programs when two county-based purchasing entities—PrimeWest and South Country Health Alliance—began providing health care services in 19 counties. This meant that a portion of DHS's administrative costs for fee-for-service health care was shifted to the health plans.

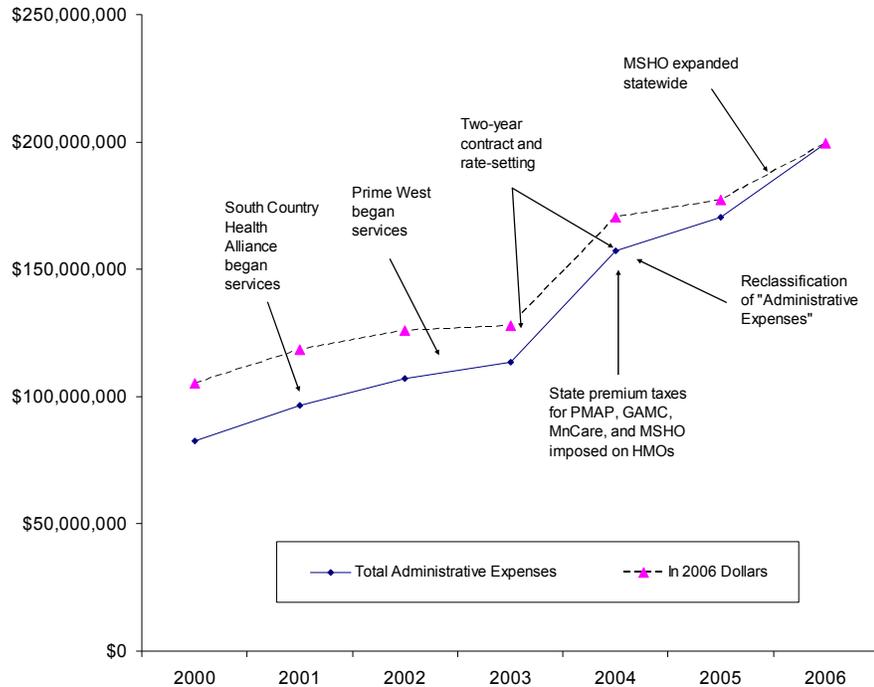
Also, starting in 2004, state law required health maintenance organizations (but not county-based purchasing plans) to pay a 1 percent premium tax on all state revenues from the four large programs.¹⁶ During that same year, health plans were also required to change how they report certain expenditures to the Department of Commerce—expenditure data that DHS uses to set capitation rates.¹⁷ The new requirements were imposed to ensure more consistency in health plans' reporting, and some expenditures previously coded as “medical expenses” were subsequently classified as “administrative expenses.”

Other factors may also have affected administrative spending levels. For 2003-04, DHS set capitation rates based on a two-year contract period (rather than the typical one-year period), and DHS staff said that this one-time approach may have resulted in higher than anticipated payments to health plans in the second year. Also, DHS and health plan staff told us that recent state and federal program requirements—such as “performance improvement projects” (to be discussed in Chapter 5)—probably contributed to increased spending. In

¹⁶ *Minnesota Laws* 2003 First Special Session, chapter 14, art.12, sec. 88-89.

¹⁷ State regulations require plans to report their revenues, expenses, and other finances in accordance with National Association of Insurance Commissioners (NAIC) accounting standards. When developing capitation rates, DHS combines the plans' reported “general administrative,” “cost containment,” and “claims adjustment” expenses to determine overall administrative costs. *General administrative expenses* include: rent; salaries, wages, and other benefits; commissions; legal expenses; accreditation fees; auditing, actuarial, and other consulting services; travel expenses; marketing and advertising; postage, printing, equipment, and office supplies; various depreciations and amortization; cost or depreciation of electronic data processing equipment and software; outsourced services; professional fees; insurance, except on real estate; collection and bank charges; group service and administration fees; reimbursements by uninsured plans and intermediaries; real estate expenses and taxes; state and local insurance taxes; state premium taxes; regulatory authority licenses and fees; payroll taxes; and investment expenses not included elsewhere. *Cost-containment expenses* are expenses that reduce the number of health services provided or the cost of such services. They include: case management activities; utilization reviews; fraud prevention and detection; network access fees and costs associated with network development or provider contracting; consumer education related to health improvement that directly relies on health personnel (such as smoking cessation and disease management programs); and expenses for appeals processes. *Claims adjustment expenses* may include: estimating and disbursing loss payments; general clerical and records maintenance; office maintenance, occupancy, utilities, and computer maintenance; supervisory and executive duties; and supplies.

Figure 4.2: Annual Growth in Health Plans' Administrative Expenses, 2000-06



NOTE: Analysis of health plans' administrative expenses includes state premium taxes and surcharges on health maintenance organizations. Totals include expenditures for Medicaid and Medicare-reimbursed services for the Minnesota Senior Health Options program. The line showing expenditures in 2006 dollars adjusted nominal spending using the Bureau of Economic Analysis' State and Local Government inflation index.

SOURCE: Office of the Legislative Auditor, analysis of health plans' statements of revenues, expenses, and net income for the Prepaid Medical Assistance Program, General Assistance Medical Care, MinnesotaCare, and Minnesota Senior Health Options program.

addition, large enrollment increases in the Minnesota Senior Health Options program in 2006 due to statewide expansion of the program may have contributed to administrative spending growth because MSHO requires more case management services than many of its enrollees previously received in the Minnesota Senior Care program.¹⁸

Although these factors might explain some of the increase in administrative costs, we think DHS should look for ways to better manage administrative expenses for publicly funded health care programs. In the next sections, we discuss two areas where the state could improve its activities for controlling the health plans' administrative costs: (1) reviewing health plans' administrative

¹⁸ Health plans include revenues and expenses for both Medicaid and Medicare-reimbursed services under the Minnesota Senior Health Options program as reported in their statements of revenues, expenses, and net income.

expenses for reasonableness, and (2) calculating payment rates for health plans' administrative costs.

STATE OVERSIGHT OF HEALTH PLANS' ADMINISTRATIVE SPENDING

Past studies have documented the potential for overpayments in publicly funded health care programs.¹⁹ To help ensure that purchasers of health care pay a reasonable price for services, state and federal policy encourages scrutiny of health plans' administrative spending.²⁰ For example, the federal Deficit Reduction Act of 2005 applies financial oversight principles used for Medicare programs to states' Medicaid programs.²¹ The Act outlines activities, such as reviewing health plans' administrative claims, which are intended to ensure that claims for payment are reasonable in their nature and amount and related to public programs. Some states have already adopted similar oversight practices, particularly when setting capitation rates.²² For our study, we examined the state's review of health plans' administrative expenditures and DHS's rate-setting methodology for calculating administrative payments in publicly funded health care programs.

Review of Administrative Claims for Payment

Rigorous oversight of Minnesota health plans' public program expenditures is important because (1) payments to health plans (even the portion for administrative activities) are among the state's largest payments to nonstate organizations, (2) many health plan expenditures occur within complicated organizational structures that combine for-profit and nonprofit enterprises, and (3) questions remain about whether certain expenditures constitute "medical" or "administrative" expenses. We found that:

- **Three state agencies (Health, Commerce, and Human Services) have authority to review health plan spending, but the depth of their reviews has been limited.**

State oversight of health plans' public program expenditures is important.

¹⁹ See, for example: U. S. Government Accountability Office (GAO), *Medicaid Financial Management: Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Efforts* (Washington, D.C., June 2006), 12-14; Victoria Wachino, *The New Medicaid Integrity Program: Issues and Challenges in Ensuring Program Integrity in Medicaid* (Washington, D.C.: Kaiser Commission, June 2007), 42-44.

²⁰ *Minnesota Statutes* 2007, 62D.19; *Minnesota Rules* 2007, 2730.0500-2730.0700; U.S. Office of Management and Budget *OMB Circular-133, Part 3, Compliance Requirements* (Washington, D.C., March 2007).

²¹ Pub. L. 109-171, sec. 6034. See also Center for Medicare and Medicaid Services, Center for Medicaid and State Operations Medicaid Integrity Group, *Comprehensive Medicaid Integrity Plans of the Medicaid Integrity Program FY 2006-2010* (Washington, D.C., July 2006).

²² For example, Maryland and New Jersey review health plans' administrative spending and disallow certain expenses when developing capitation rates. Michigan Association of Health Plans, *Best Practices in Medicaid Rate-Setting Process* (Lansing, MI, 2006), 3, 6.

In the sections below we discuss how each of these agencies reviews health plans' expenditures.

Department of Health

As the state's regulator of health maintenance organizations and county-based purchasing entities, the Department of Health has authority to review health plans' financial activities, including their costs of operation and spending practices.²³ Health plans also must undergo an annual independent audit and file the results with the department, along with quarterly and annual financial statements.²⁴ Health maintenance organizations found to be operating contrary to state financial requirements may have their licenses revoked or suspended by the department.²⁵

In recent years, the department has not retained in-house expertise to assess health plans' financial activities. Instead, the department contracts with the Department of Commerce for selected actuarial and financial services. Similar to its "financial examinations" of other health insurers, the Department of Commerce reviews the health plans' internal controls, financial solvency, and business relationships at least once every three years.²⁶ Following each examination, Commerce generates a public report and advises the Department of Health of any concerns regarding health plans' reporting, record-keeping, business relationships, or other practices. The Department of Health has final authority to take any subsequent regulatory actions against the health plans.

State law says that health plans cannot incur costs or enter into contracts that are "unreasonably high in relation to the value of the service or goods provided."²⁷ However,

- **State laws and rules give state agencies considerable latitude for determining how to evaluate the reasonableness of health plans' spending.**

A law passed in 1973 required the Department of Health to adopt rules to implement and enforce the prohibition on unreasonable expenses, but the department did not do so. Rules adopted by the Department of Commerce in

²³ *Minnesota Statutes* 2007, 62D.04 and 256B.692, subd. 2.

²⁴ *Minnesota Statutes* 2007, 60A.13, subd. 1; 60A.129, subd. 3; and 62D.08. Health maintenance organizations and county-based purchasing entities must file quarterly and annual reports detailing their expenditures, revenues, liabilities, assets, and solvency status with the Department of Health.

²⁵ *Minnesota Statutes* 2007, 62D.15. As we discuss in Chapter 5, county-based purchasing entities are not subject to suspension or revocation as they are not licensed by the department.

²⁶ *Minnesota Statutes* 2007, 62D.14 and 62D.24. Commerce conducts the examinations in accordance with standards established by the National Association of Insurance Commissioners (NAIC) and published in the NAIC *Financial Examiners Handbook*. Examinations of other health insurers must be conducted at least once every five years.

²⁷ *Minnesota Statutes* 2007, 62D.19. Also, *Minnesota Statutes* 2007, 62D.03, subd. 4(g), requires the Commissioner of Health to disapprove any health plan contract with a major participating entity if the contract will result in an unreasonable expense under *Minnesota Statutes* 2007, 62D.19.

State law prohibits health plans from incurring "unreasonable" expenses.

The Department of Health relies largely on the Department of Commerce to assess health plans' financial activities.

1984 (and still in effect today) require either the Department of Health or Department of Commerce to review the reasonableness of health maintenance organization expenditures every three years, and they set forth general guidelines for doing so.²⁸

Department of Health staff advised us that they do not have the expertise to assess plans' spending and they rely on the Department of Commerce staff to identify unreasonable expenditures when conducting their financial examinations of the health plans. However, the Department of Health's inter-agency agreement with the Department of Commerce does not specifically require Commerce to assess reasonableness (and, as we discuss below, Commerce has not conducted detailed reviews of the reasonableness of health plan administrative expenditures). Department of Health staff also said they have not assessed health plans' administrative spending for the public programs because this falls within the purview of the Department of Human Services (as the state's purchaser of publicly funded health care).

The Department of Health requires all health plans that do business in Minnesota to report information about their medical and "indirect" costs, including administrative costs. The information is annually reported in the Health Plan Financial and Statistical Report (HPFSR).²⁹ The department uses these data for general research purposes and to assess overall trends in health care costs in Minnesota, but it does not analyze in detail individual plans' administrative costs or payment arrangements with service providers.

The HPFSR data are of limited value for assessing health plans' administrative spending for public programs. The health plans are not required to break out their detailed reporting of administrative costs by their public and commercial business lines. Also, the data are not subject to independent audit requirements, although Department of Health staff told us they review the data for completeness and consistency in reporting.³⁰ However, the department did not collect this information for several years from two of the nine plans that administer publicly funded health care programs.³¹

²⁸ *Minnesota Rules* 2007, 2730.0500 requires the departments to consider "to the extent possible" the following when determining whether expenditures are unreasonable: (1) expenses incurred by other health plans and health care delivery systems for similar services or goods; (2) the cost of the services or goods to the supplier; (3) the impact of the expenses upon the organization's financial solvency; (4) cost or service data obtained by the Commissioner of Health from the health plan; (5) guidelines established for medical review organizations; (6) data from rating organizations; (7) information regarding the real cost or fair market value of the services or goods; or (8) whether the officers and trustees of the health plan acted with good faith and in the best interest of the plan.

²⁹ The HPFSR reports are required by *Minnesota Statutes* 2007, 62J.38.

³⁰ *Minnesota Rules* 2007, 4652.0120 requires health plans to certify that their reported revenue and expenses are calculated on a consistent basis with their audited financial statements, and they must provide a description of the methods used to determine the reported data. However, because of differences in reporting definitions, the department is unable to compare the HPFSR data to health plans' annual financial reports.

³¹ The Department of Human Services does not use the HPFSR data for calculating capitation payment rates; it relies on health plans' annual financial statements reported to the departments of Commerce and Health.

The Department of Commerce reviews the “reasonableness” of health plan expenditures only at a broad, aggregate level.

Department of Commerce

The Department of Commerce is the state’s lead agency for overseeing health insurers’ financial stability and protecting consumers’ investments in health insurance. Since 2000, the Department of Commerce has conducted financial examinations of health maintenance organizations and county-based purchasing entities. These examinations focus on key risk areas concerning operational, accounting, and recordkeeping systems, as well as financial procedures and internal controls—areas important for ensuring the financial viability of the health plans. Staff also review industry reports of administrative expense trends, compare individual plans’ spending trends to industry standards, and analyze spending trends within plans to check for anomalies.

However, there are some important limitations to the Department of Commerce’s reviews (and other reviews that the department relies on)—particularly as they relate to the “reasonableness” of health plans’ expenditures. First, the department does not assess the reasonableness of spending in detail. As noted earlier, state rules require either the Department of Health or Department of Commerce to review the reasonableness of health maintenance organization expenditures at least every three years.³² But Department of Commerce officials told us that they review health plan expenditures only at a very broad level—for example, the department might look for unusually large changes in a plan’s overall spending over time. They said they do not have the resources to conduct detailed reviews of expenditures, and they said there are no clear state standards for determining what constitutes an unreasonable expenditure. Commerce officials also said their main responsibility is to assess the overall financial viability of health plans, and they generally do not examine spending within individual programs (such as the publicly financed health care programs administered by health plans).³³

Second, the health plans must ensure that independent auditors review their annual financial reports and filings, but these audits are limited in scope. For example, independent auditors determine whether health plans have correctly coded their expenditures for purposes of reporting them in the plans’ annual financial statements, but they do not review the reasonableness of administrative or medical expenses. In fact, some auditors caution that their examinations do not include a review of the effectiveness of plans’ internal controls to identify errors and fraud in a timely manner.³⁴

Third, the departments of Commerce and Health review some aspects of health plans’ subcontracts for services, but neither reviews the reasonableness of subcontractor expenditures. Rather, the Department of Commerce reviews the

³² *Minnesota Rules* 2007, 2730.0500-2730.0700. These rules were developed by the Department of Commerce.

³³ The Department of Commerce assesses reported costs (administrative and medical) mainly to ensure that health plans’ accounting and financial reporting systems are functioning correctly.

³⁴ Department of Commerce staff told us they do not specifically review the independent auditors’ workpapers pertaining to health plans’ administrative expenses for the public programs.

legality of health plans' relationships with subcontractors as part of its financial examinations, and the Department of Health reviews health plans' *procedures* for overseeing contracted services as part of its quality assurance examinations.

Department of Human Services

The Department of Human Services also has responsibility for reviewing health plans' expenses, particularly to the degree that these expenses relate to the development of capitation payment rates for the state's publicly funded health care programs.³⁵ The department can do this in several ways, such as: (1) conducting annual (or other periodic) claims-level audits or examinations of administrative and medical claims, (2) comparing patient "encounter" data to medical records, or (3) reviewing samples of plans' submitted data prior to calculating capitation rates.³⁶ We found that:

- **The Department of Human Services conducts claims-level audits of public program medical claims for payment, but it does not audit health plans' administrative expenses.**

DHS does not collect detailed information on health plans' administrative costs for public programs.

The state's contracts with health plans require the plans to disclose their financial and management service arrangements. The contracts also require plans to maintain and make available records for audit, inspection, examination, and research as specifically authorized by the state in fulfillment of state or federal requirements.³⁷ However, DHS does not request detailed information on administrative spending, such as itemized lists of costs for claims processing and provider network management. And, as we noted in Chapter 3, the department has little knowledge about the nature and amount of health plans' contracts with providers and third-party administrators. DHS staff told us they prefer to focus on reviewing medical claims, given that these represent the vast majority of program costs.

³⁵ Federal Medicaid regulations require states to ensure that only administrative expenses directly related to the provision of Medicaid State Plan-approved services to eligible members are built into capitation rates. See 42 *CFR* sec. 438.6(c)(4)(ii)(A) (2007). Other federal standards require that claims and payments for public programs are (1) based on actual costs and are net of all applicable credits, (2) reasonable in their nature and amount, and related to public programs, and (3) appropriately classified—for example, distinguishing "administrative" from other expenses. See for example U.S. Office of Management and Budget (OMB), *OMB Circular A-133, Compliance Supplement, Part 3, Compliance Requirements* (Washington, D.C., March 2007), 46-52.

³⁶ Health Care Financing Administration, *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care* (Washington, D.C., October 2000), 35-45. Administrative claims include health plans' and their subcontractors' costs. Auditing medical claims to ensure appropriate coding of all services is important because (1) health plans will appear to have lower administrative cost ratios if administrative costs are improperly coded as medical costs, and (2) medical costs are typically assigned a higher increase—or "trend rate"—when setting capitation rates. DHS has conducted chart reviews of patients' medical care in the past.

³⁷ For example, see standard Prepaid Medical Assistance Program, MinnesotaCare, and General Assistance Medical Care 2006 contract, Article 19, "Disclosure," and standard Minnesota Senior Health Options 2006 contract, sec. 9.5.6.

Current state rules do not ensure consistency in the way health plans allocate expenses among public programs or their other lines of business.

In addition,

- **Federal regulations require that Medicaid capitation payment rates for health plans' administrative services be directly related to Medicaid services, but the Department of Human Services has not taken sufficient steps to ensure that this is the case.**

Currently, there are no DHS requirements for how the plans must allocate expenses across the various public programs they administer.³⁸ Also, state rules do not adequately address how plans must allocate administrative expenses among their public and commercial lines of business.³⁹ Health plans must file annual "supplemental" reports that summarize key financial information about their business lines, but neither the departments of Commerce nor Health reviews these supplemental reports for accuracy or completeness.⁴⁰ This lack of guidance and scrutiny is an important issue because these annual reports are the primary source of information on health plans' administrative expenses that DHS uses when setting capitation payment rates.

We think DHS needs to obtain more detailed information to understand the cost of health plans' administrative services. For example, the Minnesota Department of Employee Relations requires the health plans with which it contracts for state employees' health care to report administrative costs by service category. The state self-insures for public employees' health care, which involves more direct purchasing of administrative services such as claims processing, provider network rental, and utilization review services. The Department of Employee Relations pays health plans a fixed per-member-per-month fee for administration, but it retains the burden (and risk) for members' medical claims. Department staff told us that this payment arrangement allows for more transparency in the costs of services, particularly when negotiating increases in administrative rates. We do not advocate that the state self-insure for the publicly funded health care programs for lower-income Minnesotans, but we think that the state should do more to assess the reasonableness of health plans' administrative spending and how they allocate their costs for the public programs.

³⁸ 42 *CFR* sec. 438.6(c), specifies that Medicaid capitation rates be based only upon services covered under the state's Medicaid plan (or costs directly related to providing those services). These requirements do not apply to General Assistance Medical Care or MinnesotaCare (non-Medical Assistance) services.

³⁹ Department of Health rules prescribe that health plans follow National Association of Insurance Commissioners' accounting practices and procedures when completing their financial statements. The NAIC provides general guidelines for apportioning administrative expenses among a health plan's lines of business, but it gives the plan considerable discretion to select a specific method.

⁴⁰ Specifically, see Minnesota Supplemental Report #1, Statement of Revenue, Expenses, and Net Income. These reports disaggregate financial information contained in the health plans' annual statements. Health plans often allocate their administrative expenses across public programs (and other business lines) based on programs' percentage of total premiums or health care expenses. Department of Commerce staff were unable to verify for us whether these documents were prepared or reviewed by independent auditors.

Administrative Rate Setting

In Chapter 3 we noted that actuarial experts suggest Medicaid capitation rates are actuarially sound if they “provide for all reasonable, appropriate, and attainable costs” of a program.⁴¹ As part of our review of DHS’s capitation rate-setting process, we looked at the department’s general methodology for determining payments for health plans’ administrative services.⁴² We observed that:

- **DHS’s managed care rate-setting process has not adequately reviewed and controlled health plan administrative costs.**

First, as noted in the previous section, DHS conducts limited reviews of actual health plan administrative spending, either prior to or subsequent to setting capitation payment rates. It does not review the reasonableness of actual expenditures, and it relies mostly on others (mainly the Department of Commerce and health plans’ auditors) to verify the integrity of the data.⁴³ DHS hires an actuarial consultant to assist with financial analysis, but the actuary looks for consistency in data trends and specifically excludes “a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent.”⁴⁴

Second, DHS does not specifically limit the amount of health plans’ administrative spending, either overall or for specific cost categories. Health plans may use their capitation dollars for any combination of administrative or medical services, without regard to the spending assumptions that were used to compute the payments. When calculating future capitation payments, DHS’s rate-setting methodology assumes that administrative spending should grow at a slower rate than spending for medical care.⁴⁵ To compute 2007 capitation rates, DHS assumed separate growth rates for administrative expenses (a 3 percent increase) and medical care costs (a 7.62 percent increase), which were then combined into a single rate (a 7.23 percent increase). In spite of these increases, over the past three year period (2004-06), health plans spent an estimated \$49 million more for administrative activities than what DHS presumed they would

Health plans spent more for administration in recent years than DHS’s rate-setting process assumed they would spend.

⁴¹ Medicaid Rate Certification Work Group of the American Academy of Actuaries, *Health Practice Council Practice Note: Actuarial Certification of Rates for Medicaid Managed Care Programs* (Washington, D.C.: American Academy of Actuaries, August 2005), 8.

⁴² The department primarily uses data from (1) the plans’ annual statements and statements of revenue, expenses, and net income, (2) restated claims data obtained directly from the plans, and (3) plans’ encounter data. We did not perform an in-depth critique of the department’s forecasting and trend analyses.

⁴³ DHS relies on the Department of Commerce to verify the integrity of health plans’ financial statements, and it relies on the health plans’ actuaries to assert whether claims data are reported in accordance with industry accounting standards.

⁴⁴ Milliman Consultants and Actuaries, letter to R. Jason Wiley, DHS, *Trend & Surplus Adjustments for 2007 Payment Rates*, November 30, 2006.

⁴⁵ The rate increase for administrative expenses is determined through the contract negotiation process (unlike the medical expense increase, which is mostly determined through data analyses). In recent years, the administrative rate increases were: 4 percent (2003), 4 percent (2004), 2 percent (2005), 2 percent (2006), 3 percent (2007), and 3 percent (2008).

spend when setting their capitation rates.⁴⁶ Possible reasons for the discrepancy between projected and actual administrative spending could include unexpected shifts in enrollment or member needs, new program requirements, deficiencies in the capitation rate-setting process, or how health plans' have allocated their expenses among various activities and programs for rate-setting purposes. Still, DHS's contracts do not include specific penalties or incentives to encourage health plans to keep their administrative spending within the amounts presumed by DHS for rate-setting purposes.

Finally, DHS's rate-setting approach factors all types of health plans' administrative expenditures—including one-time or sporadic expenditures—into the subsequent year's capitation payments. For example, charitable contributions—such as grants to other organizations in support of public purposes—are allowable administrative expenses, and they often fluctuate from year to year. DHS does not make after-the-fact adjustments in health plans' capitation payments if the plans do not spend money for charitable contributions.⁴⁷

DISCUSSION

DHS and the health plans assert that the capitated payment system for publicly funded health care programs provides sufficient incentive to control administrative spending. But, in our view, there is a need for additional scrutiny of the administrative portion of health plans' expenditures for public programs. This is because (1) this component of health plan spending involves large public expenditures (\$200 million annually), (2) unlike expenditures for medical services, administrative expenditures have been subject to little state review, (3) there are few restrictions on health plans' administrative spending, and (4) in recent years, health plans' reported administrative spending for public programs has grown, sometimes exceeding the amounts DHS presumed in the capitation rate-setting process that the health plans would spend for administrative purposes. Although the health plans' reported aggregate administrative spending as a percentage of total spending for public programs does not appear to be higher than that reported in other states, state agencies should take stronger steps to ensure that these expenditures are accurately, consistently reported. In addition, the state should scrutinize the reasonableness of these expenditures in greater detail.

First, we think that DHS needs to obtain better information about the nature and amount of health plans' administrative spending. DHS uses medical expense data from a variety of sources to set capitation payments, but it relies exclusively on the health plans' administrative financial data reported in their annual supplemental reports to the Department of Commerce. Health plans' administrative expenses specific to public programs are not itemized in these

DHS needs better information about the nature and amount of health plans' administrative spending.

⁴⁶ Based on DHS's estimated administrative trends and health plans' reported expenditures for the Prepaid Medical Assistance Program, General Assistance Medical Care, and MinnesotaCare.

⁴⁷ Also, DHS does not review the nature or outcome of health plans' grants and contributions to ensure that they are fulfilling public purposes.

statements, and questions remain about how health plans allocate their costs and investment income across business lines. Health plans report more detailed expense data to the Department of Health for the Health Plan Financial and Statistical Report (HPFSR), but these data do not distinguish administrative expenditures for public programs from those for commercial business, and the data are not audited for accuracy.⁴⁸ DHS should either require health plans to report more detailed data on administrative spending or use data from the HPFSR (or expenses for certain of its categories) with improved review of the data.

RECOMMENDATIONS

The Department of Human Services should require more detailed reporting by health plans of their administrative spending for the state’s public programs.

The Department of Health should develop guidelines to ensure that health plans have consistent procedures for allocating administrative expenses and investment income across their lines of business (commercial and public) and across individual public programs.

The Legislature should direct the departments of Health and Commerce to develop more detailed standards and procedures for assessing the reasonableness of health plan expenditures.

In addition to improved reporting, we think that there is a need for greater state review of health plans’ administrative spending for public programs. DHS is the state’s purchaser of publicly funded health care, so we think it should periodically examine selected administrative expenditures for public programs in some detail. In addition, the Legislature should require more detailed reviews of the “reasonableness” of health plans’ public spending by the departments of Commerce and Health. In practice, these agencies fulfill their current regulatory duties to review reasonableness by examining *aggregate* expenditures, rather than through detailed examinations of individual programs or functional areas. It is doubtful that Commerce and Health would initiate more detailed reviews without legislative directives, clearer standards, and perhaps more resources.

RECOMMENDATIONS

The Department of Human Services should increase its scrutiny of health plans’ administrative expenses, particularly during the rate-setting process.

The Legislature should require the departments of Health and Commerce to establish more detailed standards and procedures for examining the “reasonableness” of health plans’ administrative expenditures for publicly funded programs.

In addition, DHS should better define which administrative expenditures to include in the “base rate” when calculating capitation payments for public

⁴⁸ These reports are required by [Minnesota Statutes](#) 2007, 62J.38.

DHS should more closely scrutinize health plans' expenditures of public funds for charitable purposes.

programs.⁴⁹ Certain expenses are directly related to state and federal requirements for the public programs, while others (such as charitable contributions) are more discretionary. Currently, DHS incorporates all types of administrative expenditures into the spending base for the next year when setting capitation payments. In our view, DHS should (1) specifically include or exclude certain expenses when calculating health plans' future administrative expenses in the rate-setting process, and (2) increase its oversight of health plans' one-time expenses pertaining to charitable contributions (when using public dollars). If the department chooses to reimburse plans for charitable donations, the department should ensure that these expenditures are related to the purposes of the state's publicly funded health care programs.

RECOMMENDATION

DHS should clearly define which types of health plan administrative expenses are allowed for purposes of calculating future capitation payments.

Furthermore, DHS does not currently impose limits on health plans' administrative expenses for the public programs, and it should consider options for exercising greater control of these expenditures. We discuss in Chapter 5 how DHS incorporated more incentives into its 2007 contracts that directly tied health plans' administrative spending to new program initiatives, and this is a good start for controlling health plan spending. But DHS incorporates annual rate increases for health plans' administrative expenses when setting future capitation rates, and it does so with few restrictions on the nature and amount of the plans' current expenditures. Also, health plans' spending has sometimes exceeded the administrative portion of their capitation payments. Some states control administrative spending by paying health plans a fixed-rate administrative payment per member per month, supplemented by an additional, variable amount for certain activities.⁵⁰ This method generally recognizes that certain administrative expenses depend on the amount of medical services provided while others do not. Another option would be to place a ceiling on administrative costs, as one recent federal review of Medicare services recommended as part of the federal government's contracting process.⁵¹

⁴⁹ For example, Medicaid Rate Certification Work Group of the American Academy of Actuaries, *Health Practice Council Practice Note*, 20, says states should document that their Medicaid capitation rates only pay for services to Medicaid enrollees.

⁵⁰ Michigan Association of Health Plans, "Best Practice in Medicaid Rate-Setting Process," 7; Mercer, *California Department of Health Services, Capitation Rate Development Process and Reimbursement Structure Review* (Phoenix, AZ, September 2006), 12-13.

⁵¹ U.S. Department of Health and Human Services, Office of Inspector General, *Review of the Administrative Cost Component of the Adjusted Community Rate Proposal at Nine Medicare Managed Care Organizations for the 1997 Contract Year* (Washington, D.C., January 2000), 12-13.

RECOMMENDATION

DHS should modify its rate-setting methodology to (1) include stricter limits on health plans' administrative spending, or (2) more closely align annual rate increases with actual administrative costs for the public programs.

Finally, there may be opportunities for state agencies to streamline some requirements that have contributed to rising administrative costs. We did not examine health plans' costs of complying with individual federal and state administrative requirements. However, one area that is a particular concern for many health plans is the process they follow for credentialing health care providers. State rules require each health plan to demonstrate to the Department of Health that the providers it uses have appropriate credentials.⁵² But, because providers often contract with multiple health plans, there is considerable duplication in the health plans' credentialing practices.⁵³

RECOMMENDATION

The Department of Health should investigate more cost-effective ways to ensure that health plans are using appropriately-credentialed providers.

⁵² *Minnesota Rules* 2007, 4685,1110, subp. 11.

⁵³ One small health plan told us that it hired two staff to help it document the credentials of more than 1,000 medical staff at a clinic, even though (1) the plan was only interested in using the services of a single physician at that clinic and (2) the credentials of staff at this clinic had probably already been documented by at least one other health plan.

Health Care Quality and Outcomes

SUMMARY

Minnesota's public managed care programs are subject to many federal and state quality assurance requirements. In contrast, there has been minimal state oversight of quality and outcomes in fee-for-service care, and there is less recourse for fee-for-service enrollees who encounter service problems. Overall, Minnesota health plans have performed fairly well on measures of service quality, although there is room for improvement. State efforts to link health plans' payments to performance have been worthwhile, but the performance targets have not always challenged health plans to improve over time.

Good financial management of health care programs requires getting good value for the money spent. Thus, we examined how the state monitors service quality and what existing evidence shows. This chapter addresses the following questions:

- **What does existing performance information indicate about the quality of health care services provided to people enrolled in Minnesota's public programs?**
- **Has the state's use of performance-related financial incentives been a useful approach for improving health plans' performance?**
- **Is there adequate opportunity for enrollees in fee-for-service and managed care to seek recourse when problems arise?**

QUALITY ASSURANCE IN MANAGED CARE PROGRAMS

Federal Medicaid regulations require states to have written strategies for assessing and improving the quality of their managed care services. States must arrange for annual, independent reviews of service outcomes, timeliness, and access. States must also set quality assurance standards in their contracts with managed care organizations and monitor compliance.¹

In addition to requirements for state-level quality assurance, federal and state regulations require managed care organizations that administer publicly funded health care programs to measure and improve the quality of their services. For example, each managed care organization must measure its performance, conduct

¹ 42 CFR sec. 438.202, 438.204 (2007).

performance improvement projects, and have mechanisms to detect underutilization and overutilization of health care.² Also, each managed care organization must develop a written quality assurance plan and an annual evaluation of quality assurance, and it must have a system to deal with enrollee complaints about the quality of care.³ In addition, DHS's contracts with managed care organizations contain some quality assurance provisions that are not required by federal or state regulations—for example, requiring these organizations to cooperate with annual enrollee satisfaction surveys.

Performance Measures

One way to assess health care programs is to look at quantitative measures of the care delivered to customers. Nationally, there is widespread acceptance of the outcome measures that comprise the Healthcare Effectiveness Data and Information Set (HEDIS), developed by the National Committee for Quality Assurance.⁴ HEDIS consists of 71 measures related to a variety of medical conditions and procedures.

The Minnesota Department of Health posts each year's HEDIS data from managed care organizations on its website. We examined 20 HEDIS measures that the department analyzes and found that:

- **On widely-used measures of service quality in public programs, Minnesota's health plans tended to perform somewhat better than the national averages among health plans.**

On 13 of 20 measures, most Minnesota health plans' performance levels exceeded the national averages.

Table 5.1 summarizes Minnesota's performance on these 20 measures for 2006. In all six measures of diabetes care, a majority of Minnesota's plans had performance levels that exceeded the national averages. Likewise, a majority of Minnesota plans exceeded national averages on two of three measures related to the treatment of depression. In three other areas—preventive screenings given to women, immunizations given to children and adolescents, and preventive visits to a physician received by children and adolescents—Minnesota's plans were less likely to have performance levels above the national averages. Overall, on 13 of the 20 measures reported by the Department of Health, a majority of Minnesota's 9 health plans had performance levels that exceeded the national averages.

² 42 CFR sec. 438.240 (2007).

³ *Minnesota Statutes* 2007, 62D.04, subd. 1, and 62D.11; *Minnesota Rules* 2007, 4685.1110, subp. 1, and 7-9.

⁴ The National Committee for Quality Assurance is a private organization whose purpose is to improve health care quality. It is the main accrediting organization of managed care organizations nationwide.

Table 5.1: Performance of Health Plans on Selected Performance Measures for Public Enrollees, 2006

| HEDIS Measure | National Medicaid Average: Percentage of Enrollees Meeting the HEDIS Standard ^a | Number of Minnesota Plans with Performance for Public Enrollees Above National Average (N=9) |
|---|--|--|
| Antidepressant Medication Management | | |
| • Received optimal care after new diagnosis | 21.3% | 3 |
| • Remained on medications during 12-week acute phase | 42.9 | 7 |
| • Remained on medications for 6 months | 27.5 | 6 |
| Asthma Management | | |
| • Use of appropriate medications for people with asthma (total) | 87.1 | 6 |
| Comprehensive Diabetes Care | | |
| • Received Hemoglobin A1c (HbA1c) testing | 78.0 | 9 |
| • Received eye exams | 51.4 | 8 |
| • Cholesterol level (LDL-C) controlled to less than 100 mg/dL | 30.6 | 7 |
| • Received serum cholesterol level (LDL-C) screening | 71.1 | 6 |
| • Received medical attention for kidney disease (nephropathy) | 74.6 | 8 |
| • Poorly controlled Hemoglobin A1c | 48.7 | 9 ^b |
| Immunization Status | | |
| • Received childhood vaccinations | 73.3 | 8 |
| • Received adolescent vaccinations | 50.9 | 3 |
| Use of Children's Services | | |
| • Received 6 or more wellness visits in the first 15 months of life | 55.6 | 5 |
| • Received wellness visits in the third, fourth, fifth, and sixth years of life | 66.8 | 3 |
| • Received adolescent wellness visits | 43.7 | 2 |
| Women's Health | | |
| • Received breast cancer screening | 49.1 | 7 |
| • Received cervical cancer screening | 65.7 | 7 |
| • Received chlamydia screening, 16-20 years | 50.5 | 2 |
| • Received chlamydia screening, 21-25 years | 55.0 | 2 |
| • Received chlamydia screening (total) | 52.4 | 2 |

^a Percentages were computed using the population of enrollees for whom the measure is appropriate. For example, the diabetes-related measures are based on the population of diabetics enrolled in health plans.

^b For this measure, lower rates indicate better performance. All nine Minnesota plans scored below the national average on this measure.

SOURCES: National Committee on Quality Assurance, 2007 "Quality Compass" database (for the year 2006); Office of the Legislative Auditor, analysis of Department of Health 2006 HEDIS data.

The departments of Human Services and Health have both publicly reported data on health plans' performance. However,

- **The departments of Human Services and Health rely on different methods to analyze health plan performance, which contributes to confusion about the plans' performance levels.**

DHS's method of assessing health plan performance is not sufficiently accurate for some measures.

DHS's approach to measuring performance is based entirely on data that health plans submit to claim reimbursement for each health care procedure performed. In contrast, performance information reported by the Department of Health relies on these same data as a base, but some measures also incorporate data collected from medical record reviews of randomly selected individuals. For example, data submitted for claims purposes might show no record of a child's immunization, yet the medical record may indicate that the child was, in fact, immunized.⁵ The National Committee for Quality Assurance allows each health plan to choose which method it uses to report performance data, but an approach based on a combination of claims data and medical records—often called a “hybrid” method—tends to show higher performance levels than a method based solely on claims data (because it reveals some events that the claims data do not record).⁶ In general, experts told us that a hybrid method is more accurate than an approach that relies entirely on claims data.⁷

While the Department of Health collects performance data directly from the health plans, DHS calculates its own performance measures. DHS officials told us that calculating its own measures allows the agency to meet the federal Medicaid requirement that performance measures be validated by someone who is financially independent from the health plan. Also, DHS prefers to calculate the data to ensure its consistency over time—for example, the performance data sometimes affect the size of DHS's capitation payments to the plans (discussed later in this chapter).⁸ But the HEDIS data that the Department of Health collects from the plans are validated as well, by private audit firms certified by the National Committee on Quality Assurance. Most states assure independence by paying for these audits, sometimes as part of the federally-required external review process.

⁵ For medical procedures where payment is minimal, like immunizations, providers may not file a claim with the health plan.

⁶ Eve A. Kerr, Dylan M. Smith, Mary M. Hogan, Sarah L. Krein, Leonard Pogach, Timothy P. Hofer, and Rodney A. Hayward, “Comparing Clinical Automated, Medical Record and Hybrid Data Sources for Diabetes Quality Measures,” *Journal on Quality Improvement* 28, no. 1 (October 2002): 555-565.

⁷ A recent article states that a method based on “administrative-only” (claims) data, like that used by DHS, results in “substantial underestimation and instability” of performance rates and health plan rankings. See L. Gregory Pawlson, Sarah Hudson Scholle, and Anne Powers, “Comparison of Administrative-Only Versus Administrative Plus Chart Review Data for Reporting HEDIS Hybrid Measures,” *The American Journal of Managed Care* (October 2007): 553-558.

⁸ A 2006 report cites five other states that, like Minnesota, comply with federal requirements to assess health plan performance by using *state-calculated* data rather than relying on *health plan-calculated* data (as validated by audit firms)—see MetaStar, *2005 Performance Measures Project Report* (St. Paul: Minnesota Department of Human Services, December 2006).

More agreement on how to measure health plan performance is needed.

In our view, it is confusing to have two state agencies that separately report on health plan performance using different approaches. Getting agreement between DHS and the Department of Health on the best way to measure and publicly report health plan performance would help to focus discussion on the existing level of performance (and how to improve it), rather than on how to interpret the different measures.⁹ In general, we favor a method that incorporates medical records (where appropriate) with claims data—because it is more accurate than relying solely on claims data.

RECOMMENDATION

The departments of Human Services and Health should agree on a single way to compute and publicly report health care performance measures.

Finally, on the topic of performance measurement, it is worth noting that two of Minnesota's nine health plans that administer publicly funded programs have been accredited by the National Committee on Quality Assurance.¹⁰ This organization evaluates health plans seeking accreditation based on their clinical performance, member satisfaction, and administrative structures and processes. About 53 percent of Minnesota's public program enrollees are served by these nationally-accredited health plans. However, obtaining accreditation is expensive, and most of Minnesota's plans have not pursued it.

Enrollee Satisfaction

Indicators of enrollee satisfaction provide a unique perspective—the consumer's—about whether health plans have provided appropriate, timely services. We examined two measures of enrollee satisfaction with Minnesota's publicly funded health care programs: (1) the results of enrollee surveys and (2) the extent to which enrollees have changed from one health plan to another.

Just as HEDIS measures provide a nationally accepted approach for measuring performance outcomes, the survey instrument known as the Consumer Assessment of Healthcare Providers and Systems (CAHPS), funded and administered by the U.S. Agency for Healthcare Research and Quality, provides a widely accepted approach for measuring consumer satisfaction with health care. For quality improvement purposes, DHS contracts for an annual CAHPS survey of its public program enrollees. We found that:

⁹ The performance of Minnesota health plans differs on some measures, depending on the method used. For example, using Department of Health data, all nine plans that administer public programs in Minnesota ranked above the national Medicaid average in 2006 for hemoglobin A1c testing (for diabetes). Using Department of Human Services data, however, only four plans ranked above the national average for this measure.

¹⁰ A third plan that administers public programs is accredited, but only for its commercial programs.

- **Minnesota surveys have often indicated high overall levels of enrollee satisfaction with health plans and services, while also identifying some areas needing improvement.**

Table 5.2 shows Minnesota enrollees' overall ratings in a variety of health care areas in 2006. For comparison purposes, the table also shows the comparable national results from surveys of adult Medicaid enrollees. The Minnesota surveys typically showed more satisfaction among enrollees in the state's programs for seniors than among enrollees in Medical Assistance and MinnesotaCare. Enrollees in all Minnesota programs expressed less satisfaction with waiting times for health care appointments than did Medicaid enrollees

Table 5.2: Selected Results from Health Plan Enrollee Satisfaction Surveys, 2006

| Percentage of Enrollees Who: | Percentage of Health Plan Enrollees Who Expressed High Satisfaction | | | | |
|--|---|------------------------------|----------------|-----------------------|---------------------------------|
| | National-Medicaid Enrollees | Minnesota-Medical Assistance | Minnesota-Care | Minnesota Senior Care | Minnesota Senior Health Options |
| Gave ratings of 9 or 10 (the highest ratings) to: | | | | | |
| • Their health plan | 53 | 51 | 44 | 57 | 67 |
| • Their health care | 55 | 53 | 59 | 65 | 62 |
| • Their doctor or nurse | 59 | 62 | 56 | 67 | 72 |
| • Their specialist | 59 | 53 | 51 | 62 | 60 |
| Said they always: | | | | | |
| • Have doctors who communicate well | 62 | 58 | 63 | 64 | 65 |
| • Get care without long waits | 45 | 35 | 39 | 40 | 41 |
| • Have courteous, respectful, and helpful office staff | 67 | 65 | 72 | 72 | 75 |
| Said they have "no problem" with: | | | | | |
| • Health plan customer service | 69 | 70 | 62 | 54 | 69 |
| • Getting care that is needed | 67 | 71 | 77 | 65 | 71 |
| Gave ratings of 9 or 10 (the highest ratings) to: | | | | | |
| • Treatment or counseling | NA ^a | 52 | 48 | 50 | 44 |

NOTE: Highlighted cells are state percentages that fall below national percentages.

^a "NA" indicates that a national average was not available.

SOURCES: National CAHPS® Benchmarking Database, *What Consumers Say About the Quality of Their Health Plans and Medical Care, 2006 CAHPS Health Plan Chartbook* (September 2006); Minnesota Department of Human Services, *2006 Managed Care Public Programs Consumer Satisfaction Survey Results* (September 2006).

nationally.¹¹ Previous reviews of Minnesota's publicly funded health care programs have identified health plan customer service and counseling or treatment services as areas with room for improvement, based on enrollee surveys.¹²

Another measure of enrollee satisfaction is the rate at which enrollees voluntarily change from one plan to another. For example, enrollees may change plans because of dissatisfaction with the services they are receiving or a desire to change their health care providers. DHS's goal has been to have less than 5 percent of enrollees statewide changing programs in a given year. DHS's most recent published report on enrollee turnover showed that:

- **Statewide, relatively small percentages of enrollees changed from one health plan to another in 2005.**

During 2005, about 0.9 percent of Medical Assistance managed care enrollees and 1.5 percent of MinnesotaCare enrollees changed plans voluntarily. One health plan had an 8 percent turnover rate among its MinnesotaCare enrollees, but the rates of other plans with at least 1,000 enrollees were all below DHS's 5 percent threshold.¹³

Compliance with Laws and Contracts

A key part of the state's efforts to ensure quality health care is to monitor health plans' compliance with legal requirements. The Department of Health is responsible for ensuring compliance with statutes and rules, and DHS is responsible for ensuring compliance with state contracts. We found that:

- **State quality assurance reviews have frequently identified instances in which health plans are noncompliant with legal requirements, although the extent to which these problems have directly affected health outcomes is unclear.**

State officials with the departments of Human Services and Health told us that health plan compliance with regulatory requirements is a critical measure of quality assurance. On the other hand, some health plan officials expressed concern that the departments' standards for evaluating compliance have not always been as clear as they would prefer.

The departments of Health and Human Services monitor health plan compliance with legal requirements.

¹¹ The CAHPS survey uses several questions to assess enrollee satisfaction with "waiting time," including questions regarding how soon the enrollee is able to schedule routine or urgent appointments, whether the enrollee waits more than 15 minutes past the scheduled appointment time to see a health care provider, and whether the health plan offers helpful phone advice.

¹² Michigan Peer Review Organization (MPRO), *2004 Annual Technical Report* (St. Paul, Minnesota Department of Human Services, September 2005), 20, and MPRO, *2005 Annual Technical Report* (St. Paul: Minnesota Department of Human Services, February 2007), 38.

¹³ DHS, *CY 2005 PMAP and MinnesotaCare Voluntary Changes in MCO Enrollment Report* (St. Paul, May 2006).

The Department of Health levied penalties against health plans totaling \$200,000 over the last five years.

Department of Health Quality Assurance Reviews

At least once every three years, the Department of Health reviews whether each health plan is in compliance with state regulatory requirements. If the department discovers problems, it requires the plan to submit a “corrective action plan” and subsequently follows up to ensure that the problems were corrected. From 1995 to 2005, the department’s quality assurance reviews of individual health plans identified an average of 4.5 “deficiencies” per review and made an average of 6.5 recommendations for changes per review. By state law, the Department of Health may levy administrative penalties up to \$25,000 for each violation.¹⁴ In the past five years, the Department of Health has issued administrative penalties totaling \$200,000 against the nine health plans with which DHS contracts (typically for \$1,000 to \$5,000 per violation).

We reviewed the department’s recent quality assurance reports, but it is difficult to know the extent to which the problems cited in these reports have directly affected health outcomes. Some of the deficiencies appeared to be procedural in nature—for example, not consistently providing written notification to enrollees of decisions regarding complaints. Other deficiencies had the potential for direct impact on enrollee health, such as a health plan’s failure to provide enrollees with contact information for alternative providers after their current providers had refused to treat them. A 2005 review of examination findings over recent years singled out two Minnesota health plans (one large and one small) that “have been able to successfully demonstrate improvement over the past 10 years,” unlike the patterns for the other plans in existence over that period.¹⁵ Department of Health staff told us they rarely find that deficiencies cited in one review still exist when the plan is reviewed the next time.

Department of Human Services External Reviews

Federal regulations require states to obtain information from external reviewers about the “quality, timeliness, and access” to the services that managed care organizations provide to Medicaid enrollees.¹⁶ External reviewers are supposed to be competent evaluators who are not employed by the purchasing agencies themselves. Regulations stipulate that a state’s external review must incorporate information from periodic reviews of each managed care organization’s compliance with state contract requirements.¹⁷

Findings from the 2004-06 compliance reviews indicated that two of the nine health plans reviewed met 100 percent of DHS’s contract requirements, and another five health plans met at least 90 percent of these requirements. Two of

¹⁴ *Minnesota Statutes* 2007, 62D.17, subd. 1.

¹⁵ Michigan Peer Review Organization, *2005 Annual Technical Report*, 14.

¹⁶ *42 CFR* sec. 438.320 (2007).

¹⁷ *42 CFR* sec. 438.358(b)(3) (2007). DHS hires a consulting firm to conduct the overall external review of its managed care program. From 2004 to 2006, this consulting firm also conducted triennial compliance reviews of each health plan. Starting in 2007, DHS made arrangements with the Department of Health to conduct these compliance reviews.

Federal rules require health plans to conduct “performance improvement projects.”

the small, county-based plans had much lower compliance rates in their initial reviews during this period (45 and 70 percent).¹⁸ Some DHS staff told us that their agency has not done as much as it should to enforce compliance with state contracts, expressing serious concern about the extent of health plans’ difficulties complying with DHS contract provisions and legal requirements.

Quality-Related Reports and Projects

Minnesota’s health plans have undertaken a number of voluntary efforts to improve the quality of health care. Since the early 1990s, for example, Minnesota health plans have funded the Institute for Clinical Systems Improvement, an organization that identifies and promotes good health care practices.

In addition, health plans are subject to a variety of federal and state requirements intended to promote health care quality. State rules require managed care organizations to annually prepare a written work plan that details the quality improvement activities they will pursue that year, sets a timetable for their completion, and states how those activities will be evaluated.¹⁹ Federal regulations require that health plans administering public programs pursue performance improvement projects, which are targeted interventions intended to improve outcomes of care.²⁰ However,

- **The impact of managed care organizations’ quality improvement projects has been uneven.**

Federal regulations require states to annually review each health plan’s quality improvement efforts, including performance improvement projects.²¹ In 2004, DHS’s external quality reviewer examined health plans’ quality improvement projects from 2001 to 2004 and concluded that the plans did not have appropriate structures “to create real and sustained improvements in the delivery of health care services.”²² In 2005, the same reviewer concluded that “some [managed care organizations] are more successful than others” at developing performance improvement projects.²³ The reviewer added that many of the plans need to “improve their techniques for critical evaluation,” and that the health plans

¹⁸ The plan that had a 45 percent compliance rate was reviewed again in 2006, and its compliance rate was 95 percent.

¹⁹ *Minnesota Rules* 2007, 4685.1130.

²⁰ 42 *CFR* sec. 438.240(b)(1) (2007). For example, one Minnesota plan established a performance improvement project to encourage its “dual-diagnosed” enrollees—people who are both mentally ill and chemically dependent—to comply with their treatment regimens by assigning each of them a case manager or “coach.”

²¹ 42 *CFR* sec. 438.240(e) (2007).

²² Michigan Peer Review Organization, *2004 Annual Technical Report*, 15.

²³ Michigan Peer Review Organization, *2005 Annual Technical Report*, 20.

Performance improvement projects have not always had lasting impacts.

exhibited a “mixed level of understanding” about the value of quality-related work plans and evaluations.²⁴

In addition, health plan officials told us that some performance improvement projects have not had a lasting impact. Health plan officials expressed a desire for DHS to authorize performance improvement projects that are better aligned with incentive payments in state managed care contracts and with the Governor’s “QCare” initiative to improve health care quality.²⁵ Also, health plan officials said it has been challenging to get health care providers to implement fundamental changes in practices and procedures, partly because plans and providers are often working on a variety of performance improvement projects simultaneously. DHS officials told us they would welcome collaboration by multiple health plans on a single Medicaid performance improvement project for a given year. However, ongoing discussions between DHS and the health plans have not yet resulted in agreement on a sufficiently focused, collaborative approach.²⁶

Performance-Related Withholds and Incentives

One approach to encouraging cost-effective service is the use of a performance-based payment system that ties financial rewards and penalties to service standards. At the direction of the 2002 Legislature, DHS developed a performance-based payment system for the state’s managed care programs.²⁷ Since 2003, the department has incorporated provisions into health plan contracts that (1) withhold a percentage of the plans’ capitation payments unless or until certain administrative services are satisfactorily completed and (2) increase compensation if selected health care services are provided to enrollees.²⁸

We reviewed how these financial incentives have affected health plans’ performance and improved health care since 2003. We found that:

²⁴ *Ibid.*, iii-iv.

²⁵ QCare was initiated by Executive Order on July 31, 2006. The order stated that state contracts with health plans “will contain significant new incentives” for meeting quality “targets.” QCare’s incentives are meant to reward the actual results of quality care, not the process of delivering it.

²⁶ An exception is the Minnesota Senior Health Options (MSHO) program, which some health plans cited as a model of a more collaborative approach. With MSHO, DHS authorized a single performance improvement project for the health plans, aimed at promoting the use of low-dose aspirin for enrollees with diabetes and heart disease. Health plan officials said that this project offered proven benefits at a low cost.

²⁷ *Laws of Minnesota* 2002, chapter 220, art. 15, sec. 15 and 23. Prior to 2003, the state contracts included several financial performance incentives that focused on child and teen checkups, access to dental services, and lead screening. In 2002, the department worked with a consultant to develop a more comprehensive performance-based payment system, including measuring and rewarding health plans’ administrative performance—see The Lewin Group, *Performance-Based Payments to Minnesota Health Plans: Program Design Features* (St. Paul, November 2002).

²⁸ *Minnesota Statutes* 2007, 256B.69, subd. 5a, and 256L.12, subd. 9.

The state bases a portion of its payments to health plans on measures of administrative and clinical performance.

- **Health plans have generally fared well on performance incentives in state contracts, although DHS limits the amount of funding at stake and some of the benchmarks have not challenged plans to improve their performance over time.**

State law allows DHS discretion to select and develop the performance areas for the payment “withholds,” but it requires that the performance targets be “quantifiable, objective, measurable, and reasonably attainable.”²⁹ Most of the performance measures have been based on administrative functions, such as ensuring timely claims processing and accurate data reporting, and they have not changed much since 2003, as shown in Table 5.3. Some measures, such as the accurate reporting of provider identification numbers on health care claims, are based on federal law.³⁰ DHS typically includes one withhold measures (out of a total of eight in 2007) that focus on health-related services. However, these health-related measures have periodically been suspended, primarily due to deficiencies in the underlying data used to calculate performance.³¹

To ensure that financial incentives result in some improvement in health plan performance, state law requires that DHS hold back 5 percent of health plans’ total capitation payments.³² But, since 2005, provisions in the health plan contracts have guaranteed that any plan will eventually receive back at least 80 percent of its withheld payments.³³ As shown in Table 5.4, the plans have consistently performed well on these measures, earning back all but 3 percent of the \$331 million in funds withheld between 2003 and 2006.³⁴

DHS also gives plans an opportunity to earn “extra” money (up to 5 percent of their capitation amount) for achieving benchmarks on measures of clinical performance.³⁵ These incentives focus on preventive care activities, requiring the health plans to work with their providers on implementation. For example, some measures aim to improve accessibility to health care for children by requiring primary care check-ups, immunizations, and mental health screening. Other measures focus on screening adults for certain diseases or monitoring individuals diagnosed with chronic conditions, such as diabetes or coronary heart disease. In

²⁹ *Minnesota Statutes* 2007, 256B.69, subd. 5a(c), and 256L.12, subd. 9(c).

³⁰ 42 *U.S. Code* 1396b(m)(2)(A)(xi).

³¹ Health plan contracts allow the state to suspend any of the contract performance target measures if the department determines that the reported data are not dependable. Performance is then evaluated based on the remaining measures. For example, see 2007 Prepaid Medical Assistance Program contract section 4.5.1.

³² *Minnesota Statutes* 2007, 256L.12, subd. 9(c), and 256B.69, subd. 5a(c).

³³ Although not required in statute, DHS limits the total amount of funds to be withheld and not returned to the plans. For example, see 2007 Prepaid Medical Assistance Program contract, section 4.5.3, which limits the amount of a health plan’s loss to 20 percent of all funds withheld from the health plan.

³⁴ The withholds do not necessarily hold health plans accountable for performance. For example, one plan earned back all of its administrative withholds related to grievances and appeals over a recent four-year period, despite problems cited during this period with the plan’s grievance and appeals processes in external reviews.

³⁵ 42 *CFR* sec. 438.6(c)(5)(iii) (2007).

Table 5.3: Performance Measures Used for Managed Care Contract Withholds and Incentives, 2003-07

| | Contract Year | | | | |
|--|---------------|-----------|-----------|-----------|------|
| | 2003 | 2004 | 2005 | 2006 | 2007 |
| Administrative Withhold Measures for PMAP, GAMC, and MinnesotaCare Programs | | | | | |
| Reporting and activities regarding denial, termination, or reduction of services | X | X | X | X | X |
| Reporting and activities regarding grievances and appeals | X | X | X | X | X |
| Timeliness of claims payments | X | X | X | X | X |
| Identification of treating providers in encounter claims data | X | X | X | X | X |
| Deficiencies cited in Department of Health quality assurance examinations | X | X | X | X | X |
| Responsiveness to member phone calls for assistance | X | X | X | X | X |
| Psychiatrist utilization review and quality assurance advisor availability | X | X | X | X | X |
| Lead screening for children | Suspended | Suspended | X | X | X |
| Screening and assessment for Elderly Waiver services ^a | | | Suspended | | |
| Asthma medication use | | | Suspended | Suspended | |
| Clinical Pay-for-Performance Measures | | | | | |
| Well-child primary care accessibility incentive measures | | | | | |
| • Well-child visits | X | X | X | X | X |
| • Children newly enrolled in managed care | X | X | X | X | X |
| • Lead screening | X | X | X | X | X |
| • Critical access dental care | X | X | X | X | X |
| QCare preventive care incentive measures | | | | | |
| • Chlamydia screening | | | | | X |
| • Child immunizations | | | | | X |
| • Breast cancer screening | | | | | X |
| • Cervical cancer screening | | | | | X |
| Developmental and mental health screening measures | | | | | |
| • Child development | | | | | X |
| • Child mental health | | | | | X |
| Other pay-for-performance measures | | | | | |
| • Providing optimal diabetes care | | | | X | |
| • Implementation of best practices for coronary artery disease, heart failure and stroke initiatives | | | | X | X |
| • Improving services for children in foster care | | | | X | X |

NOTE: The lead screening measure was suspended for 2003 and 2004 due to legislative changes in coverage for newborn children.

^a Required for county-based purchasing organizations only in 2005.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services documents.

Table 5.4: Funds Withheld from—and Returned to—Health Plans Under DHS Contracts, 2003-06

| Contract Year | Funds Initially Withheld (in thousands) | Funds Returned to Health Plans (in thousands) | Percentage of Withheld Funds Returned |
|---------------|--|--|---------------------------------------|
| 2003 | \$ 60,405 | \$ 60,405 | 100% |
| 2004 | 84,735 | 84,735 | 100 |
| 2005 | 94,092 | 89,425 | 95 |
| 2006 | <u>92,068</u> | <u>86,928</u> | 94 |
| Total | \$331,300 | \$321,493 | 97% |

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data for the Prepaid Medical Assistance Program, General Assistance Medical Care, MinnesotaCare, and Minnesota Senior Health Options program.

2007, the department expanded the use of these incentives considerably by including health care services targeted by the Governor's QCare Preventive Care Initiative. Still, the amount of money distributed to date for these health care incentives has been relatively small (a total of \$10.6 million over four years), and no health plan has come close to earning the 5 percent cap.

In our view, the state's use of financial incentives is an important step towards ensuring that the state receives cost-effective services for its publicly funded health care programs. Some health plan officials told us that DHS's mix of administrative and clinical measures is sensible and reasonable. Others expressed concern that certain benchmarks (such as for lead screening) were becoming more difficult to achieve over time, or that other measures (such as deficiencies cited in Department of Health quality assurance reviews) were based on subjective judgments.³⁶

DHS should take additional steps to improve its performance-based payment system.

Earlier, we noted that DHS and the health plans have not yet agreed on ways to focus performance improvement efforts on a limited number of strategically important goals. Beyond this, we think DHS should take additional steps to improve the performance-based payment system. First, DHS does not always verify the accuracy of health plans' reported performance on its measures. For some measures, the plans' performance and clinical outcomes are determined by either DHS or the Department of Health (as part of their quality assurance reviews). For other measures—such as processing claims in a timely manner—DHS relies on the health plans to self-report the results. We think DHS should ensure that the health plans' performance results are accurate.

Second, DHS has used the same administrative measures for the past five years, none of which require the health plans to improve their performance over the

³⁶ The lead screening withhold measure requires that a health plan's lead screening rate be 10 percent greater than the difference between the 80 percent target and the plan's screening rate in the previous year.

previous year. As we noted in Table 5.4, the health plans have consistently achieved these benchmarks, with a few exceptions. DHS staff told us that, for the administrative measures, the department does not expect performance to improve year to year. Rather, DHS sets the benchmarks relatively high and expects compliance. We think the department should periodically change these measures to improve performance across a broader range of administrative services.

Third, the department does not incorporate any incentives or penalties for the health plans to contain spending for health care or administrative activities. As noted in Chapter 4, there are no upper limits on health plans' administrative spending, and the plans have exceeded the amount presumed under DHS's capitation rate setting. We think the state is missing out on opportunities to control health care costs by not including cost-focused financial incentives.

Finally, the ability of individual health plans to meet DHS's health-related performance objectives may sometimes depend on factors beyond the plans' control, such as the characteristics of their enrollee populations. When this is the case, DHS should consider adopting plan-specific benchmarks that directly take these factors into account.³⁷

RECOMMENDATION

The Department of Human Services should (1) improve its verification of health plans' performance data used for administrative withholds and performance incentives, and (2) periodically rotate its administrative measures to ensure performance improvement across a broader range of administrative services.

The 1987 Legislature established an ombudsman to advocate on behalf of enrollees in public managed care programs.

Managed Care Ombudsman

When Minnesota began providing publicly funded health care services through a managed care model in the 1980s, some people feared that health plans would deny needed services to enrollees. Thus, the 1987 Legislature established a state ombudsman to advocate for enrollees in public managed care programs.³⁸ State law says: "The ombudsman shall advocate for recipients enrolled in prepaid health plans through complaint and appeal procedures and ensure that necessary medical services are provided either by the prepaid health plan directly or by referral to appropriate social services."³⁹

The state's ombudsman told us that she receives about 700 calls a month and acts directly as a mediator or advocate for about 80 to 100 cases a month. Many of

³⁷ In the Minnesota Family Investment Program, DHS has set performance targets that vary among counties, based on county and client characteristics.

³⁸ *Laws of Minnesota* 1987, chapter 403, art. 2, sec. 76.

³⁹ *Minnesota Statutes* 2007, 256B.031, subd. 6.

the concerns raised by enrollees relate to billing problems, service quality, and access to services. In our view, the managed care ombudsman—as the state’s designated advocate for managed care enrollees—has a unique perspective for commenting on the quality of Minnesota’s health care services. We found that:

- **The state’s ombudsman for managed care believes that enrollees in publicly funded health care programs have, for the most part, been well-served by managed care.**

The ombudsman gave us several reasons for this opinion. First, as we discuss in the next section, managed care enrollees get more information than fee-for-service clients about the benefits to which they are entitled and any services which have been denied. Second, the ombudsman said that managed care enrollees have adequate recourse for addressing their concerns, including complaints filed with her office as well as managed care organizations’ own grievance and appeals procedures.⁴⁰ She expressed concern that some Minnesota health plans have overturned high percentages of initial decisions that led to enrollee grievances, perhaps indicating problems with the fairness of the health plans’ initial decisions. However, she said that Minnesota health plans have generally been responsive to concerns she has raised. Finally, the ombudsman said that some health plans have been able to “leverage” their commercial networks of providers to provide services to public enrollees around the state, even in rural areas.

QUALITY ASSURANCE IN FEE-FOR-SERVICE PROGRAMS

We also examined the nature of DHS’s quality assurance activities in public fee-for-service health care programs. These programs mainly serve enrollees with disabilities, who tend to have higher medical needs (and higher costs) than the average enrollee in public programs. First, we found that:

- **Users of fee-for-service health care have less recourse than managed care enrollees when they have service concerns.**

One appeal option—available to applicants or enrollees in either managed care or fee-for-service—is the state’s “fair hearing” process. This process allows individuals to appeal for a hearing before an administrative judge if they believe that a county or state agency has (1) inappropriately suspended, reduced, or terminated their health care services, or (2) inappropriately denied an application

⁴⁰ Federal regulations require Medicaid managed care organizations to have grievance and appeals processes, and state law outlines timeframes for resolving complaints. The number of managed care grievances and appeals increased from 1,507 in 2003 to 2,809 in 2004, but the ombudsman attributed this mostly to legislative changes in benefit levels. The number dropped to 2,056 in 2005 and 2,233 in 2006.

Fee-for-service enrollees often get less information about their services than managed care enrollees.

of service or failed to act on it in a timely manner. Individuals may also seek hearings in response to rulings by managed care organizations.⁴¹

Beyond the state appeals process, however, individuals in Minnesota’s fee-for-service health care programs do not have options available to people in managed care. Health plans are required to have internal grievance and appeals processes to address enrollee service concerns; there is no comparable process for fee-for-service enrollees. Likewise, there is a state managed care ombudsman to address concerns raised by managed care enrollees, but there is no counterpart for fee-for-service clients.⁴² A DHS “help desk” responds to questions from fee-for-service clients, but some people suggested to us that the help desk has been short-staffed and gives less attention to broad, system-level issues than does the ombudsman’s office. In addition, fee-for-service enrollees often receive less information about their services than managed care enrollees, which could affect their likelihood of initiating appeals. Federal regulations require health plans to send notifications of service denials, reductions, or terminations to their enrollees; in contrast, fee-for-service enrollees are notified when services requiring authorization are denied or reduced, but there is no assurance that enrollees will be notified of denials or reductions for other types of services. Also, enrollees in managed care programs receive detailed descriptions (called “certificates of coverage”) outlining the benefits for which they are eligible, while fee-for-service clients receive a more general, one-page summary of services covered by publicly funded health care programs.

Furthermore, we found that:

- **Fee-for-service care has been subject to minimal external oversight of service quality and outcomes.**

As described earlier in this chapter, managed care organizations are subject to external quality assurance reviews; there are no such reviews for fee-for-service care. Also, DHS conducts annual consumer satisfaction surveys of managed care enrollees but not fee-for-service enrollees.

In addition, the departments of Health and Human Services analyze and report data on the performance of each managed care organization, using the “HEDIS” measures described earlier. In contrast, the state’s only previous assessment of HEDIS measures for fee-for-service care reported statewide data, without breakdowns by provider groups.⁴³ The 2005 Legislature required DHS to publicly report on the performance of individual “medical [provider] groups” by October 2007, with separate reporting for the managed care and fee-for-service

⁴¹ *Minnesota Statutes* 2007, 256.045, subd. 3.

⁴² Enrollees in either fee-for-service or managed care can also report service concerns to the DHS Surveillance and Integrity Review Section, but this unit focuses mainly on legal compliance and fraud and abuse issues.

⁴³ DHS, *Analysis of Race-Ethnic Group Disparities in Minnesota Health Care Programs, 2000-04* (St. Paul, March 2006).

DHS has not yet produced fee-for-service performance information required by the 2005 Legislature.

systems.⁴⁴ DHS did not meet this deadline. DHS has hired a contractor to prepare performance information by spring 2008 on managed care ambulatory services for some, but not all, of the state's medical provider groups. After the managed care data are released, DHS intends to use existing administrative data to conduct similar analyses of performance by medical provider groups in fee-for-service ambulatory care.

Shortcomings in the quality assurance practices of fee-for-service systems are not unique to Minnesota. State fee-for-service systems were developed mainly as mechanisms for processing health care providers' payment claims, with limited attention to quality of care issues. As a consultant's review of Pennsylvania's public programs concluded:

Therein lies the crux of a key problem with the [fee-for-service] model. While [the Pennsylvania managed care program] is a system of care that was designed to incorporate strong quality management and improvement strategies, and which lends itself to quality measurement, the traditional [fee-for-service] model was neither designed nor is it a system. Quality measurement in the [fee-for-service] setting is exceedingly difficult; if quality cannot be measured well, improving it is that much more challenging.⁴⁵

Finally, DHS officials expressed concern to us that there was little coordination of care for Minnesota's fee-for-service enrollees prior to 2008. However, the Legislature and DHS have initiated several recent projects with the goal of improving care coordination for these enrollees. First, the 2007 Legislature authorized "provider-directed care coordination" for enrollees in fee-for-service Medical Assistance with "complex and chronic medical conditions."⁴⁶ The Legislature authorized DHS to pay health care providers an additional \$50 per month for each enrollee that receives DHS-specified types of care coordination. Second, the 2005 and 2007 Legislatures required DHS to develop care coordination pilot projects for several subgroups of fee-for-service Medical Assistance enrollees with complex health care needs.⁴⁷ Third, DHS has obtained a federal grant to implement a "Communication and Accountability in Primary

DHS is implementing projects to improve care coordination for fee-for-service enrollees.

⁴⁴ *Laws of Minnesota* First Special Session 2005, chapter 4, art. 8, sec. 43. The law required DHS to measure individual medical groups' performance for asthma, diabetes, hypertension, coronary artery disease, and preventive care services. For managed care, a DHS contractor is currently collecting data from those medical groups that submit data to the "Minnesota Community Measurement" project. The law also required DHS to report hospital-specific performance information on services to public enrollees, but the federal government informed DHS in 2007 that it would not allow this.

⁴⁵ The Lewin Group, *Comparative Evaluation of Pennsylvania's HealthChoices Program and Fee-for-Service Program* (Falls Church, VA, for Coalition of Medical Assistance Managed Care Organizations, May 2005), 52.

⁴⁶ *Laws of Minnesota* 2007, chapter 147, art. 15, sec. 16.

⁴⁷ *Laws of Minnesota* First Special Session 2005, chapter 4, art. 8, sec. 44, authorized an "intensive care management program" for certain child enrollees. *Laws of Minnesota* 2007, chapter 147, art. 15, sec. 19, authorized up to four "care coordination pilot projects" for certain child and adult enrollees.

Care Systems” project. This project would allow health care providers to (1) submit information on enrollees’ clinical status to DHS, and (2) obtain claims information from DHS to support clinical decisions. All of these efforts are in their early stages of implementation and have not yet been evaluated.

We think it will be important for the Legislature to hold DHS accountable for some key statutory requirements related to fee-for-service care—specifically, requirements to implement an ongoing system for measuring performance by medical provider groups, and to implement and evaluate various activities to improve care coordination. We see no need for additional legislation in these areas at this time, as long as the Legislature monitors the results of current mandates.

The Legislature should consider expanding the duties of the managed care ombudsman.

However, we think the Legislature should consider the option of extending the duties of the state’s managed care ombudsman to fee-for-service clients. As noted, fee-for-service clients have more limited choices than managed care clients when they encounter service-related problems. In addition, it would be useful to have an ombudsman independently monitoring system-level issues in fee-for-service care, as the ombudsman for managed care now does in the managed care arena. If the Legislature decides to expand the duties of the ombudsman for managed care in this way, we think it should consider making this office independent, rather than part of DHS. DHS directly administers fee-for-service health care, and independence would address potential conflicts of interest that could occur if the ombudsman remained a part of DHS. Also, the Legislature would need to consider whether the ombudsman’s office needs more resources to handle additional clients.

RECOMMENDATION

The Legislature should consider changing the state’s “ombudsman for managed care” to an “ombudsman for health care,” who would advocate on behalf of both managed care and fee-for-service enrollees.

County-Based Purchasing

SUMMARY

Three of the nine health plans that administer managed care on behalf of the state operate under Minnesota’s “county-based purchasing” statute, and they serve enrollees in 27 counties. County-based purchasing organizations have made significant efforts to respond to local priorities and work with county agencies. However, county-based purchasing organizations have had higher administrative cost rates than other health plans, in aggregate, and mixed records on measures of quality and compliance. The Legislature should retain county-based purchasing, but it should amend state law to restrict all health plans’ expenditures of public funds to health-related purposes. Also, the Legislature should ensure that various plans—county-based or other—can periodically submit proposals for consideration by the Department of Human Services (DHS) in those counties served by a single health plan.

In 1997, the Minnesota Legislature authorized counties (individually or in groups) to purchase or provide health care services on behalf of enrollees in public programs.¹ This chapter addresses the following questions:

- **Have county-based purchasing organizations proven to be cost-effective alternatives to health maintenance organizations?**
- **Is there a need for the Legislature to modify state statutes governing county-based purchasing organizations?**

BACKGROUND

Many Minnesota counties became interested in county-based purchasing when the Legislature required all counties to participate in the state’s Medical Assistance managed care program by 1999.² Outstate counties were particularly concerned that private health plans based in urbanized parts of Minnesota might not adequately meet their needs. A University of Minnesota report cited three reasons that county-based purchasing organizations developed: (1) to foster improved coordination of local social services and public health services; (2) to ensure that local health care providers would be included in managed care organizations’ provider networks; and (3) to prevent “cost-shifting” that could occur if counties spent money to provide services that health maintenance organizations would not.³ Also, local officials told us that county-based

¹ *Laws of Minnesota* 1997, chapter 203, art. 4, sec. 56.

² *Laws of Minnesota* 1997, chapter 203, art. 4, sec. 49.

³ Astrid Knott and Jon B. Christianson, *A Rural Government Role in Medicaid Managed Care: The Development of County-Based Purchasing in Minnesota* (Minneapolis: University of Minnesota Rural Health Research Center, January 2001), 16.

County-based purchasing organizations have many similarities with other health plans, as well as a few key differences.

purchasing may help counties improve health care and social services for people for whom the counties bear considerable financial responsibility.

Currently, all or parts of 27 counties are served by three county-based purchasing organizations. South Country Health Alliance is the largest county-based purchasing organization, with 24,780 enrollees in 2007 in 14 counties. PrimeWest Health System serves ten counties, and its enrollment totaled 10,397 in 2007. Itasca Medical Care serves all of Itasca County and portions of Aitkin and Koochiching counties; its 2007 enrollment was 5,317. Altogether, these organizations served about 9 percent of the state's enrollees in public programs.⁴ Many other counties are considering possible participation in a county-based purchasing organization or have established joint powers boards for this purpose.

There are many similarities in the state's regulation of county-based purchasing organizations and health maintenance organizations. For example, county-based purchasing organizations are subject to the Department of Health's oversight and enforcement authority, as are health maintenance organizations.⁵ All health plans—whether county-based purchasing organizations or health maintenance organizations—are subject to the state's laws governing administration of Minnesota's Medicaid managed care programs, and all plans are required to offer the same health care services to enrollees in public programs.⁶

There are also several key differences in the regulatory requirements for county-based purchasing organizations and other health plans, as shown in Table 6.1. Some of these differences are acceptable, in our view. For example, although county-based purchasing organizations are directly accountable to a governing body of elected officials while most health maintenance organizations are not, both types of organizations are subject to oversight and enforcement authority from the state departments of Health and Human Services. Also, county-based purchasing organizations are not required to obtain "certification" from the Department of Health, unlike health maintenance organizations. Still, county-based purchasing organizations' contracts with the Department of Human Services provide an important mechanism for accountability, although the department's ability to discontinue state contracts with county-based purchasing organizations is limited by statutory provisions discussed later in this chapter.⁷

⁴ Based on November 2007 enrollments. *Minnesota Statutes* 2007, 256B.69, subd. 3a, says the DHS commissioner and a county's governing board "shall mutually select health plans" that serve a particular county. However, the emergence of county-based organizations as health plans means that county boards sometimes face conflicts of interest in these cases. If the DHS commissioner and county board cannot reach agreement on the selection of health plans, the commissioner is required by law to resolve the dispute after considering input from a three-person panel (with appointees by the commissioners of Human Services and Health, and an appointee by the Association of Minnesota Counties.)

⁵ *Minnesota Statutes* 2007 62D.17 and 256B.692, subd. 2(d).

⁶ *Minnesota Statutes* 2007, 256B.69, 256D.03, and 256B.692.

⁷ Statutes specify that, in certain counties, the sole health plan administering certain programs will be the county-based purchasing organization that now performs this role.

Table 6.1: Key Differences in Operating Requirements Between Health Maintenance and County-Based Purchasing Organizations

| | Health Maintenance Organizations (HMOs) | County-Based Purchasing Organizations (CBPOs) |
|--|---|--|
| “Certificate of authority” from the Department of Health | Each HMO must obtain a certificate and pay an annual renewal fee (\$21,500 plus 70 cents per enrollee). The department has authority to grant, suspend, or revoke certificates. | CBPOs are not required to have a certificate to operate. Also, they are not required to pay the annual renewal fee that HMOs pay. |
| Governing body | The body includes enrollees, providers, or other individuals. ^a | The body is (1) the county board of commissioners, or (2) a joint powers board (for a multi-county structure). |
| Minimum levels of risk-based capital | HMOs are subject to state regulation if their risk-based capital is less than 200 percent of the “authorized control level.” | County taxing authority can be used as a guaranty of CBPO ability to ensure solvency—thus, CBPOs are not required to retain a specified level of reserves. |
| Statutory designation of which health plans shall serve certain counties | Not specified in state law. | State law designates CBPOs as the only plans allowed to serve certain counties. |
| “Unreasonable expenditures” | Prohibited by state law. | Unclear whether the HMO provision applies to CBPOs. ^b |
| Restrictions on expenditures of net earnings | State law sets some restrictions on these expenditures. | Not explicitly addressed in state law. |
| Contracting for administrative services | Authorized by state law. | Not explicitly authorized in state law. |
| Status of information on provider rates | Considered to be “trade secret” information—thus, not public. | CBPOs differ. One considers its rates to be public data, one does not, and one lacks information on the rates its own providers are paid. ^c |
| Required to pay for Health and Commerce department audits | Yes | No |

^a For HMOs operating for at least a year, at least 40 percent of board members must be elected by enrollees/members.

^b [Minnesota Statutes](#) 2007, 256B.692 subjects CBPOs to the Department of Health’s general “enforcement and rulemaking powers” for HMOs, but this law does not specifically cite the HMO statute for unreasonable expenses—even though it explicitly subjects CBPOs to some other HMO statutes. A CBPO official told us of an instance where the Department of Health did, in fact, review an expenditure by his organization for reasonableness.

^c One CBPO contracts with a health maintenance organization for its provider network and does not know the rates the HMO pays the providers.

SOURCES: [Minnesota Statutes](#) 2007, 60A, 62D, 256B.692, and 256.9697, subd. 3; [Laws of Minnesota](#) 2006, chapter 264, sec. 15; [Minnesota Rules](#) 2007, 4687.20; Office of the Legislative Auditor, interviews with state agency and health plan officials.

For some of the other differences noted in Table 6.1, we think the Legislature should consider adopting more uniform provisions for county-based purchasing organizations and health maintenance organizations. Specifically, we offer recommendations later in this chapter that address statutes regarding (1) “unreasonable” expenditures, (2) expenditures of net earnings, and (3) authority to serve as the sole health plan for a county.

COORDINATION WITH COUNTY SERVICES

County-based purchasing organizations were developed partly to foster improved coordination of health care with county-delivered social services and public health services. In fact, some county officials told us that efforts to address a wide range of social outcomes—not just health care outcomes—distinguish the county-based plans from other health plans. We found that:

- **County-based purchasing organizations have worked closely with county agencies and have considerable support from county officials.**

For example, South Country has funded a “county resource manager” in each of its member counties to help coordinate public health and social services for certain enrollees. South Country is also assembling “county resource management teams” of multi-disciplinary staff in each county to assist with case management and coordination issues. Similarly, PrimeWest meets monthly with an advisory committee of county public health and human services agency directors. PrimeWest said this committee has been instrumental in shaping the health plan’s care management policies.

Local elected officials play key roles in the governance of county-based purchasing organizations.

In addition, the governance structures of the three county-based purchasing organizations create unique opportunities for elected officials to discuss local service needs with county-based purchasing organizations and hold these plans accountable. PrimeWest and South Country were created through joint powers agreements, and elected county commissioners from each of the member counties serve on their governing boards. Itasca Medical Care is governed by the Itasca County board of commissioners.

We did not systematically evaluate whether county-based purchasing organizations have done a better job of working with counties than privately-owned health plans, and we do not know whether the efforts of county-based purchasing organizations to work with counties have yielded better enrollee outcomes. Nevertheless, many county officials told us they would like to see a continuation or expansion of Minnesota’s county-based purchasing options, and the Association of Minnesota Counties has supported expansion of this approach. As one county human services director told us:

One of the unique characteristics of county-based purchasing is the close working relationship that [our county-based purchasing organization] has with county health and human services. We meet at all levels on a regular basis; our nurse and social work Community Resource Management Team are the focal point of this coordination. Because we

are a health and human services agency, our services are well integrated. Taking this all into consideration, we are close to a seamless system; a one-stop shop for customers who have a variety of needs.

Establishing and maintaining close working relationships between health plans and local agencies will be a continuing challenge, even for county-based purchasing organizations. One local official told us that his region's county-based purchasing organization has considered serving additional counties as a way of remaining financially viable, but he is concerned that an expansion would make it difficult for the plan to continue to customize its operations to local needs.

ADMINISTRATIVE COSTS

We examined county-based purchasing organizations' aggregate administrative costs for the state's main health care programs: Medical Assistance, MinnesotaCare, General Assistance Medical Care, and Minnesota Senior Health Options (MSHO). We found that:

- **County-based purchasing organizations' aggregate administrative spending per enrollee has been higher than that of other health plans which contract with the state.**

Some county officials said that county-based plans' higher administrative spending per enrollee may be justified if these expenditures improve service outcomes.

Overall, county-based purchasing organizations spent about \$51 per member-month in 2006 for administration, compared with \$30 for other health plans (excluding state premium taxes and surcharges). Also, county-based purchasing organizations' administrative spending in 2006 was 9.2 percent of total expenditures, in aggregate, compared with 6.7 percent for other health plans (excluding premium taxes and surcharges).⁸ This partly reflects the relatively small enrollments of county-based purchasing organizations and, thus, their lack of economies of scale in meeting the state's reporting and other administrative requirements. As shown earlier in Table 4.4, the four health plans with the largest enrollments (all privately owned) had the lowest administrative spending per member-month of the nine plans with state contracts. On the other hand, none of the county-based purchasing plans' administrative costs were nearly as high as the health maintenance organization that reported the highest administrative costs in recent years (Metropolitan Health Plan, with 2006 administrative expenditures of \$107 per member-month and 19.7 percent of total spending).⁹ County-based purchasing officials told us that their above-average administrative expenditures may be worthwhile if these expenditures help to improve service outcomes (and reduce medical or other costs) for their enrollees.

⁸ Health care premium taxes are usually categorized as administrative expenditures, but publicly owned health plans are not required to pay them. Including these premium taxes, the other health plans' administrative expenditures were about 7.9 percent of total expenditures, in aggregate.

⁹ Metropolitan Health Plan is owned by Hennepin County, but it is licensed as a health maintenance organization and is not considered to be a county-based purchasing organization.

One county-based health plan's subcontracting arrangements with private plans have limited its ability to manage care and costs.

Two of the county-based purchasing organizations are still developing their administrative infrastructure, so their administrative spending bears watching in future years.¹⁰ PrimeWest contracted with Metropolitan Health Plan through 2007 for many of its administrative services, but it hired staff during 2007 to assume many of these duties. South Country Health Alliance currently contracts with a private health plan (BluePlus) for some administrative services. South Country has had minimal staffing during much of its history, but its director told us that he hoped to deliver more of the administrative services internally in coming years.

Two of the county-based purchasing organizations have developed their own networks of providers, while the other (South Country) has paid private health plans to use their networks. From a state perspective, it is unclear whether South Country's expenditures to purchase network access have been cost-effective, given that DHS already contracts with two of the plans (BluePlus and UCare) from which South Country has purchased access.¹¹ Furthermore, this arrangement has limited South Country's ability to manage the care and costs of its enrollees. South Country officials told us that the organizations from which they have purchased network access have not provided South Country with information on individual enrollees' service utilization, costs, complaints, or outcomes; the contractors have viewed these records as proprietary.

SURPLUS REVENUES

We reviewed the statutory requirements regarding financial solvency that apply to county-based purchasing organizations, and we discussed these requirements with state officials. We found that:

- **In contrast to health maintenance organizations, county-based purchasing organizations are allowed to use their authority to levy taxes as a guaranty for statutory risk-based capital requirements.**

In other words, county-based purchasing organizations do not have to maintain actual reserves to meet fiscal emergencies so long as they have *access* to financial resources through the taxing authority of member counties. This occurs because the law authorizes county-based purchasing organizations to meet the statutory solvency requirements that apply to "community integrated service networks."¹² However, some DHS officials expressed concern to us that

¹⁰ The third county-based purchasing organization—Itasca Medical Care—has existed for more than 20 years. Unlike the other county-based purchasing organizations, Itasca does not contract for any administrative services.

¹¹ DHS could have contracted directly with plans that already had established networks in the South Country counties, perhaps at a lower cost to administer this contract. However, it is also possible that South Country enrollees receive benefits from being served by a county-based purchasing organization that they would not have received from other plans.

¹² *Minnesota Statutes* 2007, 256B.692, subd. 2. The law says county-based purchasing organizations must meet the fiscal solvency requirements applicable to health maintenance organizations *or* community integrated service networks (CISNs). *Minnesota Statutes* 2007, 62N.29 authorizes counties to serve as guaranteeing organizations for CISNs.

counties might be inclined to seek legislative remedies (rather than using local tax revenues) if their county-based purchasing organizations faced significant financial losses. Also, it might be challenging for counties to collect tax revenues on short notice to address fiscal problems with county-based health plans. In addition, it is worth noting that there are no community integrated service networks operating in Minnesota—thus, the statute that addresses the solvency of county-based purchasing organizations does not apply to other organizations. We think it would be fiscally prudent if county-based purchasing organizations were required to maintain reserves in a manner more comparable to health maintenance organizations.

RECOMMENDATION

The Legislature should amend state law to disallow county-based purchasing organizations from relying primarily on county taxing authority as a guaranty of their reserve requirements.

We also examined the way that county-based purchasing organizations have used their surplus revenues. Some legislators asked us to examine whether counties have used these revenues for appropriate purposes. We found that the three county-based purchasing organizations differ significantly from each other in their policies for using surplus revenues, as discussed below.

Some county-based purchasing organizations have used their surpluses to increase health care provider payments or invest in health-related community projects.

Itasca Medical Care is unique among the state’s health plans because many of its health care providers bear the financial risks that are borne elsewhere in Minnesota by health plans.¹³ Specifically, Itasca’s providers are responsible for covering the health plan’s net annual losses, although Itasca staff recalled only one year in which losses occurred. Itasca also allocates its annual surpluses to the providers that have chosen to bear this risk.¹⁴ Itasca officials said this risk-sharing arrangement gives providers incentives to deliver high quality, low cost care. In addition, by dedicating surplus revenues solely to providers, Itasca’s approach helps to address the concerns many providers have expressed regarding low rates of provider payment in Minnesota’s publicly funded health care programs.¹⁵

Unlike Itasca Medical Care, PrimeWest does not dedicate surplus revenues solely to provider payments, and PrimeWest’s providers do not directly bear risks associated with PrimeWest’s financial health. Rather, PrimeWest’s joint powers governing board—composed of one county commissioner from each of ten member counties—retains authority to annually determine how surplus revenues

¹³ Most of Itasca’s providers are “at-risk,” but Itasca also contracts on a non-risk basis with some providers who prefer to have Itasca bear the financial risks.

¹⁴ A task force of Itasca Medical Care providers meets regularly to discuss issues related to allocations of surpluses and provider rates. Providers typically receive allocations based on the volume of business they do for Itasca.

¹⁵ Itasca does not have policies regarding minimum reserve levels that it should maintain. Its reserves are funded solely by interest earnings, not by operating surpluses.

South Country Health Alliance allocated \$9 million in surplus revenues to member counties.

will be used. The PrimeWest board has a “Community Reinvestment Committee” to advise it on decisions about how to “reinvest” surplus revenues. PrimeWest’s board spent \$3.5 million in fiscal year 2006 and \$4 million in fiscal year 2007 to increase provider reimbursement rates. Also, PrimeWest’s board set aside \$3.5 million of surplus revenues in 2007 to make grants in its service area that will address (1) access to health care and human services, (2) health care service delivery and efficiency, (3) health status improvements among PrimeWest enrollees, or (4) preventive and wellness services.¹⁶

In contrast to Itasca and PrimeWest, South Country Health Alliance grants each member county “an explicit and measurable right to its share of the Total Capital Surplus.”¹⁷ In 2006, South Country expanded from 9 to 14 counties, and the South Country board asked each new county to make an initial capital investment. The board decided that South Country’s total reserves were larger than necessary, so it allocated a portion of its surplus reserves (more than \$9 million) in 2006 and 2007 to the original nine counties. Table 6.2 shows the amounts of the South Country surplus allocations and how they had been used, as of October 2007. Some counties are using these funds for specific health-related service improvements, such as Waseca County’s expansion of its family support program for at-risk families and Kanabec County’s home visiting program for at-risk pregnant women. Brown County used the funds for capital improvements to its public health and family services building.¹⁸ Goodhue County used part of its revenues to help balance the county’s human services budget, paying for a portion of social services and mental health costs. As of October 2007, counties had not yet determined how to use a majority of their South Country allocations.

South Country’s joint powers agreement, as amended in January 2007, allows for distribution of “any excess of revenues over expenses” to the member counties’ human services agencies “for the health of their citizens.”¹⁹ Although South Country’s policies now require counties to spend allocated surpluses for health-related purposes, we think it makes sense for spending restrictions to be in state

¹⁶ PrimeWest officials told us they use the statutory definition of risk-based capital to define what constitutes the organization’s minimum level of reserves; PrimeWest has not adopted its own policy specifying a minimum level of reserves.

¹⁷ South Country Health Alliance, Joint Powers Agreement, as amended January 1, 2007, sec. 5. In contrast to South Country’s policy, PrimeWest’s joint powers agreement explicitly prohibits the allocation of surplus revenues to individual member counties. Even if a county withdraws from PrimeWest, it is not entitled to a share of PrimeWest’s accumulated revenues and reserves.

¹⁸ The state’s capitation payments to health plans—whether publicly or privately owned—can be used to pay for the plans’ basic operating expenses, including the costs of the building space they use. Brown County officials told us that their county’s use of South Country surplus funds for building improvements was done to benefit the two agencies directly involved with South Country’s services in Brown County.

¹⁹ South Country Health Alliance Joint Powers Agreement, as amended January 1, 2007, sec. 1.4(d). South Country made its 2006 distributions to counties before adopting its policy that such allocations should be used for health-related purposes. Board policy requires South Country to keep a specified level of reserves (300 percent of its risk-based capital control level), and surpluses above this level “will be available for distribution [to member counties], at the discretion of the board.”

Table 6.2: Reserves Allocated to Counties from South Country Health Alliance

| County | 2006 Allocation | 2007 Allocation | Uses of the Allocation, As of October 2007 |
|--------------|--------------------|--------------------|---|
| Brown | \$174,805 | \$912,952 | Used all allocations to expand and remodel the county's Community Services Building (which houses the public health and family services departments). |
| Dodge | 103,347 | 533,604 | No decisions yet on how to spend the funds. |
| Freeborn | 259,825 | 1,322,096 | \$300,000 to reduce the deficit in the human services budget, funding human services and public health staff who work with South Country clients. No decisions yet on how to spend the remainder. |
| Goodhue | 217,257 | 1,168,447 | \$109,000 allocated to the county Public Health Fund for physical and mental health services; \$109,000 used to help balance the county's 2007 welfare budget; no decisions yet on how to spend the remainder. |
| Kanabec | 133,019 | 685,455 | County board dedicated the funds to preventive health care services. Spending in 2007: \$53,000 for home visiting program for high-risk pregnant women; \$53,000 for psychiatric nurse practitioner services. |
| Sibley | 101,496 | 517,914 | Expenditures at Sibley County Service Center: \$80,000 for phone system; \$10,000 for handicapped-accessible doors; \$5,000 for defibrillators; no decisions yet on how to spend the remainder. |
| Steele | 249,668 | 1,329,359 | The county intends to fund projects in the following areas over the next five years: (1) home visiting programs for at-risk families with young children, (2) grants to address unmet needs of the county's children and elderly residents, (3) hiring a case manager to work with hospital and clinic staff on mental health issues, (4) a community "club house" for people with mental illness, (5) grants for county jail inmates enrolling in college classes. |
| Wabasha | 98,158 | 499,885 | County board designated funds for meeting health care needs of Medicaid-eligible and other low-income persons. Expenditures (\$33,000) have been for items related to South Country client services, with no decisions yet on how to spend the remainder. |
| Waseca | 154,425 | 781,703 | Will use all allocations to fund unification and expansion of the county's family support programs for at-risk families (public health and human services departments) for at least seven years. |
| Total | \$1,492,000 | \$7,751,415 | |

NOTE: South Country finance staff said that some of the money allocated to counties represented a portion of the counties' original investments rather than surplus revenues earned over time.

SOURCES: South Country Health Alliance; Office of the Legislative Auditor, correspondence with county administrators and human services directors.

The Legislature should require all health plans—county-based and others—to spend their funds from state health care programs on health-related services.

law—for example, in case new county-based purchasing organizations are created in the future. Currently,

- **State law does not specify whether it is allowable for county-based purchasing organizations to spend revenues for general county purposes, rather than for purposes specifically related to health care.**

State law already has some restrictions on how health maintenance organizations may spend their revenues.²⁰ However, we think it makes sense for the Legislature to clarify in law the purposes for which health plans (both county-based organizations and health maintenance organizations) may spend revenues from the state’s publicly funded health care programs. A requirement for health plans to spend their public funds on health-related services would provide a stronger basis for ensuring that expenditures are “reasonable.” In addition, the Legislature should explicitly clarify in law that county-based purchasing organizations—like health maintenance organizations—should be subject to state oversight for “unreasonable” expenses.²¹

RECOMMENDATIONS

The Legislature should (1) amend Minnesota Statutes, chapters 256B.692 and 62D.12 to restrict expenditure of revenues for publicly funded health care programs to health care-related services, and (2) subject county-based purchasing organizations to the prohibition on unreasonable expenses outlined in Minnesota Statutes 62D.19.

QUALITY AND COMPLIANCE MEASURES

It would be helpful to know whether county-based purchasing organizations have served their enrollees more or less effectively than these same enrollees would have been served by health maintenance organizations. Unfortunately, without a carefully controlled study—perhaps with random assignment of enrollees to one type of health plan or the other—it is not possible to compare service quality or effectiveness in a definitive way.

Lacking this type of rigorous study (which is rarely done in health care programs), it is worthwhile to consider some rougher measures of service quality. Chapter 5 discussed the overall performance of Minnesota health plans on

²⁰ For example, see *Minnesota Statutes* 2007, 62D.12, subd. 9a, 62D.05, and 62D.19. The law does not limit health maintenance organizations’ expenditures entirely to health care-related purposes; *Minnesota Statutes* 2007, 62D.12, subd. 9a, authorizes payments to organizations operated for charitable, educational, religious, or scientific purposes.

²¹ *Minnesota Statutes* 2007, 256B.692 lists several parts of the health maintenance organization statute (chapter 62D) that apply to county-based purchasing organizations, but it does not specifically reference the “unreasonable expense” portion of this law (62D.19). Statutes grant the Department of Health the same enforcement authority over county-based purchasing organizations that it has over health maintenance organizations, but we think it should be clearer in statute that this enforcement authority can be applied to unreasonable expenditures.

various quality and compliance measures. These measures can also be used to compare health plans, although differences in plans' performance can partly reflect factors beyond the control of the plans (such as the characteristics of the population served). Still, we think that these measures provide at least a useful starting point. We found that:

- **Among Minnesota's health plans, county-based purchasing organizations have typically had average performance, at best, on measures of quality and compliance.**

First, we examined how the health plans that administer Minnesota's public programs fared on the Health Effectiveness Data and Information Set (HEDIS) measures commonly used to evaluate health care quality. For this analysis, we examined the same 20 measures we used to characterize performance in Chapter 5, based on 2005 and 2006 data from the Department of Health. Among the nine health plans that administer Minnesota's public programs, a large health maintenance organization (HealthPartners) had the best performance in both years—exceeding national averages on all 20 measures in 2005 and on 19 measures in 2006. Among all nine plans, the median number of measures for which a plan had performance above the national average was 11 in 2005 and 12 in 2006. For each of the three county-based purchasing organizations, the number of HEDIS measures exceeding the national average level of performance was at or below the median of Minnesota's health plans in each year.²²

External reviews conducted for DHS found that two of the three county-based purchasing organizations had more noncompliance with state requirements than other health plans.

Second, we examined the external reviews of each health plan conducted for DHS by an independent firm.²³ During 2004-06, each Minnesota plan was the subject of an in-depth review that assessed its compliance with DHS contract requirements. One county-based purchasing organization (PrimeWest) fared very well, complying with 99 percent of the state's administrative requirements in state contracts. External reviews initially found that the other two county-based purchasing organizations had significantly more instances of noncompliance with DHS contract requirements than the state's other health plans, as shown in Table 6.3. The plan with the lowest compliance level (Itasca) in the initial reviews subsequently completed a corrective action plan, and a follow-up review by DHS's external reviewing firm concluded that Itasca complied with most state contract requirements.

Finally, we examined quality assurance reviews of the health plans conducted by the Department of Health, which assesses compliance with statutes and other regulations. Over a recent six-year period, the department made an average of 4.6 recommendations for changes per review, based on an average of 5.5 "deficiencies" per review. In the most recent reviews of the three county-based purchasing plans, the department reported an average of 7.7 recommendations

²² In 2005, county-based purchasing organizations exceeded the national averages on 8 to 10 of the 20 measures we examined; in 2006, these organizations exceeded the national averages on 9 to 12 of the 20 measures.

²³ These reviews were called "triennial structural and operational component" (TSOC) audits, and DHS contracted with the Michigan Peer Review Organization to conduct them until 2006.

Table 6.3: Independent Reviewer Assessment of Health Plans' Compliance with DHS Contracts

| Health Plan (and Year of Review) | Percentage of DHS Contract Requirements Met, According to Reviews in 2004-06 |
|-------------------------------------|--|
| HealthPartners (2004) | 100% |
| BluePlus (2006) | 100 |
| First Plan (2006) | 99 |
| PrimeWest (2006) | 99 |
| Medica (2005) | 98 |
| Metropolitan (2004) | 94 |
| UCare (2004) | 91 |
| South Country (2005) | 70 |
| Itasca (2005, 2006) | 45 → 95 ^a |

NOTE: County-based purchasing organizations are shaded gray.

^a A comprehensive follow-up review in 2006 showed that Itasca met 95 percent of the contract requirements.

SOURCES: Michigan Peer Review Organization, 2005 Annual Technical Report (St. Paul: Minnesota Department of Human Services, February 7, 2007), 7-12; Office of Legislative Auditor, correspondence with Department of Human Services staff regarding 2006 reviews.

and 9.0 “deficiencies” per review—thus, higher than the department’s six-year averages for all plans.²⁴

Again, these results should be viewed with caution. There has been variation in performance among the county-based purchasing organizations, just as there is variation in performance among Minnesota’s health maintenance organizations. Also, two of the three county-based purchasing plans are relatively new, so performance should be monitored over a longer period of time. But, overall, there has often been room for improvement in the county-based plans’ performance on the measures discussed above. In the future, it would also be useful to systematically assess whether county-based plans’ efforts to integrate health care and social services are having a positive impact on client outcomes.

SINGLE-PLAN COUNTIES

Federal law used to require states to offer all Medicaid enrollees the option of at least two health plans. However, some states had difficulty getting health plans

²⁴ The discussion in this paragraph is based on the comprehensive quality assurance reviews conducted by the department every three years. It is not based on the department’s follow-up reviews, which are done mainly to ensure that previously-cited deficiencies have been addressed.

Federal law allows states to contract with a single health plan to administer Medicaid in certain rural counties.

to serve rural areas, so Congress changed the law to allow states to contract with a single plan to administer Medicaid services in certain rural counties.²⁵

We heard significant disagreement on the issue of whether the state should authorize multiple plans or a single plan to administer health care programs in rural counties. Advocates of multiple-plan service delivery suggest that it is essential to give consumers a choice among health plans. They contend that multiple plans (whether publicly or privately owned) are willing to submit proposals to administer services in most Minnesota counties, and they believe that competition will foster better services.²⁶ On the other hand, advocates of a single-plan service delivery model believe that consumers care less about choosing among health plans than about choosing among service providers.²⁷ They say that having multiple health plans serving sparsely populated counties will increase health care administrative costs, create difficulties for providers (who would have to work with multiple health plans), and complicate efforts to integrate county and health plan services.

In many counties served by county-based purchasing, DHS initially authorized a county-based purchasing organization to be the only health plan administering the Medical Assistance program. In some cases, DHS received competing proposals but selected the county-based purchasing organization; in other cases, the county-based purchasing organization was the only health plan that submitted a proposal. Since these initial decisions, however,

- **The Legislature has statutorily locked DHS into single-plan purchasing arrangements in some counties indefinitely, which could limit DHS's future ability to consider other arrangements that might provide better health care values.**

DHS should have authority to periodically consider competing proposals from health plans, even if it only selects one plan to administer services in a part of the state.

The 2006 Legislature required DHS to purchase (or continue purchasing) health care from a single health plan in certain counties, and it also specified that these plans must be county-based purchasing organizations.²⁸ These provisions appear to require DHS to contract exclusively with county-based purchasing organizations for certain publicly funded health care programs in more than 20 counties, and the statute specifies no time limit to this requirement. Even if

²⁵ 42 *CFR* sec. 438.52(b) (2007) authorizes single-plan purchasing in counties that are not designated as "metropolitan statistical areas," but enrollees must still be able to choose among health care providers.

²⁶ In many counties where the county-based purchasing organization is the sole health plan authorized to administer Medical Assistance, multiple plans have been authorized to administer other health care programs, such as MinnesotaCare.

²⁷ Advocates of single-plan delivery suggest that most health care providers serving a given county would be a part of the provider network of any health plan serving the county. Thus, they contend, contracting with more plans does not necessarily give enrollees more choice of providers.

²⁸ *Laws of Minnesota* 2006, chapter 264, sec. 15. This law required DHS to approve a county-based purchasing proposal in five counties, and it required DHS to continue single plan purchasing arrangements with county-based purchasing organizations that existed as of May 1, 2006. In contrast, for services to people with disabilities, the law authorized DHS to consider single-plan purchasing arrangements with county-based plans "or with other qualified health plans."

single-plan arrangements are a good idea in rural counties, we think it makes sense to have periodic reviews to determine which health plans could best serve these counties. Ultimately, DHS might affirm that county-based purchasing plans are better suited than other plans to continue serving the areas now served by county-based purchasing, but DHS should have authority to consider the merits of competing proposals.

RECOMMENDATION

The Legislature should amend Minnesota statutes to authorize DHS to periodically seek proposals to determine which health plans—county-based purchasing organizations or others—should serve areas now served by single-plan purchasing arrangements.

DISCUSSION

Minnesota's experiment with county-based purchasing organizations is still relatively new. These organizations have a limited track record, and some are still developing their administrative capacities. There has been no rigorous comparison of the cost-effectiveness of county-based purchasing organizations with other health plans. With these cautions in mind, we concluded that:

- **County-based purchasing organizations' performance on measures of administrative cost, service quality, and compliance with state requirements has often shown room for improvement.**
- **County-based purchasing organizations have made significant efforts to respond to local priorities and work with county agencies.**

The Legislature should retain county-based purchasing but continue to monitor its performance.

We see no compelling reason at this time for the Legislature to repeal county-based purchasing. In our view, county-based purchasing has the potential to be cost-effective, and its performance should be monitored over a longer period. Also, while the performance of county-based purchasing organizations has been mixed, so has the performance of the other health plans serving Minnesota's publicly funded health care programs.

However, we think the Legislature should make some changes in the laws governing county-based purchasing. There are various differences in the statutes governing health maintenance organizations and county-based purchasing organizations, and a few of these differences are, in our opinion, more pressing for the Legislature to address than others. This is why we recommended that the Legislature: (1) restrict all health plans' expenditure of public program revenues to health-related purposes, (2) clarify that county-based purchasing organizations are subject to a prohibition on "unreasonable" expenses, and (3) give DHS authority to periodically determine which health plans should serve counties now served solely by a county-based purchasing plan. In addition, we think the Department of Commerce should, consistent with existing statutes, apply the same reserve requirements to county-based purchasing organizations that other health plans face.

Discussion

SUMMARY

Nationally, research has shown mixed results regarding managed care's impact on health care costs, outcomes, and access, relative to fee-for-service care. Minnesota established demonstration projects in the 1980s to determine whether managed care was more cost-effective than fee-for-service care, but these projects did not provide definitive evidence. Still, managed care has been implemented in Minnesota in a way that provides several advantages over fee-for-service. For example, managed care limits the state's financial liability, provides considerable leverage for improving health care, and offers its enrollees more recourse than fee-for-service when problems arise. There are alternative service delivery models that the Legislature could consider if the state's contracts with managed care organizations do not succeed in containing medical or administrative costs, but it is unclear whether these options would yield better results.

Managed care has been an important part of Minnesota's publicly funded health care programs for more than 20 years. Recently, however, some legislators have asked whether the state should consider alternatives to managed care. This chapter addresses the following questions:

- According to past research, how does managed care compare with fee-for-service on measures of cost, quality, and access?
- Is it reasonable for the state to rely considerably on managed care organizations to administer its publicly funded health care programs?
- Should the state consider alternatives to its existing arrangements for purchasing publicly-funded health care services?

MANAGED CARE'S ROLE IN MINNESOTA'S PROGRAMS

As used in this chapter, "managed care" is an approach to purchasing health care that typically involves prepayment of a fixed (or "capitated") rate per enrollee to one or more health plans to administer health care programs. This contrasts with the traditional "fee-for-service" approach, in which states reimburse health care providers after-the-fact for costs incurred in providing authorized services. In Chapter 1, we observed that managed care has been a growing part of publicly funded health care programs, both in Minnesota and the nation as a whole. Researchers from the Urban Institute have described the promises and risks of managed care as follows:

States have embraced [Medicaid managed care] as a way to control Medicaid program costs while potentially improving beneficiaries'

access to health care and quality of care. States hope that [Medicaid managed care] will provide recipients with a medical home where preventive care is promoted and primary care is readily available. By having such care, it is hoped that recipients' continuity of care will improve, and their use of costly services, such as emergency rooms and inpatient hospital care, will decline. Managed care is not without risks, however, as it could diminish access to care, both because of its limits on choice of providers and its incentives to providers to reduce use (including the possibility of limiting needed medical services).¹

Some legislators have asked whether it makes sense for Minnesota to rely on managed care organizations to administer publicly funded health care programs. Specifically, they have asked whether managed care is more cost-effective than fee-for-service care, and whether managed care "adds value" to Minnesota's health care programs that justifies any additional costs.

To address these issues, we examined the findings of previous research, from both national and Minnesota studies. We also talked with representatives from each of the nine health plans that administer public programs in Minnesota. In addition, we interviewed representatives from counties, advocacy groups, and research organizations.

National Research on Managed Care

We examined dozens of studies and research summaries that have addressed the impact of managed care programs.² We focused mainly on studies that evaluated public programs, but we also reviewed some broader studies of health plan impacts. Typically, researchers have compared managed care programs with fee-for-service programs, although some studies have compared alternative forms of managed care.³ Overall, we found that:

- **Nationally, studies have shown mixed evidence regarding the impact of managed care—and, more specifically, publicly-funded managed care—on health care cost, quality, and access.**

¹ Sharon K. Long and Teresa A. Coughlin, "Impacts of Medicaid Managed Care on Children," *Health Services Research* 36, no. 1 (April 2001): 7-23.

² Most studies have not involved random assignment of individuals to various types of care, an approach that provides the most assurance that there are no significant differences in the populations being served by these alternative approaches. Random assignment is usually not feasible for evaluations of health care services, so researchers typically take other steps to help ensure comparability between the populations under review.

³ Stephen Zuckerman, Niall Brennan, and Alshadye Yemane, "Has Medicaid Managed Care Affected Beneficiary Access and Use," *Inquiry* 39 (Fall 2002): 221-242, found that different approaches to Medicaid managed care had different effects on beneficiaries' access and use: "[M]andatory [full-risk] programs have had a positive impact on both children and adults, particularly when compared to Medicaid fee-for-service plans. ... In contrast, mandatory primary care case management plans [often referred to as "partial-risk" managed care] provided some benefits to children, but appeared to have little impact on adult Medicaid beneficiaries."

**Research findings
on managed
care's impacts
are mixed.**

Table 7.1 provides a sampling of comments from national research literature that characterize the varying findings.

In the area of cost savings, a reputable national health care consulting firm (the Lewin Group) summarized prior studies as showing that Medicaid managed care “typically” yields cost savings, although it reported that savings have varied a lot among studies.⁴ Kaestner reported that there has been “considerable evidence” of cost reductions in private sector managed care,⁵ and various studies have found evidence of reductions in expensive services (such as emergency room use or hospitalizations) under managed care. On the other hand, a review of five state Medicaid programs said that “the states were unable to realize their high hopes for large savings from managed care.”⁶ In addition, an analysis found evidence of “a substantial increase in government spending” associated with California’s transition of welfare recipients from fee-for-service to managed care.⁷

Researchers have also examined the impact of managed care on outcomes, again with mixed results. Several of the major reviews cited in Table 7.1 (Miller/Luft, Kaestner, Mathematica) concluded that managed care has had limited impact on quality of care or health care outcomes. Such conclusions undermine the claims of managed care critics (who suggest that managed care’s emphasis on cost reduction will reduce health care quality) and advocates (who hope that managed care will lead to widespread improvements in client outcomes). Meanwhile, some other studies have shown that managed care increases the use of preventive care, which could improve enrollees’ health care over the long term.⁸ Also, some studies suggest that the implementation of Medicaid managed care in California may have reduced quality of care or contributed to poorer health outcomes.⁹

Finally, studies have reported mixed findings regarding managed care’s impact on health care access. One summary cited “fairly consistent” findings that Medicaid managed care (1) increases the likelihood of enrollees having a “usual source of care,” (2) reduces reliance on emergency room use, and (3) reduces

⁴ The Lewin Group, *Medicaid Managed Care Cost Savings—A Synthesis of 14 Studies* (Falls Church, VA, 2004), ii.

⁵ Robert Kaestner, Lisa Dubay, and Genevieve Kenney, “Managed Care and Infant Health: An Evaluation of Medicaid in the U.S.,” *Social Science & Medicine* 60 (2005): 1815-1833.

⁶ Randall Brown, Judith Wooldridge, Sheila Hoag, and Lorenzo Moreno, *Reforming Medicaid: The Experiences of Five Pioneering States with Mandated Managed Care and Eligibility Expansions* (Princeton, NJ: Mathematica Policy Research, Inc., 2001), 14.

⁷ Mark Duggan, “Does Contracting Out Increase the Efficiency of Government Programs? Evidence from Medicaid HMOs,” *Journal of Public Economics* 88, no.12 (2004): 2549-2572.

⁸ For example, see Zuckerman, “Has Medicaid Managed Care Affected Beneficiary Access and Use.”

⁹ For example, see Anna Aizer, Janet Currie, and Enrico Moretti, “Does Managed Care Hurt Health? Evidence From Medicaid Mothers,” *The Review of Economics and Statistics* 89, no. 3 (August 2007): 385-399, and Ming Tai-Seale, Anthony T. LoSasso, Deborah A. Freund, and Susan E. Gerber, “The Long-Term Effects of Medicaid Managed Care on Obstetric Care in Three California Counties,” *Health Services Research* 36, no. 4 (August 2001): 751-771.

Table 7.1: Sampling of National Research Literature Regarding the Impact of Managed Care

Miller and Luft: “Compared with non-HMOs, HMOs had roughly comparable quality of care, more prevention activities, less use of hospital days and other expensive resources, and lower access and satisfaction ratings. ... At the same time, most (but not all) HMOs have not accomplished what their proponents had promised: changing clinical practice processes and improving quality of care relative to the existing system, while containing costs for both purchasers and consumers.” (*Based on 79 peer-reviewed articles published 1997-2001.*)^a

Kaestner and others: “In sum, the switch to Medicaid managed care has occurred in the absence of definitive empirical information related to the effect of Medicaid managed care on health care utilization and health. ... [T]here is considerable evidence that managed care has reduced costs in the private sector. ... Our findings provide no evidence that the move to managed care within Medicaid resulted in improvements in prenatal care or in infant health nationally.” (*Based on national data for 1990-96.*)^b

Mathematica evaluation: “By introducing managed care, states have enhanced the potential for improving the quality of care delivered to Medicaid beneficiaries. This potential has not yet been fully realized, but the evidence suggests that managed care has not had a detrimental effect on enrollees. ... A number of recent research studies, representing a variety of research designs, databases, and states, show no clear pattern of significant differences in the health care, access, utilization, or satisfaction of low-income children or adults in Medicaid managed care relative to those in Medicaid fee-for-service. ... [L]imited evidence suggests that the demonstrations had little impact on expenditures in any of the five states.” (*Based on a six-year evaluation of Medicaid reforms in five states.*)^c

Kirby and others: “Our findings suggest that the increase in HMO enrollment [among Medicaid enrollees] may have held down use and expenditures to rates modestly lower than what would have been expected had HMO enrollment not increased.” (*Based on national data for 1987 and 1997.*)^d

Lewin Group summary of state studies: “[T]he studies strongly suggest that the Medicaid managed care model typically yields cost savings. While percentage savings varied widely (from 2 to 19 percent), nearly all the studies demonstrated a savings from the managed care setting.” (*Based on 14 studies.*)^e

Baker and Afendulis: “Increases in Medicaid health maintenance organization enrollment are associated with less emergency room use, more outpatient visits, fewer hospitalizations, higher rates of reporting having put off care, and lower satisfaction with the most recent visit. ... On the whole, this study, in combination with previous work, does not present a clear picture of the effects of Medicaid managed care.” (*Based on multi-state data from the late 1990s.*)^f

^a Robert H. Miller and Harold S. Luft, “HMO Plan Performance Update: An Analysis of the Literature, 1997-2001,” *Health Affairs* 21, no. 4 (July-August 2002): 63-86.

^b Robert Kaestner, Lisa Dubay, and Genevieve Kenney, “Managed Care and Infant Health: An Evaluation of Medicaid in the U.S.,” *Social Science & Medicine* 60 (2005): 1815-1833.

^c Randall Brown, Judith Wooldridge, Sheila Hoag, and Lorenzo Moreno, *Reforming Medicaid: The Experiences of Five Pioneering States with Mandated Managed Care and Eligibility Expansions* (Princeton, NJ: Mathematica Policy Research, Inc., 2001).

^d James B. Kirby, Steven R. Machlin, and Joel W. Cohen, “Has the Increase in HMO Enrollment Within the Medicaid Population Changed the Pattern of Health Use and Expenditures?” *Medical Care* 41, no. 7, Supplement (2003): III-24 – III-34.

^e The Lewin Group, *Medicaid Managed Care Cost Savings—A Synthesis of 14 Studies* (Falls Church, VA, 2004).

^f Laurence C. Baker and Christopher Afendulis, “Medicaid Managed Care and Health Care for Children,” *Health Services Research* 40, no. 5 (October 2005): 1466-1488.

Table 7.1 (continued)

Garrett and others: “Mandatory [managed care] programs improved access and utilization relative to traditional [fee-for-service] Medicaid, primarily for children. Mandatory HMO programs caused some access problems for women.” (*Based on 1991-95 national survey results.*)^g

Basu and others: “In general, the literature on Medicaid managed care access utilization, quality, and patient outcome and satisfaction shows mixed results. ... [This] study shows that while HMOs were associated with fewer preventable admissions in the privately insured population, there was no such association found among the Medicaid population.” (*Based on 1997 data for four states.*)^h

Landon and others: “Our data suggest that managed care was better at delivering preventive services, whereas [fee-for-service] Medicare was better in other aspects of care related to access and beneficiary experiences.” (*Based on survey responses from nearly 500,000 Medicare beneficiaries.*)ⁱ

LeCook: “[Medicaid managed care] programs’ reduction of some disparities suggests that recent shifts in Medicaid policy toward managed care plans have benefited minority enrollees.” (*Based on 1997-2001 national survey data.*)^j

^g Bowen Garrett, Amy J. Davidoff, and Alshadye Yemane, “Effects of Medicaid Managed Care Programs on Health Services Access and Use,” *Health Services Research* 38, no. 2 (April 2003): 575-594.

^h Jayasree Basu, Bernard Friedman, and Helen Burstin, “Managed Care and Preventable Hospitalization Among Medicaid Adults,” *Health Services Research* 39, no. 3 (June 2004): 489-509.

ⁱ Bruce E. Landon, Alan M. Zaslavsky, Shulamit L. Bernard, Matthew J. Cioffi, and Paul D. Cleary, “Comparison of Performance of Traditional Medicare vs. Medicare Managed Care,” *Journal of the American Medical Association* (April 14, 2004): 1744-1752.

^j Benjamin Le Cook, “Effect of Medicaid Managed Care on Racial Disparities in Health Care Access,” *Health Services Research* 42, no. 1 (February 2007): 124-145.

SOURCE: Office of the Legislative Auditor.

rates of referral to specialists for adults.¹⁰ According to this summary, Medicaid managed care has generally expanded access for children, while constraining access among women to some aspects of health care.

Overall, the results from a variety of studies throughout the U.S. leave a lot of unanswered questions. As the quotation from researchers Baker and Andulis in Table 7.1 indicates, previous research “does not present a clear picture of the effects” of managed care in public programs. The variation in research findings may partly reflect differences in the quality of the managed care programs studied, the programs to which they were compared, and the population subgroups to which they were administered.

¹⁰ Bowen Garrett, Amy J. Davidoff, and Alshadye Yemane, “Effects of Medicaid Managed Care Programs on Health Services Access and Use,” *Health Services Research* 38, no. 2 (April 2003): 575-594.

Minnesota piloted managed care in its public programs in the 1980s, with the intent of evaluating how it compared with fee-for-service care.

Minnesota's Managed Care Projects

Minnesota was one of the first states in the nation to begin implementing managed care in its Medicaid program. In 1983, the Legislature authorized the Department of Public Welfare (later called the Department of Human Services, or DHS) to establish a “demonstration project to determine whether prepayment combined with better management of health care services is an effective mechanism to ensure that all eligible individuals receive necessary health care in a coordinated way while containing costs.”¹¹ Minnesota began implementing a three-year demonstration program in three counties in 1985.¹² A 1988 report said that the state would conduct “utilization and cost analyses” comparing the managed care approach to fee-for-service Medicaid services, based partly on service data provided by the health plans.¹³ However,

- **Minnesota has not comprehensively evaluated whether its Medicaid managed care programs have provided health care more cost-effectively than fee-for-service care, contrary to early intentions.**

DHS concluded in 1989 that it was “difficult to evaluate the [demonstration] project,”¹⁴ yet Minnesota obtained congressional authorization to extend the project beyond its original end date. In 1990, a University of Minnesota report provided the most conclusive findings on the cost-effectiveness of the Medicaid managed care demonstration, although the findings were limited to one subgroup of enrollees who participated in the demonstration for a short period of time. Based on random assignment of Hennepin County enrollees to either fee-for-service or managed care, the study examined services for chronically mentally ill Medicaid enrollees. The report said that “significant cost savings were achieved without any adverse effects on the physical or mental health status, access, or satisfaction of the chronically mentally ill.”¹⁵

Meanwhile, a statewide assessment of the cost-effectiveness of the demonstrations remained elusive. A 1993 draft DHS report said:

¹¹ *Laws of Minnesota* 1983, chapter 312, art. 5, sec. 27.

¹² Initially, the federal demonstration project's objectives were to (1) control spending, (2) help develop a more competitive public health care system, and (3) test the viability of a managed care approach, according to Peter D. Fox and Janet C. Gornick, *Evaluation of Medicaid Competition Demonstrations: The Minnesota Prepaid Medicaid Competition Demonstration* (Washington, D.C.: Lewin and Associates, April 1984), III-2. Later reports on the project do not reference the goal of enhanced competition, emphasizing cost savings and access to quality health care instead.

¹³ Peter D. Fox and Luann Heinen, *Evaluation of Medicaid Competition Demonstrations: The Minnesota Prepaid Medicaid Competition Demonstration (IV)* (Washington, D.C.: Lewin/ICF, August 1988), 43-44.

¹⁴ DHS, *Minnesota Prepaid Medicaid Demonstration Project, 3-Year Report* (St. Paul, June 1, 1989), 4.

¹⁵ Nicole Lurie, Ira Moscovice, Michael Finch, and Jon Christianson, *The Impact of Capitation on Chronically Mentally Ill Medicaid Clients, Final Report—Part 2* (Minneapolis: University of Minnesota, June 1990), 27. DHS terminated the demonstration project for enrollees with disabilities in 1988, so the study was based on one year or less of client follow-up data.

Because it has not been possible to compare the utilization patterns of Medicaid eligibles in the health plans with those in the fee-for-service setting, it has proved difficult to assess the comparative value of the services provided to Medicaid eligibles through the health plans. Even though the premium paid to the health plans was designed to save money for the Medicaid program, without knowing the types and quantities of services provided it has not been possible to determine if the plans provide good value. And, beyond the issue of value, little information has been available to judge the effect on utilization of services which capitated care exerts in a low-income population.¹⁶

This 1993 DHS draft report attempted to compare service utilization patterns in managed care and fee-for-service settings, but it “raises more questions than it provides answers.”¹⁷ The report cited a variety of data limitations and recommended that DHS routinely monitor service use, service appropriateness, access to care, and outcomes in both managed care and fee-for-service.

An Urban Institute study found no evidence that Minnesota’s expansion of managed care in the mid-1990s improved Medicaid enrollees’ access to care.

In 1995, a DHS report estimated that, from 1987 through 1993, the state saved a total of \$3.3 million (or less than \$500,000 per year) over fee-for-service costs in the three counties where the demonstration project was initially implemented.¹⁸ The report emphasized that its analysis of cost savings did not consider the effectiveness of services under the demonstration. The report also did not examine differences in service utilization among fee-for-service and managed care enrollees.

Minnesota received federal authorization in 1995 to expand its managed care Medicaid program statewide, a process that began in 1996. The goals of this expansion were (1) to improve enrollees’ access to services, and (2) to save money over the costs of fee-for-service care.¹⁹ An evaluation of Minnesota’s program expansion by Urban Institute researchers concluded that “[t]here is no evidence that [Medicaid managed care] improved access to care for Medicaid

¹⁶ Steven S. Foldes, *Health Plan and Fee-for-Service Utilization Patterns: A Comparison of Use by Medicaid Enrollees in the Twin Cities Metropolitan Area in 1991, Draft Report* (St. Paul: Minnesota Department of Human Services, May 1993), 2. This draft report was distributed publicly, but a finalized version of the report was apparently never issued.

¹⁷ *Ibid.*, 31.

¹⁸ Minnesota Department of Health and Minnesota Department of Human Services, *Prepaid Medical Assistance Cost Study Addendum* (Minneapolis-St. Paul, April 11, 1995), 6. The report estimated that the managed care program saved \$26.8 million over fee-for-service in 1987-91 but cost \$23.5 million more than fee-for-service in 1992-93.

¹⁹ Sharon K. Long, Teresa A. Coughlin, and Jennifer King, “Capitated Medicaid Managed Care in a Rural Area: The Impact of Minnesota’s PMAP Program,” *The Journal of Rural Health* 21, no. 1 (Winter 2005): 13. A 1995 report questioned the potential for cost savings, citing Minnesota’s relatively high capitation rates, payments for services such as transportation outside the capitation amount, and the already low costs of the health care system (Mathematica Policy Research, *Managed Care and Low-Income Populations: A Case Study of Managed Care in Minnesota* (Princeton, NJ, November 1995), 30).

There is a limited amount of hard evidence regarding managed care's overall cost-effectiveness in Minnesota's public programs.

beneficiaries, as the state had hoped.”²⁰ Regarding possible cost savings, the evaluation said that “Minnesota does not have hard data to document a reduction in costs under [Medicaid managed care].”²¹ The evaluation said it is possible that the managed care expansion reduced state spending compared with the costs that would have been incurred under fee-for-service, although it said some reductions may have reflected shifts of costs to non-Medicaid funding sources (such as counties).

More recently, Minnesota has expanded managed care options for elderly and disabled enrollees of publicly funded health care programs. The Minnesota Senior Health Options (MSHO) demonstration project (started in 1997) was initially designed to be no more expensive than fee-for-service Medicaid, and a 2000 DHS report said that the program achieved this goal in its first three years.²² Subsequently, an independent evaluation compared service utilization of MSHO managed care enrollees with enrollees who received a combination of fee-for-service Medicare and Medicaid managed care. That evaluation found that the results were “mixed but favor MSHO.”²³ Specifically, MSHO had lower rates of preventable hospitalizations and emergency room visits, apparently through greater use of preventive and community-based care services. Since this evaluation, the MSHO program has expanded from a demonstration in a limited number of counties to a statewide program, and DHS staff told us there is a need for an updated evaluation. In addition, DHS implemented the Minnesota Disabilities Health Options (MnDHO) program in several counties in 2001, giving disabled Medicaid recipients the option of enrolling in a managed care program. A 2004 analysis said that MnDHO participants reported improved satisfaction and care coordination compared with fee-for-service care, but the report said that it was too early to determine if the program led to net savings in Medicaid spending.²⁴ Some local officials have expressed concern about the transfer from counties to health plans of certain case management responsibilities for seniors and people with disabilities, claiming that the health plans’ performance has been uneven.

²⁰ Long and others, “Capitated Medicaid Managed Care in a Rural Area”: 17. An earlier report said there was little data from which to evaluate whether the initial demonstrations in Hennepin, Dakota, and Itasca counties improved access to services. It said that a sample of providers, health plans, consumers, and policy makers generally thought the pilot improved access for clients in Hennepin County (Mathematica Policy Research, *Managed Care and Low-Income Populations*: 25-26).

²¹ Long and others, “Capitated Medicaid Managed Care in a Rural Area.” 19. The evaluation noted that Minnesota set capitation rates 10 percent below estimated fee-for-service costs.

²² Pamela J. Parker, Michael J. Zis, and Susan Westrich, *The Minnesota Senior Health Options Demonstration in Review: Draft Final §1115 Waiver Report, 1997-1999* (St. Paul: Minnesota Department of Human Services, July 2000).

²³ Robert L. Kane, Patricia Homyak, Boris Bershady, Shannon Flood, and Hui Zhang, “Patterns of Utilization for the Minnesota Senior Health Options Program,” *Journal of the American Geriatrics Society* 52, no. 12 (December 2004): 2044.

²⁴ Susan Palsbo, Phillip Beatty, Pamela Parker, and Chris Duff, *Minnesota Disability Health Options: Expanding Coverage for Adults with Physical Disabilities: Resource Paper* (Hamilton, NJ: Center for Health Care Strategies, January 2004).

Overall, it is possible that managed care has, in fact, improved the cost-effectiveness of Minnesota's health care programs. However, despite implementing various "demonstrations" of managed care, Minnesota does not have definitive documentation on a statewide level that managed care has reduced health care costs, improved access, or improved health care outcomes.

Managed Care's "Added Value"

To help us evaluate whether Minnesota's expansion of managed care has been justified, we talked with staff from DHS, health plans, counties, and interest groups. We also looked at differences in the characteristics of managed care and fee-for-service care in Minnesota, plus other health care approaches that have been used in other states. We concluded that:

- **The state's efforts to provide accountable, client-focused health care have been better served by managed care than fee-for-service in several important ways.**

Managed care contracts have provided the state with a mechanism for leveraging improvements in services for public program enrollees.

First, through the development of detailed contracts with each health plan, DHS has a mechanism for leveraging improvements in access, accountability, and quality that it has generally lacked in fee-for-service care. For example, the state contracts specify requirements such as those shown in Table 7.2, and it provides financial incentives for improved performance in the areas discussed in Chapter 5. These contract provisions have not always led to improved services. Nevertheless, DHS's annual negotiation of contracts with nine health plans have provided more opportunity to shape health plan services than it has had to shape the services provided by thousands of fee-for-service providers statewide.²⁵

Second, the use of capitated payments to health plans makes the managed care portion of Minnesota's health care spending more predictable than it is under fee-for-service. A former DHS official told us that Minnesota's Medical Assistance program had a history of cost overruns in the years when most enrollees received services through a fee-for-service approach. Capitated payments do not ensure that the state will contain health care growth cost, but they limit the state's financial risk. If the cost of serving enrollees exceeds the capitated amounts set by the state, health plans bear the higher costs.

Third, competition and collaboration among health plans have fostered creative efforts to serve enrollees. For example, several of Minnesota's health plans jointly fund the Institute for Clinical Systems Improvement, a nonprofit organization that works on improvements in health care services and community outreach. These health plans also initiated Minnesota Community Measurement in 2001, a project that is providing consumers with clinic-level data on health care performance. Individually, health plans have developed many approaches intended to improve services to lower-income Minnesotans, including: providing

²⁵ In chapters 2 and 5, we noted that DHS is in the early stages of implementing intensive care coordination projects involving fee-for-service enrollees. Thus, improving service delivery in fee-for-service care is an important state goal, although there are many challenges to doing so.

Table 7.2: Examples of Requirements in DHS's Contracts with Managed Care Organizations

- Provide all enrollees with information in their primary language
- Get advance DHS approval for all enrollment materials
- Notify enrollees regarding the termination of contracted providers
- Report "encounter data" to DHS on services provided to individuals
- Implement a care management system for all enrollees
- Advise enrollees of the appropriate use of health care and how they can maintain their own health
- Demonstrate that the plan's provider network meets statutory standards
- Implement policies and procedures for utilization review of services provided
- Adopt preventive and chronic disease practice guidelines for various subgroups of enrollees
- Adopt a uniform process for provider credentialing
- Prepare an annual quality assurance work plan
- Conduct performance improvement projects in areas intended to affect health care outcomes and enrollee satisfaction
- Make available disease management programs for enrollees with asthma and diabetes
- Have a grievance and appeals system in place
- Send enrollees notices of service denials, terminations, or reductions
- Have administrative and management procedures to guard against fraud and abuse

SOURCE: Office of the Legislative Auditor, review of health plan contracts with Department of Human Services.

Managed care organizations have made significant efforts to engage enrollees in health improvement activities.

enrollees with gift cards if they obtain key preventive or wellness services, such as prenatal or postnatal care, immunizations, or cancer screening; distribution of car seats to new parents; the assignment of care coordinators to certain enrollees; and special efforts to improve client access to services (examples include a mobile dental unit, a drop-in dentistry center, and increased provider payments in regions with provider shortages). Many of these activities are funded from the state's capitation payments to health plans, and the overall impact of these efforts is unclear. Still, these active efforts by managed care organizations to engage public program enrollees in health improvement activities contrast with the more passive and uncoordinated approaches that have characterized the fee-for-service system.

Fourth, health plans have played a valuable role in helping to assemble the networks of providers that serve public program enrollees. The plans have sometimes convinced providers in their commercial programs to serve clients in public programs, and plans have generally paid their providers at rates somewhat higher than the state's fee-for-service payment rates. DHS officials said that, in their opinion, some of Minnesota's current provider networks might not exist if not for the efforts of health plans.

Fifth, as Chapter 5 noted, managed care enrollees generally have more recourse when problems arise than do fee-for-service enrollees. Enrollees in either system have the option of expressing their concerns directly to a service provider, seeking a state hearing to appeal a state or county decision, or submitting a complaint to DHS's Surveillance and Integrity Review Section (SIRS). But enrollees in managed care have the additional options of (1) contacting customer service staff at the health plan, (2) filing a formal grievance or appeal with the health plan, and (3) reporting the problem to the state's managed care ombudsman. In addition, managed care enrollees receive notices regarding service denials, reductions, and terminations (fee-for-service clients do not), and managed care enrollees receive a more detailed listing of covered services than fee-for-service enrollees receive.

OTHER SERVICE DELIVERY OPTIONS

While offering some apparent advantages over fee-for-service, managed care's costs are significant. In Chapter 4, we said that DHS and health plans spent a total of more than \$259 million in 2006 to administer Minnesota's public managed care programs, compared with the \$42.5 million that DHS estimated it spent to administer fee-for-service. Chapter 3 noted that federal requirements for "actuarially sound" managed care programs could contribute to ongoing growth in health care spending, and it noted significant growth in Minnesota health plans' total reserves. In addition, some Minnesota health plan officials told us that the ability of their organizations to manage health care costs has waned in recent years. For example, one health plan official offered the following comments:

Legislative mandates concerning coverage of certain medical procedures has, in some cases, rendered health plan decision making around medical necessity obsolete. ... Management of emergency room usage is all but non-existent. ... Prescriptive prior authorization rules for high-tech diagnostic imaging so enrages providers that most health plans are reluctant to take aggressive action to control utilization. ... Pressures to provide free and open choice of provider has made most primary care-oriented health plans obsolete. Getting people to the lower cost provider has given way to the open access to specialists and emergency rooms. ... Experimental and scientifically unproven therapies used to be routinely not covered by health plans. These historic boundaries are constantly being challenged by providers, advocates, and members. Legislators hear these anecdotes and respond with mandates. ... Attorney General and other legal actions against health plans trying to control mental health costs have rendered most of them unwilling to make reasonable decisions about these services and the needs of the individual members.²⁶

We think that Minnesota's past decisions to test and then expand the use of managed care in public programs were reasonable and consistent with the actions

The Legislature should continue to consider alternative ways of delivering publicly funded health care, especially if faced with increases in managed care costs.

²⁶ Letter to Joel Alter, Office of the Legislative Auditor, from a health plan chief executive officer, October 16, 2007.

of other states. The state's managed care programs have substantial administrative costs, but many of these administrative services would have to be performed under any alternative approach, too—whether by DHS, health care providers, or others. Still, we think the Legislature should take a hard look at alternative ways of delivering health care services, particularly if faced with significant increases in managed care costs. We discuss some options in the following sections. We offer no recommendations because it is unclear from existing evidence whether these alternatives would be practical or more cost-effective than Minnesota's current practices.

Contract Directly with Providers

Health plans serve as intermediaries between DHS and health care providers. The plans perform many administrative tasks on behalf of DHS, such as assembling networks of providers. However, some people have suggested that it might be more cost-effective for DHS to contract directly with provider organizations, bypassing the health plans and perhaps reducing administrative costs. For instance, providers would not have to accommodate the different billing systems and administrative practices of multiple health plans. There is also the potential for economies of scale if administrative services now performed by the plans were provided centrally (by DHS or a DHS contractor).

Direct contracting could take several forms. About 30 states have implemented “primary care case management” (PCCM) programs, which are a type of managed care that does not involve capitation payments to managed care organizations. Under the PCCM approach, beneficiaries enroll with a primary care provider rather than a health plan. The state pays primary care providers on a fee-for-service basis, and it also makes a per-member-per-month payment to providers to coordinate enrollees' primary, preventive, and specialty care services.²⁷ Unlike the type of managed care used in Minnesota's public programs (which is often called “full-risk” or “fully capitated” managed care), PCCM programs typically require the state to retain the financial risk for services provided or approved by the primary care providers.²⁸

Some states have increased their use of PCCM programs partly because of concerns about the rising costs of traditional managed care. For example, Oklahoma operated two types of managed care until 2004: (1) the state contracted with managed care organizations, and (2) the state contracted directly with primary care providers (a PCCM approach). Oklahoma decided to terminate its contracts with managed care organizations in 2003, faced with double-digit increases in managed care capitation payments and the decision by one managed care organization to discontinue its business in the state. Consequently, Oklahoma placed all of its Medicaid enrollees into the state's

Some states pay health care providers directly for services, while retaining the financial risks borne elsewhere by health plans.

²⁷ This is similar to the Intensive Care Management program that Minnesota recently started to implement for certain fee-for-service enrollees, as discussed in Chapter 2.

²⁸ However, it might also be possible for states to contract directly with provider organizations, make capitation payments to them, and require these organizations to assume financial risk for costs above the capitation payments.

PCCM program. Oklahoma officials told us they have experienced annual savings of \$85 million from this change, and they also contend that the change enabled the state to improve and expand services to beneficiaries.²⁹

In contrast, University of Maryland researchers examined the respective merits of “full-risk” managed care, PCCM programs, and fee-for-service in Michigan and concluded the following: “A capitated [full-risk] managed care program, involving multiple [managed care organizations], is the most cost-effective delivery system for Michigan. It also incorporates many public health benefits that are not usually found in less intensively managed program types.”³⁰ This study concluded that a PCCM program and fee-for-service approach would cost the state more than contracting with managed care organizations. Likewise, a recent study by The Lewin Group concluded that Connecticut’s capitated contracts with managed care organizations have greater potential for cost savings than PCCM models. The study said that administrative costs under PCCM-type approaches “will be significantly lower than (generally less than half of) those associated with the [managed care organization] model, since the [PCCM-type] models engage in fewer cost containment initiatives and do so less aggressively than do capitated [managed care organizations].”³¹ Overall, however, it concluded that expenditures under Connecticut’s existing capitated managed care program “are at least five percent below what any newly implemented non-capitated Medicaid managed care model would be able to deliver.”³²

There remain unanswered questions about the feasibility and likely impact of a “direct contracting” approach to state health care procurement.

We think there are many unanswered questions about the feasibility and likely impact of direct contracting. For instance, the state would have to decide whether contracts with health care provider organizations would involve capitated payments that would limit the state’s financial risk. If so, this would be different from the approaches used in PCCM programs in most states, and it is unclear whether provider organizations would be willing to accept this risk. Also, a direct contracting approach would require DHS to perform or contract for certain administrative tasks that are now performed by the health plans. Currently, health plans spend about \$200 million a year to conduct these activities, and it would be challenging to transfer duties of this magnitude (or even a somewhat more limited set of duties) to DHS or others over a short period of time. Finally, it is important for Minnesota’s publicly funded health care programs to effectively coordinate and manage health care and related services, and it is unclear whether PCCM-type approaches could do this better than health

²⁹ A federal official told us that states could reduce spending for quality assurance activities by eliminating their full-risk managed care programs. He said that most of the federal regulations for managed care quality assurance do not apply to PCCM-type programs.

³⁰ Center for Health Program Development and Management, *Michigan Medicaid: Relative Cost Effectiveness of Alternative Service Delivery Systems: Final Report* (Baltimore: University of Maryland, April 2005), 36. Michigan’s cost savings from full-risk managed care occurred largely because a premium fee paid only by full-risk health plans was counted as an administrative cost by the plans and, thus, was included in rate-setting calculations. Michigan received the revenues from this fee, and the federal government paid for half of the fee-funded expenditures.

³¹ The Lewin Group, *Assessment of HUSKY, Connecticut’s Medicaid Managed Care Program* (Falls Church, VA, 2007), 20.

³² *Ibid.*, 22.

plans. Because of these unresolved questions, we suggest that the Legislature proceed cautiously if it is interested in exploring direct contracting—preferably with a limited-scale pilot (perhaps in one region of the state) rather than making statewide changes at this time.

Contract with Fewer Health Plans

The Department of Human Services contracts with nine health plans to administer publicly funded health care programs throughout the state. Each of these plans provides or purchases a variety of administrative services, such as billing, claims processing, utilization management, customer service, fraud detection, and other activities. Some people have questioned whether it is duplicative and inefficient to have nine different organizations performing similar administrative tasks. An alternative would be for DHS to contract with fewer health plans—perhaps even with just one. However, we concluded that:

- **It would probably not be practical or cost-effective in the short run for Minnesota to contract with a single health plan to administer public programs on a statewide basis.**

First, federal regulations require Medicaid recipients to be offered a choice of at least two health plans, except in certain rural areas.³³ States can apply for waivers of federal requirements, but we are aware of only one state (Vermont) that relies on a single managed care organization to administer comprehensive health care programs on a statewide basis.³⁴ Second, most of Minnesota’s health plans that administer public programs do not operate throughout the state, which might significantly limit the state’s options for selecting a single, statewide health plan. As of November 2007, only two plans (BluePlus and UCare) operated Medical Assistance or MinnesotaCare programs in more than 33 Minnesota counties. In fact, six of the nine plans operated in 15 or fewer counties. Third, contracting with just one plan would not necessarily lead to lower costs or better services. For example, it might be more difficult for DHS to negotiate rates and contract provisions favorable to the state if there was a single contractor rather than competing plans. Fourth, contracting with a single plan would probably end Minnesota’s use of county-based purchasing, an approach that many rural counties favor as a way to improve health plan responsiveness to local needs.

If it is not feasible to implement single-plan contracting statewide, another option would be for DHS to contract with fewer plans. The purpose of such an approach would be to limit the state’s contracts to those health plans that provide the best value for the money. One way to accomplish this would be through a competitive bidding process. In 1996, a state task force recommended—and DHS endorsed—implementing a competitive bidding approach for the state’s

Only one state—Vermont—relies on a single managed care organization to administer public programs on a statewide basis.

³³ 42 CFR sec. 438.52 (2007).

³⁴ Vermont established the state’s Medicaid agency as a managed care organization, the only one serving that state’s public program enrollees. This was part of a waiver that granted Vermont flexibility in the design of its Medicaid program in exchange for operating under a capped amount of federal Medicaid funds.

Some states set managed care rates using competitive bidding rather than an administrative process.

public managed care programs. The task force said this approach might “increase efficiency, quality, and innovation while decreasing or maintaining program costs.”³⁵ The task force also said that a competitive bidding approach would free DHS and health plans from an “artificial” process for setting capitated rates.³⁶ According to a national survey in 2001, competitive bidding was used in about 28 percent of the states with managed care; the remaining states set managed care rates through administrative processes or negotiations with plans.³⁷

DHS staff told us they are now skeptical that competitive bidding would result in more cost-effective services. For example, they noted that few health plans seem interested in serving certain parts of the state, thus limiting the likely amount of competition. Also, staff said health plans submitted some very high bids several years ago when DHS explored competitive bidding, and they said there was political pressure for DHS to accept the submitted bids. We offer no recommendation on competitive bidding, but we think it is an option that deserves consideration if the Legislature wishes to reduce the number of health plans with which the state contracts.

An alternative to contracting with fewer plans would be for the state to implement incentives to enroll clients in the higher-performing plans. For example, when newly enrolled Medicaid clients do not select a health plan within the prescribed time period, some states assign these clients to plans that have performed well on selected measures. States have typically used quality measures (such as the percentage of children screened in a timely manner) to distinguish the performance of plans, but other measures (such as the level of administrative costs) could also be used.

³⁵ Department of Human Services, *Managed Care Rate Setting for Public Programs: Report to the Legislature* (St. Paul, December 1996), 2. Also, the report said that DHS did not see a need to retain a fee-for-service payment system.

³⁶ *Ibid.*

³⁷ John Holahan and Shinobu Sukuki, “Medicaid Managed Care Payment Methods and Capitation Rates in 2001,” *Health Affairs* 22, no. 1 (January/February 2003): 204-218. Thirty-six of 39 states (including the District of Columbia) with capitated managed care responded to the survey; 10 of the 36 responding states (28 percent) used some form of competitive bidding.

List of Recommendations

- The Legislature should require the Department of Human Services to present the 2009 Legislature with a status report on its 2005 report that identified strategies for cost containment. When appropriate, the status report should identify new or alternative strategies for containing the costs of Minnesota's publicly funded health care programs (p. 33).
- DHS should report to the 2009 Legislature on recent differences between targeted and actual health plan net income in various programs, providing explanations for these differences to the extent possible (p. 48).
- DHS should include at least a portion of health plans' interest earnings in their calculations of revenues for rate-setting purposes (p. 48).
- The Legislature should classify information provided to the Department of Human Services on a health plan's contracts and contract-related payment rates as "not public" data (p. 49).
- DHS should report to the 2009 Legislature on the adequacy of Minnesota's fee-for-service provider rates. As part of this analysis, DHS should identify service areas or regions of the state in which public program enrollees have had difficulty accessing providers (p. 54).
- The Legislature should consider increasing fee-for-service payment rates for certain types of providers, such as primary care physicians (p. 54).
- As required in Minnesota statutes, DHS should implement a "relative value unit" payment system for Medicaid and related programs, and it should update the 2008 Legislature regarding the expected completion date for this task (p. 54).
- DHS should require more detailed reporting by health plans of their administrative spending for its public programs (p. 74).
- The Department of Health should develop guidelines to ensure that health plans have consistent procedures for allocating administrative expenses across their lines of business (commercial and public) and across individual public programs (p. 74).
- The Department of Human Services should increase its scrutiny of health plans' administrative expenses, particularly during the rate-setting process (p. 74).

- The Legislature should require the departments of Health and Commerce to establish more detailed standards and procedures for examining the “reasonableness” of health plans’ administrative expenditures for publicly funded programs (p. 74).
- DHS should clearly define which types of health plan administrative expenses are allowed for purposes of calculating future capitation payments (p. 75).
- DHS should modify its rate-setting methodology to (1) include stricter limits on health plans’ administrative spending, or (2) more closely align annual rate increases with actual administrative costs for the public programs (p. 76).
- The Department of Health should investigate more cost-effective ways to ensure that health plans are using appropriately-credentialed providers (p. 76).
- The departments of Human Services and Health should agree on a single way to compute and publicly report health care performance measures (p. 81).
- The Department of Human Services should (1) improve its verification of health plans’ performance data used for administrative withholds and performance incentives, and (2) periodically rotate its administrative measures to ensure performance improvement across a broader range of administrative services (p. 90).
- The Legislature should consider changing the state’s “ombudsman for managed care” to an “ombudsman for health care,” who would advocate on behalf of both managed care and fee-for-service enrollees (p. 94).
- The Legislature should amend state law to disallow county-based purchasing organizations from relying primarily on county taxing authority as a guaranty of their reserve requirements (p. 101).
- The Legislature should (1) amend *Minnesota Statutes*, chapters 256B.692 and 62D.12 to restrict expenditure of revenues for publicly funded health care programs to health care-related services, and (2) subject county-based purchasing organizations to the prohibition on unreasonable expenses outlined in *Minnesota Statutes* 62D.19 (p. 104).
- The Legislature should amend Minnesota statutes to authorize DHS to periodically seek proposals to determine which health plans—county-based purchasing organizations or others—should serve areas now served by single-plan purchasing arrangements (p. 108).



Minnesota Department of **Human Services**

January 25, 2008

James R. Nobles, Legislative Auditor
Office of the Legislative Auditor
Centennial Office Building
658 Cedar Street
St. Paul, MN 55155

Dear Mr. Nobles:

The Minnesota Department of Human Services (DHS) appreciates the opportunity to respond to the January, 2008 program evaluation report on the Financial Management of Health Care Programs. The report will be a useful guide in our ongoing management of the Minnesota Health Care Programs (MHCP). It is a comprehensive review of a broad and complex set of program activities that triggers the possibility of further analysis. We recognize the difficulty of covering such an extensive topic, but in our view it was thorough and conducted in a professional manner.

In balance, we believe that this report provides a fair and accurate accounting of MHCP management activities. It identifies some of the challenges associated with managing a set of programs of this size and complexity. We would like to provide the following responses and observations regarding the report's key findings and recommendations.

It is true that the managed care organizations (MCOs) have achieved financial margins that have exceeded the targeted margins set in our capitation rates, but that outcome results in lower capitation increases in future years, given our rate setting structure. The State benefits financially if the MCOs spend less than their capitation rates. However, in more recent years we are seeing margins that approximate the targeted margin, i.e. .5%.

The report relies heavily on comparing DHS performance to a report that was issued by the department in 2005, entitled Health Care Services Study: Findings and Strategies for Savings. This was a report that was mandated by the State Legislature directing DHS to identify possible strategies for program cost savings. Not all of those strategies were recommended by DHS, but were presented as possible ideas that required further analysis. DHS did present some of those strategies as recommendations, which were included in the Governor's 2005 legislative proposals, and were ultimately adopted by the legislature. However, the department should not be judged against a set of strategies that we were not authorized to implement.

James R. Nobles
January 25, 2008
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The report focuses a great deal on the administrative expenses incorporated in the capitation rates paid to the MCOs. It accurately states that the department's emphasis has been on overseeing the MCOs performance on managing the health care services provided by the MCOs, which consists of approximately 92% of the expenses incurred. We agree that there should be more understanding and oversight of MCO administrative expenses, but without incurring significant auditing and cost accounting expenses, by DHS and the MCOs. These expenses should be examined in more detail, and, as the report points out, that whatever additional means the State might use to address this issue need to be determined as compliant with federal regulations. However, we believe that further analysis is needed before we take the step of adopting a cost allocation or auditing approach to setting rates for administrative expenses, as the report recommends. We will also work closely with the Commerce and Health departments in addressing this legitimate concern.

Again, thank you for the opportunity to respond to your report.

Sincerely,



Cal R. Ludeman
Commissioner



Protecting, maintaining and improving the health of all Minnesotans

January 28, 2008

James Nobles, Legislative Auditor
Office of the Legislative Auditor
Room 140 Centennial Building
658 Cedar Street
St. Paul, Minnesota 55155-1603

Dear Mr. Nobles:

Thank you for the opportunity to provide comment on your report, "Financial Management of Health Care Programs." The topics covered in the report are complex and challenging, and I commend your staff for their excellent work sorting through these issues in an understandable and comprehensive manner.

The Minnesota Department of Health comments relate to three areas of the report. As the report notes, administrative expenses account for 8% of publicly funded health care program expenditures, with 92% of spending going for hospital and medical expenses. While we agree with the report's finding that more information about administrative expenses of managed care companies would be useful for oversight and accountability, it is important to note that the Department of Health examines aggregate administrative costs as part of our regulatory review. As noted in your report, these reviews provide an indication of relative value. To date, none of those reviews has triggered concerns that might lead to a more in-depth review. However, should the legislature, as recommended in the report, require MDH to establish more detailed standards and procedures for examining administrative costs, we certainly will cooperate in its implementation.

Second, the report recommends that the Departments of Human Services and Health should agree on a single way to compute and publicly report health care performance measures. This is a reasonable recommendation, and MDH will work with the Department of Human Services to examine ways to implement this recommendation.

Finally, to the extent that administrative simplification can assist the plans to spend less in administrative costs, we will also examine ways to accomplish the recommendation that MDH investigate more cost-effective ways to ensure the use of appropriately-credentialed providers.

Again, we thank you for the opportunity to comment on your report.

Sincerely,

A handwritten signature in black ink that reads "Sanne Magnan". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Sanne Magnan, M.D., Ph.D.
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975



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January 31, 2008

James Nobles
Legislative Auditor
Office of the Legislative Auditor
State of Minnesota
Room 140 Centennial Building
658 Cedar Street
St. Paul, MN 55155-1603

Dear Mr. Nobles:

We have reviewed the report of the Legislative Auditor titled *Financial Management of Health Care Programs* dated January 18, 2008. We note that the role of Commerce (DOC) is to assess and monitor the financial solvency of the entities and Commerce is *not* charged with oversight responsibility of the actual programs administered by the entities.

Our response is limited to areas of the report where there is information involving DOC that is incorrect and clarification is warranted.

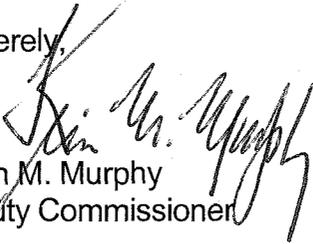
| Response Number | Page Reference | Comment |
|-----------------|----------------|--|
| 1 | Pg. xii | The Commerce Department (DOC) is charged with determining the solvency of health plans licensed by the Minnesota Department of Health (MDH). The basic charge is to determine if the plan has funds to cover its contractual obligations as they come due. With this as our stated objective, the "reasonableness" of expenses is measured in an overall context, and is not determined, or even considered, at the program level. |
| 2 | Pg. xii | With respect to the solvency of county-based purchasing plans, sources of revenue are important. The ability of a county to raise funds via taxing authority is a very strong source of funds to meet obligations, if necessary. |
| 3 | Pg. 2 | DOC does not maintain documents and data concerning Minnesota's <i>public health care programs</i> . DOC receives copies of financial reports and financial statements filed by <i>health plans</i> with the MDH. |

James Nobles
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|---|--------|--|
| 4 | Pg. 3 | DOC does not participate in the financial management of Minnesota's public health care programs. |
| 5 | Pg. 15 | The responsibility for the review of the reasonableness of HMO expenses rests with MDH. This is not covered in the interagency agreement and to our knowledge it has never been the intent of the MDH to transfer this responsibility. |
| 6 | Pg. 43 | The report refers to "reserves" as synonymous with "net worth", however, these terms are not interchangeable. |

We appreciate the opportunities to comment on the report.

Sincerely,


Kevin M. Murphy
Deputy Commissioner

cc: Jaki Gardner, Assistant Commissioner
Patrick Sexton, Commerce Legislative Liaison



January 24, 2008

James R. Nobles
Legislative Auditor
Office of the Legislative Auditor
Centennial Office Building
58 Cedar Street
St. Paul, MN 55155

Dear Mr. Nobles:

Thank you for the opportunity to respond to the Office of the Legislative Auditor's report on Financial Management of Health Care Programs. The report provides a clear overview of management of health care spending in Minnesota's publicly funded health care programs. There are many parts of the report of interest to counties. AMC is limiting comments primarily to Chapter Six, which addresses county - based health care purchasing.

The report found that "County-based health plans have made significant efforts to improve services in rural Minnesota, but it is still unclear whether their services are better or less expensive than those other health plans". The comparison of county-based purchasing products to health plans' products is, to some extent, an "apples to oranges" comparison. County-based purchasing was established for a different purpose than that of commercial health plans. Counties became interested in county-based purchasing in response to Minnesota's decision to use managed care organizations to purchase publicly funded health services for vulnerable populations. Counties' primary interest is to assure access to coordinated health care, public health, and social services for people for whom counties bear financial responsibility. Minnesota's managed care organizations, on the other hand, exist to provide health care services to enrolled populations, including public program enrollees. Counties would generally agree that it is appropriate to hold county-based purchasing organizations to the same standards as health plans to the extent this is necessary to meet quality of care and cost-containment goals. However, evaluation of the effectiveness of county-based purchasing should be based on the broader public policy goals above. This would indicate, for example, that measures beyond HEDIS indicators be used to assess whether county-based purchasing is achieving its goals.

Counties also suggest that administrative expenses be considered in relation to total expenditures. That is, do investments in administration--which under current practice may be defined differently from one plan to another--reduce overall health care expenditures? We agree with the recommendation in Chapter Four that the state increase its scrutiny of administrative spending by health plans. Perhaps state agencies could establish consistent definitions of allowable administration across all health plans and require that health plans break out administrative costs for public programs. This would make it possible to compare administrative spending for public programs across all plans. Finally, the report does not address administrative costs at the *provider* level. Since county-based purchasing is currently

the only health plan in most of the geographic areas where it exists, administrative costs at the provider level may be substantially less.

The report recommends that “The legislature should retain the option of using both private and county-based health plans to administer managed care for public programs, but it should restrict expenditures to health-related purposes.” Counties do not disagree with suggested changes that would limit use of surplus revenues to health-related purposes, as long as these purposes are defined to include public health and social services and also apply to private managed care organizations. One advantage of county-based purchasing is that of transparency: administrative expenses, use of reserves, and other facets of operation are public information. We believe that consumers and the public have a right to information on expenditures of public dollars regardless of whether the entity managing these dollars is public or private.

The report recommends that the legislature authorize DHS to periodically reconsider which plans will serve counties that have single-plan purchasing arrangements. Counties entered into county-based purchasing as a long-term endeavor. Assuming that they continue to meet state requirements and effectively coordinate services, these arrangements should be continued to allow stability of services to clients and communities. The re-procurement process that the federal government requires provides one feedback mechanism to assess whether performance is satisfactory.

The report recognizes that county-based purchasing arrangements are relatively new and still evolving. Counties anticipate that such arrangements in the long run will demonstrate their cost-effectiveness in using public funds to address health and social needs in Minnesota. We encourage the legislature to continue to explore these and other arrangements to best serve Minnesota’s vulnerable citizens.

Sincerely,

A handwritten signature in cursive script, appearing to read "Paul Wilson".

Paul Wilson, President

Association of Minnesota Counties

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