Minnesota Department of Human Services Health Care

Mission Statement

The Department of Human Services, in partnership with the federal government, county and other public, private, and community agencies throughout Minnesota, is a state agency directed by law to assist those citizens whose personal or family resources are not adequate to meet their basic human needs. It is committed to helping them attain the maximum degree of self-sufficiency consistent with their individual capabilities. To these ends, the Department will promote the dignity, safety, and rights of the individual, and will assure public accountability and trust through responsible use of available resources.

A Report to the 2000 Minnesota Legislature as required by Laws of Minnesota 1999, chapter 245, article 4, section 114

Rate Setting and Risk Adjustment

February 2000

Cost of completing this report:

Minnesota Statutes, section 3.197, requires the disclosure of the cost of preparing this report.

Staff time:	$2000
Administrative costs:	200
Total:	$2200

Legislative Requirements

The 1999 legislature required a report related to rate setting and risk adjustment under the Medical assistance (MA), General Assistance Medical Care (GAMC) and MinnesotaCare managed care programs of the Department of Human Services (DHS). The legislative requirements are contained in Laws of Minnesota, 1999, Chapter 245, Article 4, Section 114. This states:

> **[REPORT ON RATE SETTING AND RISK ADJUSTMENT.]**
> **The commissioner of human services shall report to the legislature, by January 15, 2000, on the current rate setting process for state prepaid health care programs, rate setting and risk adjustment methods in other states, and the results of the application of risk adjustment on a trial basis in Minnesota for calendar year 1999. The report must also present an analysis of the feasibility of requiring prepaid health plans to report vendor costs rather than charges, an analysis of capitation rate equalization for MinnesotaCare and the prepaid medical assistance program, an analysis of the fiscal impact on state and county government of repealing Minnesota Statutes 1998, section 256B.69, subdivision 5d, and recommendations for providing actuarial and market analyses related to setting prepaid health plan rates to the legislature on a timely basis that would allow this information to be used in the appropriations process.**

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This report is divided into areas detailing the seven specific requirements contained in the law.

EXECUTIVE SUMMARY

Minnesota's Prepaid Health Care Plans currently provide services to 307,000 recipient/enrollees through managed care. Prepaid managed care plans operate in 51 of Minnesota's 87 counties. Under the prepaid managed care plans, DHS makes a capitation payment each month to a health plan or county purchaser on behalf of each recipient/enrollee. Based on this payment, the health plan/county purchaser provides all covered services.

The capitation rate is established by an analysis of multiple cost factors, followed by a negotiation process between DHS and health plans/county purchasers. The costs that are calculated by the formula are segregated into demographic rate cells that reflect enrollee age, sex, eligibility, Medicare coverage and institutional status and into risk cells that reflect enrollee diagnosis history. However, it is important to note that the rate formula does not vary by health plan/county purchaser.

Minnesota is one of four states to implement a comprehensive health status based risk adjustment payment system for enrollees in public health care programs under managed care. Only Colorado, Maryland, and Oregon have implemented a risk based payment system. Minnesota and Maryland utilize Adjusted Clinical Groups (ACG) software for rate setting and risk adjustment. Colorado and Oregon employ the Disability Payment System (DPS) classification software for rate setting and risk adjustment because of the population they are focusing on.

As part of the legislative mandate for this report, DHS conducted trial risk adjustment for calendar year 1999. DHS modeled the effect of risk adjustment only for the first quarter of 1999 since that was the most recent data available. Encounter data from the health plans/county purchasers is necessary for test modeling because it includes diagnoses and treatment information for each individual enrollee. This information is the basis for the payment under risk adjustment and for the development of the capitation payment rate. The results of the test illustrate the average financial effect across eligibility categories on health plans/county purchasers prior to calendar year 2000 negotiated rate increases.

Reporting vendor costs rather than charges provides little assistance for rate setting and risk adjustment. Both categories can often include more than the service rendered. Provider charges reflect the price that a provider chooses to set for a given service. The provider charge is similar to the "suggested retail price" of consumer goods. Determining the cost of providing services is very difficult because standard definitions and procedures are required if the cost numbers are to be accurate and comparable across provider groups. The primary problem is the addition of

the costs of indirect services, such as administration and equipment, to the overall value of many services. The reliability of reporting vendor costs or charges is basically a function of how the numbers are used. Reporting costs or charges does not need to be an "either-or" decision. A provider may want to label their self-calculated costs as charges. The payment system would then treat them as such and a problem would not be created. However, trying to convert charge-based providers to cost would cause large problems.

Although MinnesotaCare and MA have the same benefit set, many differences exist between the two in terms of payment levels. This occurs because the two have very different utilization and acuity patterns. Comparing MinnesotaCare and MA rates under the current demographic rate structure is difficult because the cost of providing services to the populations is very different. For example, MinnesotaCare has an "adults without children" eligibility group while MA does not. Therefore, it is inappropriate to combine all of the MA and MinnesotaCare rates. However, while it is difficult to equalize all MA and MinnesotaCare rates, it is possible to successfully combine a few categories for rate setting purposes. Merging the MFIP rate groups under MA and the family rate groups under MinnesotaCare would be the least disruptive. This would combine about 80 percent of the MA and MinnesotaCare populations.

The delay of HMO payments was passed during the 1997 session and had a fiscal savings of over $32 million in state share under MA and over $8 million under GAMC. The impact of repealing this law over a three year period, based on the current forecast, would cost the state budget $31.8 million under MA, and $8.1 million under GAMC (See attached fiscal note # 2). This large savings occurs because the state is on a cash basis accounting system. Thus, one month of capitation cost is "saved" by forever pushing the cost into the next year. A repeal of the delay in HMO capitation payments could also be implemented just for the 36 counties not currently in PMAP. This could encourage the participation of new providers in these areas.

Providing data and analyses to the legislature so that future rate setting could be part of the appropriations process presents timing problems . Rates are negotiated with each health plan/county purchaser in September and October for implementation beginning the next calendar year. The legislature currently sets part of the rate increase through the normal legislative process each year. The rate increase is partly composed of legislatively required eligibility, benefit and fee-for-service rate inflation changes. At present, the capitation rate increase is calculated into DHS's forecasts. If the rate increase were to become a part of the appropriations process, it would have to be legislated and allocated for every year rather than automatically included in DHS's forecasts.

Minnesota's Prepaid Health Care Programs: Current Rate Setting Process

Introduction

Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare (MNCare) comprise Minnesota's Health Care Programs (MHCP). Through these three programs there are approximately 307,000 recipient/enrollees who receive services through a prepaid managed care plan (all 107,000 MNCare enrollees are in managed care). While a majority of MHCP recipients/enrollees utilize the managed care system, there are still 211,000 recipients of MHCP who currently having their health care needs met on a fee-for-service basis. Of this group 203,000 are MA recipients and 8,000 are GAMC recipients.

Prepaid managed care plans operate in 51 of Minnesota's 87 counties for MA and GAMC, and in all counties for MNCare. Under the prepaid managed care plans, DHS makes a capitation payment each month to a health plan or county purchaser on behalf of each recipient/enrollee. Based on this payment, the health plan/county purchaser provides all covered services except home and community-based waiver services, nursing facility services, ICF/MR services, and targeted case management services.

Capitation Rate Setting Methodology

The capitation rate is established by an analysis of multiple cost factors, followed by a negotiation process between DHS and health plans/county purchasers. Initially, an actuarial firm is contracted to analyze multiple cost factors to establish a per member, per month capitation rate formula. The capitation rate formula takes into consideration factors related to historical fee-for-service costs, legislatively required eligibility benefits, and inflation changes made since the historical cost period (i.e., the fee-for-service base costs). Cost changes occurring due to utilization and acuity increases, such as more physician visits per enrollee, more use of specialists or higher levels of medical needs, are also added. However, it is important to note that the rate formula does not vary by health plan/county purchaser.

The costs that are calculated by the formula are segregated into demographic rate cells that reflect enrollee age, sex, eligibility, Medicare coverage and institutional status and into risk cells that reflect enrollee diagnosis history. The cells are used to reflect the differing costs of providing coverage to different enrollees. The demographic cells are currently in effect for 95 percent of the payment and the risk cells for 5 percent based on a phase-in to the risk adjustment methodology. The costs in each cell are then divided by the total number of months of eligibility to derive a rate per member per month for each cell. The rates are further adjusted based on the following:

The demographic rates are subdivided based on historical fee-for-service cost differences into Hennepin, other metropolitan, and greater Minnesota counties. The differences are primarily due to historical fee-for-service inpatient costs, medical education and disproportionate population adjustment payments to hospitals and historical utilization levels of the enrollees. By statute, greater Minnesota rates must be at least 88 percent of

metropolitan, non-Hennepin county rates. If not, metropolitan and Hennepin rates are reduced and greater Minnesota rates are increased to achieve the 88 percent on a budget neutral basis. Beginning 2001, this relationship is increased to 89 percent, but the extra percentage point is not required to be budget neutral. Risk adjusted rates do not have differentials based on county location.

When approved by the federal government, medical education costs embedded in the rates will be removed and distributed directly to education entities by a Minnesota Department of Health formula. This will result in a 4.4 percent average change in rates due to the diversion in monies. This translates to 6.3 percent for Hennepin county, 2 percent for other metropolitan counties and 1.6 percent for greater Minnesota counties.

Rates are currently reduced 1% as a contractual withholding. The 1% withholding is disbursed when health plans/county purchasers meet specific performance requirements. The purpose of the 1% withholding is to assure that capitation spending does not exceed the amount that would be paid under fee-for-service.

The computed capitation rates are then subject to the negotiation process. Negotiated calendar year 2000 average rates with a standardized enrollment and risk factor for comparability are:

Hennepin County	$282.26
Metropolitan Counties	$251.22
Greater Minnesota Counties	$226.80

Rate Setting And Risk Adjustment Methods In Other States

Minnesota is one of four states to implement a comprehensive health status based risk adjustment payment system for enrollees in public health care programs under managed care. Only Colorado, Maryland, and Oregon have implemented a risk based payment system. At present there are many states in the process of developing risk adjustment systems. Moreover, there are many employer-based purchasers who have also implemented risk adjustment payment systems.

Generally, the risk adjustment approach varies the payment to a health plan/county purchaser based on a person's expected costliness as measured by their diagnosis history. This methodology allows risk adjustment payment systems to redistribute payments while maintaining budget neutrality. While Minnesota utilizes essentially the same approach, it differs in that it employs age and sex, among others, as demographic proxies for cost cells instead of diagnosis. Arguably, these measures are not as accurate. The following paragraphs detail the risk adjustment methodologies of Minnesota and the other three states.

Minnesota

Minnesota uses the Adjusted Clinical Groups (ACGs) software to assign a person to a payment category based on diagnosis. The ACG system of assignment to cost groups was developed by Johns Hopkins University and was chosen because it is the most widely accepted enrollee classification methodology used by managed care entities. The Department of Human Services (DHS) assigns each ACG category a different rate per member per month by eligibility based on historical fee-for-service cost. Rates are differentiated by eligibility so that rates are more accurately targeted to cost and to account for differing benefit sets. The ACG rates are based on the same cost data that is used in the non-risk-adjusted portion of the payment system. However, ACG rates are statewide after medical education and disproportionate population adjustment monies have been removed and paid separately.

The risk adjustment payment is based on a concurrent model. In a concurrent model, an enrollee's diagnosis, from a previous period, is classified into an ACG payment cell. This payment cell is paid in the current period. Each quarter, this period is moved forward in time. Risk adjusted payments constitute five percent of the total payment during the calendar year 2000 as part of the phase-in to the risk adjustment methodology.

A concurrent model is used for risk adjusting because it allows all enrollees to be classified to an ACG category, whereas a large percentage of the enrollees under the alternative prospective model cannot be classified. The inability to classify enrollees under the prospective model is due to the short average time of enrollment in the public health care programs per enrollee. Many enrollees with short enrollment periods fail to meet the minimum criteria for inclusion.

Colorado

The State of Colorado uses the Disability Payment System (DPS) classification software rather than ACGs software. Capitation rates are established on a prospective model methodology. The prospective model focuses on historical cost by eligibility and location. Once the historical cost is calculated a negotiation process takes place to establish the final capitation rate for covered services.

Colorado is currently considering a change to the concurrent model for capitation rate setting. This impetus for change is due to the limitations on the number of enrollees that can be included. (in what?) Utilization of the prospective model employs an individual's diagnosis history to project that person's cost in the future. However, it should be noted that this model requires a long period of continuous eligibility in order to establish effective capitation rate setting.

There is still utility in the DPS classification software. Therefore, Minnesota will use the DPS classification software to determine payments made under the Demonstration Project for Persons with Disabilities (DPPD).

Maryland

The State of Maryland currently employs a multi- tiered procedure for capitation rate setting. The state first utilizes ACG classification software with a prospective model based on historical cost by eligibility and location. Thereafter, Maryland engages in a negotiation process. The state then applies carve-outs for services such as deliveries and mental health.

Maryland is one of many states presently considering a change to the concurrent model methodology due to the length of eligibility problems. The purpose of the change would be to eliminate the carve-outs. Maryland recently encountered an expensive problem at the implementation stage. At the last minute, officials uniformly decided to increase the time frame for gathering diagnoses for payment. This differed from the period used to gather diagnoses for setting ACG rates. The effect was a mathematical error, which created a large monetary windfall for health plans.

Oregon

The State of Oregon sets its' capitation rate using the Disability Payment System (DPS) classification software. This type of software best fits Oregon's needs because the state is primarily risk adjusting the disabled population of the state. DPS is considered more accurate capitation rate setting methodology for disabled populations. A concurrent model based on historical cost and a negotiation process is also used to develop final capitation rates. Risk adjusted payments constitute ten percent of the total payment for services rendered.

Trial Application of the Risk Adjustment Rate Setting: Calendar Year 1999

As part of the legislative mandate for this report, DHS conducted trial risk adjustment for calendar year 1999. DHS modeled the effect of risk adjustment only for the first quarter of 1999 due to data unavailability. Health plans/county purchasers did not submit the majority of the encounter data needed for modeling to DHS until August 31, 1999. This was after specific data requirements were loosened by the DHS.

Encounter data from the health plans/county purchasers is necessary for test modeling because it includes diagnoses and treatment information for each individual enrollee. This information is the basis for the payment under risk adjustment and for the development of the capitation payment rate.

A comparative test model between the existing payment system and the risk adjusted payment system was determined for each health plan/county purchaser based on the first quarter of 1999. There is a six month time lag between when a health care service is provided and when the DHS receives the associated encounter data. Therefore, more current quarters could not be analyzed. However, the one quarter comparison test is a reasonable proxy for an annual effect. Nonetheless, the risk portion of the payment will change quarterly based on a reassessment of the health status of the enrollees so the analysis is not attempting to precisely predict future payments.

The risk adjustment payment system is budget neutral with the existing payment system in aggregate across all health plans/county purchasers. Risk adjustment simply "cuts the pie" of money more accurately based on the riskiness of enrollees more so than the current demographic method does. Thus, individual health plans/county purchasers may see revenues increase or decrease when compared to the demographic method of paying for risk. Risk adjustment currently affects five percent of the payment due to the phase-in. This is expected to increase in future years. The results of the test illustrate the average financial effect across eligibility categories on health plans/county purchasers prior to calendar year 2000 negotiated rate increases:

Percent Change From Existing, Demographic Rate Cells

Health Plan / County Purchaser	Payment Effect If 100% Risk Based	Payment Effect At 5% Risk Based
Blue Plus	(15.6)	(0.8)
Itasca Medical Care	3.2	0.2
Group Health Plan	1.9	0.1
Medica	13.3	0.6
Ucare Minnesota	2.6	0.1
Health Partners	(11.7)	(0.6)
First Plan of Minnesota	1.8	0.1
Metropolitan Health Plan	(0.5)	0.0

* Calendar Year 2000 Financial Effect.

Prepaid Health Plans Reporting Vendor Costs Rather Than Charges: Is It Feasible?

Reporting vendor costs rather than charges provides little assistance for rate setting and risk adjustment. Both categories can often include more than the service rendered. The paragraphs below illustrate the various problems posed by each category.

Provider charges reflect the price that a provider chooses to set for a given service. It may or may not bear a relationship to cost. The provider charge is similar to the "suggested retail price" of consumer goods. Most providers have a standard set of charges for their services, although providers are generally not paid that amount due to contracting.

Determining the cost of providing services is very difficult because standard definitions and procedures are required if the cost numbers are to be accurate and comparable across provider groups. The primary problem is the addition of the costs of indirect services, such as administration and equipment, to the overall value of many services. Complicating the problem further is the fact that health care entities tend to be dissimilar in the accounting methods used and accounting sophistication. This makes it almost impossible to compare across provider

groups. The federal government has recognized the perplexity in the health care cost reporting system as it has attempted to keep hospital calculations consistent. This is evident in the current Medicare regulation which requires hospitals to submit complex financial reports that are based on volumes of rules. Medicare then audits them to assure compliance.

Furthermore, requiring health plans/county purchasers to report payments to individual providers also presents certain difficulties. Unlike the Department's fee-for-service system where providers are paid a set fee for each service, health plans/county purchasers have a wide variety of payment arrangements including capitation, salaries, and risk pools. Since these payments are often made for a group of patients, there is no consistent method to report how much was paid for an individual patient or service. However, health plans/county purchasers provide the Minnesota Department of Health (MDH) with information on the aggregate payments made to providers by major service category (i.e., inpatient, pharmacy, mental health). This information is furnished as part of the health plans/county purchasers annual report to MDH.

The reliability of reporting vendor costs or charges is basically a function of how the numbers are used. Provider reported costs or charges shouldn't be used to set base rates since both can be skewed to reflect inefficiencies. Relying on providers to simply report costs would result in a poor product for payment purposes for the reasons stated above. Yet, costs and charges should not be eliminated from use in risk adjustment. Currently, a percentage of charges are sometimes used on an all provider average basis. Moreover, risk adjustment employs charges to determine the relative riskiness and cost of an enrollee. These charges simply are used to distribute the aggregate payments which are determined from a different basis.

Reporting costs or charges does not need to be an "either-or" decision. A provider may want to label their self calculated costs as charges. The payment system would then treat them as such and a problem would not be created. However, trying to convert charge-based providers to cost would cause large problems.

An Analysis of Capitation Rate Equalization: MinnesotaCare and the Prepaid Medical Assistance Program

Although MinnesotaCare and MA have the same benefit set, many differences exist between the two in terms of payment levels. This occurs because the two have very different utilization and acuity patterns. In order to accommodate these cost differences, MinnesotaCare is broken into two rate groups by age/sex, and adults/ families. MA is broken into four rate groups by age and sex; MFIP, medically needy children, and aged institutionalized/non-institutionalized. Cost differences and thus, rates, in both cases, are based on eligibility groups and benefit sets. The programs also use different state budgets to fund the services as MA is an entitlement with open ended funding while MinnesotaCare is not.

Comparing MinnesotaCare and MA rates under the current demographic rate structure is difficult because the cost of providing services to the populations is very different. For example, MinnesotaCare has an "adults without children" eligibility group while MA does not. MA has "aged," and "medically needy children" eligibility groups while MinnesotaCare does not. All of these groups have different rates with a large variation among them. Therefore, it is inappropriate to combine all of the MA and MinnesotaCare rates because equalization would

create a broad average rate that does not bear a relationship to actuarial targeting of payments by rate cell.

While it is difficult to equalize all MA and MinnesotaCare rates, it is possible to successfully combine a few categories for rate setting purposes. Merging the MFIP rate groups under MA and the family rate groups under MinnesotaCare would be the least disruptive. This would combine about 80 percent of the MA and MinnesotaCare populations.

Comparability between the MinnesotaCare and MA programs is enhanced by the risk adjustment methodology. Unlike the demographic rates, risk based rates are further adjusted by the health status factor that allows the payment to be differentiated by the costliness of the enrollee. However, equalizing the rates would still create actuarial problems since the final rates still could be considerably different from the cost of providing services.

The average MinnesotaCare family rate for calendar year 2000 is approximately $137.26 per-member per-month while the MA MFIP rate is $148.09. Equalization of MinnesotaCare and MA (See attached fiscal note # 1) rates could occur in one of three ways:

1) The rates could be set at the weighted average rates between the two programs so that budget neutrality existed. Since MA rates are higher than MinnesotaCare rates, a financial disincentive to serve MA enrollees could be created.

2) The MinnesotaCare rates could be increased to equal the MA rates. This would have an annualized fiscal cost in SFY 01 of approximately $7.3 million on MinnesotaCare. The state share of this amount would be $3.7 million. It should be noted, however, that because some MinnesotaCare enrollees receive federal funding, a federal limit on rates exists. Increasing MinnesotaCare rates would have the effect of limiting rate increases that result from other factors.

3) The MA rates could be decreased to equal the MinnesotaCare rates. This would have an annualized fiscal savings in SFY 01 of $17.1 million on MA. The state share of this amount would be $8.4 million. Since MA rates are higher than MinnesotaCare rates, a financial disincentive to serve MA enrollees could be created.

Repealing the Delay of HMO Payments:
Fiscal Impact on State and County Government

The relevant law addressing the Delay in HMO payments is Minnesota statutes, section 256B.69, subdivision 5d, which states:

> [MODIFICATION OF PAYMENT DATES EFFECTIVE JANUARY 1, 2001.] Effective for services rendered on or after January 1, 2001, capitation payments under this section and under section 256D.03 shall be made no earlier than the first day after the month of service.

The above statute was passed during the1997 session and had a fiscal savings of over $32 million in state share under MA and over $8 million under GAMC. The impact of repealing this law over a three year period, based on the current forecast, would cost the state budget $31.8 million under M.A, and $8.1 million under GAMC (See attached fiscal note # 2). Seventy-five percent of the cost would be in the first year, which is state fiscal year 2001. The county share, of the MA amount, would be $2.4 million. Yet, the cost is fully reimbursed by the state with a small delay in time. Section 256B.69, subd. 5d, does not affect the MinnesotaCare program and payments which will continue to be prepaid.

This large savings occurs because the state is on a cash basis accounting system. Thus, one month of capitation cost is "saved" by forever pushing the cost into the next year. However, this is not the financial effect on health plans/county purchasers. They essentially lose the cash flow, cost of not having access to the money, or the interest that could be accumulated on the money during the month. For example, if the interest rate is 5 percent, the cost to the health plans/county purchasers or to providers, if the payment delay is passed on, would be $3.3 million under MA and $0.4 million under GAMC each year. A further point of consideration is that health plans/county purchasers do not usually prepay providers, therefore, the delay may not effect their schedule of payments.

A repeal of the delay in HMO capitation payments could also be implemented just for the 36 counties not currently in PMAP. This could be advantageous to encourage the participation of new providers in these areas. The state cost of delaying the implementation of this section until June 2002 for the 36 counties not currently in PMAP would be:

	FY 2001	FY 2002
MA	$700,000	<$700,000>
GAMC	$150,000	<$150,000>

Utilization of Actuarial and Market Analysis in the Appropriations Process: Recommendations for Future Rate Setting

Providing data and analyses to the legislature so that future rate setting could be part of the appropriations process presents timing problems. Rates are negotiated with each health plan/county purchaser in September and October for implementation beginning the next calendar year.

The legislature currently sets part of the rate increase through the normal legislative process each year. The rate increase is partly composed of legislatively required eligibility, benefit and fee-for-service rate inflation changes. Every fiscal note that is prepared for a statute change in these areas includes an accounting for the effect on total capitation payments.

For calendar year 2000, the part of the rate increase that the legislature controlled amounted to approximately 45% under the MA/GAMC programs and 25% under the MinnesotaCare program. The remaining 55% under MA/GAMC and 75% under MinnesotaCare is the trend amount. The trend amount is composed of actuarial changes and amounts negotiated by DHS. Actuarial changes occur due to increased utilization and acuity increases such as more

physician visits per enrollee, more use of specialist, and higher levels of medical needs.

The legislature meets from January through May during the first year of each biennium. Primary appropriations occur in the first year of the biennium. If market analyses were presented in January, the information could be used to appropriate trend monies for the two following years. However, since the market analysis may be out-of-date for the second year, a budget request for the second year could be used to make any correction when necessary.

A similar methodology involving the legislative process is used for fee-for-service inpatient hospital rates. These rates are also based on calendar years with an economic index that is set by the legislature every two years. However, the use of broader market-based information for capitation rates appears to indicate that an annual approach of appropriating trend monies for the following calendar year be used.

At present, the capitation rate increase is calculated into DHS's forecasts. If the rate increase were to become a part of the appropriations process, it would have to be legislated and allocated for every year rather than automatically included in DHS's forecasts.

Fiscal Note # 1

MINNESOTACARE
Fiscal Analysis of a Proposal to
Equalize Capitation Rates Between MA-MFIP and MinnesotaCare Families

The average capitation rate for pregnant women and children under two for the CY 2000 rate year is estimated at $521.25 for MFIP-MA and at $429.07 for MinnesotaCare. Equalization would require the MinnesotaCare rates to be increased or the MFIP-MA rates to be decreased by $92.18.

The average capitation rate all other children and parents two for the CY 2000 rate year is estimated at $126.91 for MFIP-MA and at $124.92 for MinnesotaCare. Equalization would require the MinnesotaCare rates to be increased or the MFIP-MA rates to be decreased by $1.99.

The fiscal effects of the two options are calculated, assuming that the dollar difference would remain constant and assuming an effective date of January 2000.

OPTION ONE: INCREASE MINNESOTACARE

MINNESOTACARE	**FY 2000**	**FY 2001**	**FY 2002**	**FY 2003**
FAMILIES WITH CHILDREN **(Excluding pregnant** & under two)				
Number of eligibles	91,177	98,301	101,951	103,791
Avg. monthly payment	$1.99	$1.99	$1.99	$1.99
Number of months	6	12	12	12
Total payments	1,088,651	2,347,431	2,434,584	2,478,520
Federal share %	51.49%	51.20%	51.11%	51.11%
% with fed. share	88.00%	91.48%	94.62%	94.48%
Federal share	493,281	1,099,482	1,177,370	1,196,832
State share	595,370	1,247,949	1,257,214	1,281,688
MINNESOTACARE PREGNANT WOMEN AND CHILDREN UNDER TWO **Funded Under MEDICAL ASSISTANCE**				
Number of eligibles	4,133	4,449	4,610	4,687
Avg. monthly payment	$92.18	$92.18	$92.18	$92.18
Number of months	6	12	12	12
Total MA Cost	$2,285,880	$4,921,306	$5,099,398	$5,184,572
State share	997,992	2,161,438	2,493,095	2,534,737
County share	110,888	240,160	0	0
Federal share	1,176,999	2,519,709	2,606,302	2,649,835
State budget	1,099,640	2,410,838	2,493,095	2,534,737
TOTAL STATE COSTS FOR OPTION ONE				
HCA Fund: MinnesotaCare	$595,370	$1,247,949	$1,257,214	$1,281,688
General Fund: MA MFIP & Families	1,099,640	2,410,838	2,493,095	2,534,737
Total	1,695,010	3,658,787	3,750,309	3,816,426

OPTION TWO: DECREASE IVIA-MFIP

MEDICAL ASSISTANCE	FY2000	FY 2001	FY 2002		FY 2003
Avg. MFIP-MA enrollees	159,493	159,646	158,355	160,617	
% in Managed Care	71.57%	74.76%	77.95%	77.95%	
MFIP-MA enrollees in HMO	114,152	119,354	123,440	125,203	
Pregnant women & under two					
Number of eligibles = 11% of no..in HMO	12,557	13,129	13,578	13,772	
Avg. monthly cost	($92.18)	($92.18)	($92.18)	($92.18)	
Number of months	6	12	12	12	
Annual Cost	(6,944,868)	(14,522,651)	(15,019,845)	(15,234,383)	
All other MFIP MA					
Number of eligibles = 89% of no. in HMO	101,595	106,225	109,861	111,431	
Avg. monthly cost	($1.99)	($1.99)	($1.99)	($1.99)	
Number of months	6	12	12	12	
Annual Cost	(1,213,047)	(2,536,644)	(2,623,488)	(2,660,961)	
Total MA Cost	($8,157,915)	($17,059,295)	($17,643,333)	($17,895,344)	
State share	(3,561,664)	(7,492,442)	(8,625,826)	(8,749,034)	
County share	(395,740)	(832,494)	0	0	
Federal share	(4,200,511)	(8,734,359)	(9,017,508)	(9,146,310)	
State budget	(3,924,426)	(8,357,914)	(8,625,826)	(8,749,034)	

TOTAL STATE COSTS FOR OPTION TWO

HCA Fund: MinnesotaCare	$0	$0	$0	$0
General Fund: MA MFIP & Families	(3,924,426)	(8,357,914)	(8,625,826)	(8,749,034)
Total	(3,924,426)	(8,357,914)	(8,625,826)	(8,749,034)

Fiscal Note #2

Fiscal Analysis of a Proposal to Repeal the Delay of HMO Payments

Minnesota's MEDICAL ASSISTANCE PROGRAM

MA Basic Families & Children

	FY 2000	FY 2001	FY 2002	FY 2003
Total MA Cost	$0	$34,430,779	$6,844,423	$4,803,027
State share	0	15,121,998	3,346,238	2,348,200
County share	0	1,680,222	0	0
Federal share	0	17,628,559	3,498;185	2,454,827
State budget	0	16,802,220	3,346,238	2,348,200

MA Basic Elderly & Disabled

	FY 2000	FY 2001	FY 2002	FY 2003
Total MA Cost	$0	$13,835,818	$3,106,435	$2,168,392
State share	0	6,076,691	1,518,736	1,060,127
County share	0	675,188	0	0
Federal share	0	7,083,939	1,587,699	1,108,265
State budget	0	6,751,879	1,518,736	1,060,127

	FY 2000	FY 2001	FY 2002	FY 2003
Total GAMC Cost	$0	$6,577,337	$422,754	$1,128,812