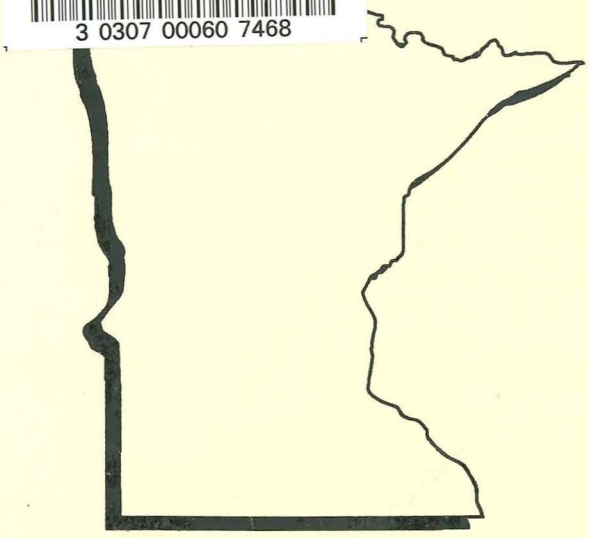

Prepaid Medical Assistance Cost Study

Prepared Jointly by:

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Department of Human Services
444 Lafayette Road
St. Paul 55155

February 15, 1995

Pursuant to 1994 Minn. Laws Chap. 625
Art. 5 Sec. 11

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COST OF PREPARING THIS REPORT

The following is an estimate of the cost of preparing this report:

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Salaries - Department of Human Services: $14,400

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PREPAID MEDICAL ASSISTANCE COST STUDY

INTRODUCTION

The Minnesota Department of Human Services (DHS), in cooperation with three counties, implemented a managed care program for Medicaid recipients in 1985 through the Prepaid Medical Assistance Program (PMAP). PMAP was initially implemented as a demonstration project in Dakota, Hennepin and Itasca Counties. In 1993, the program was expanded to Ramsey County and in 1994 to Anoka, Carver, Scott and Washington Counties. Through PMAP, AFDC, needy children and aged medical assistance (MA) recipients enroll in managed care systems delivered through seven prepaid health plans. With the support and assistance of county governments, DHS will expand medical assistance managed care throughout the State over the next few years utilizing the PMAP model.

The 1994 MinnesotaCare Act, Chapter 625, Article 5, Section 11 required the Departments of Health and Human Services to prepare a report on the impact of PMAP implementation. The purpose of this report is twofold. First, the report will explain the coordination between health care reform and PMAP. Second, the report will discuss whether cost savings, cost shifting, or cost increases have resulted from PMAP implementation. The Departments of Health (MDH) and DHS have convened an interagency work group and have consulted with the Association of Minnesota Counties and representatives of Dakota, Hennepin, Itasca and Ramsey Counties to develop this study for the Minnesota Legislature.

The goal of health care reform in Minnesota is quality health care that is accessible and affordable to all Minnesotans. Each element of the goal will be accomplished through implementation of various components. A direct link between health care reform components and PMAP is demonstrated through the following analysis.

Cost shifting to counties may occur when county property tax revenue must be used to cover the cost of services to PMAP enrollees that PMAP health plans do not cover. DHS does not intend that PMAP cause any such cost shift. The ability to accurately measure such cost-shifting on a retrospective basis is extremely limited. Counties with populations enrolled in PMAP provided data in the form of public health nurse (PHN) visit and payment statistics for services provided to PMAP enrollees. Data demonstrate that county PHN departments are providing care to PMAP enrollees that PMAP health plans do not reimburse. Because these data are not uniform across the counties, determination of the actual extent of cost shifting is difficult. DHS and MDH have proposed action steps, which follow the discussion, to fully assess the scope of any cost-shifting. A uniform data collection and analysis effort will be undertaken.

Whether cost savings or cost increases exist is necessarily a function of the same analysis. Previous studies found that cost savings in the MA budget resulted from PMAP implementation.

These studies involved comparisons of expenditures for PMAP enrollees with fee-for-service costs for MA recipients in "similar" counties. In order to develop a more detailed assessment, DHS and actuary consultants are reviewing utilization of a different methodology. This section of the Cost Study will be presented as an addendum by April 1, 1995.

I. COORDINATION BETWEEN HEALTH CARE REFORM AND THE PREPAID MEDICAL ASSISTANCE PROGRAM

The goal of health care reform in Minnesota, as enacted by the Minnesota Legislature, is high quality health care that is accessible to all Minnesotans at an affordable cost. The elements of this goal may be understood by reviewing their component objectives. PMAP represents one aspect of the health care system, that of health care purchasing. While purchasing is a major function, it does not encompass the entire scope of health care reform envisioned by the MinnesotaCare Acts. However, coordination between health care reform and PMAP can be demonstrated through the following analysis which focuses on the key objectives driving the goals of health care reform.

HIGH QUALITY HEALTH CARE

♦ **Improved data and information about quality and outcomes**

Coordinated data collection is an essential component of health care reform efforts. Uniform data is necessary: 1) to monitor the broad effects of health care reform; 2) to effect a higher degree of public accountability among health plans and providers; and 3) to help consumers and purchasers make informed decisions on the basis of quality, access and cost. The Minnesota Health Data Institute (MHDI) has been formed to coordinate several aspects of these data collection activities, in particular, data collected for comparing health plans and provider organizations. The Data Institute's goal is to create an integrated data system that will provide clear and usable information on health plan performance. Data for population based access, quality and cost will be coordinated by MDH, while data collected for PMAP administration will be coordinated by DHS.

MHDI has three primary goals:

- to establish an electronic data interchange system to be used by the public and private sectors to exchange health care data;

- to develop a mechanism to collect, analyze and disseminate information for comparing the cost and quality of health care delivery system components, including health plan companies and provider organizations; and

- to develop a plan that provides coordination for data collected to measure the degree to which a health plan company, provider organization or other entity delivers quality, cost effective services compared to similar entities.

MDH, through the Health Care Delivery Policy Division, is responsible for collecting health data, including the collection of encounter level data, for the following purposes:

- assisting the State in developing and refining its health policy in the areas of access, utilization, quality and cost;

- assisting the State in promoting efficiency and effectiveness in the financing and delivery of health services;

- monitoring, tracking, and trending accessibility, utilization, quality, and cost of health care services within the State;

- evaluating the impact of health care reform activities; and

- assisting the State in public health activities.

Data collected by MHDI and MDH, along with data from other sources, will be used to develop reports including: health plan report cards; provider profiling reports; and other reports on quality of care for consumers, policymakers, purchasers, providers and health plans. The reports that will become available through data collection and analysis initiatives will assist individuals and purchasers to choose a health plan or provider that will be responsive to their needs.

Currently, provisions of federal law prevent DHS or health plans under contract with DHS from releasing MA recipient-specific information to third parties without the express consent of the individual recipient under certain circumstances. Because of the difficulty in meeting this standard, MDH and DHS have applied to the federal government for a waiver of the provisions that restrict PMAP participation in health care reform data collection activities.

DHS has made performance measurement a priority and is in the process of creating a new Performance Measurement Division within Health Care Administration. The Performance Measurement Division will be responsible for all activities related to data collection and quality improvement for PMAP and will work closely with MDH and the Data Institute. This division will undertake the following activities:

- Collection and reporting of encounter-specific data from health plan contractors. DHS will coordinate data collection with MDH's data collection efforts.

- Consumer satisfaction survey to be administered by the Data Institute to include PMAP enrollees and address issues specific to public populations.

- Quality Assurance Reform Initiative (QARI), a Health Care Financing Administration (HCFA) demonstration project, sponsored through the Kaiser Foundation to test quality assurance guidelines in three states, including Minnesota. QARI is examining quality of care for PMAP populations in focused areas, including clinic facility care, childhood immunizations, prenatal care, asthma, and diabetes. Results of QARI will be available in May 1995. QARI will be followed by annual quality improvement studies in several focused areas, which are currently being defined by the DHS Quality Advisory Committee. These activities are being coordinated with MDH's oversight of Health Maintenance Organizations and Community Integrated Service Networks/Integrated Service Networks quality assurance systems.

- Design and implementation of Medicaid Performance Measures in line with the Health Plan Employer Data and Information Set (HEDIS) 2.5. Minnesota is participating in this Packard Foundation funded, national initiative to define Medicaid-specific performance measures. These measures will subsequently be reviewed for utilization in Minnesota to measure outcomes for the PMAP population.

♦ Incentives to improve quality

As noted above, incentives to improve quality will stem from the collection and analysis of a wide range of health data from and about health plans and providers, including cost, outcome and consumer satisfaction information. The incentive for providers to deliver a quality health care product will be the ability to capture market share among well-informed consumers and purchasers.

Except for Itasca County, DHS contracts with more than one health plan in each county to provide PMAP covered services. PMAP enrollees select a health plan based upon the same information available to other consumers and purchasers through a face-to-face education process by county enrollment staff. Where only one health plan is under contract, PMAP enrollees may choose among the physicians and providers under contract with the health plan using the same information available to all other consumers. PMAP delivers quality health care to enrollees by contracting with health plans that meet PMAP standards.

ACCESS TO HEALTH CARE

♦ Subsidized health coverage for low-income uninsured persons

The Minnesota Legislature has developed the goal of universal health coverage for all Minnesotan's by July 1, 1997. One strategy to achieve this goal is subsidized coverage for low income Minnesotans. Currently, the MinnesotaCare Program offers low income Minnesotans a package of health benefits for a sliding-scale premium.

The MinnesotaCare Program is administered by DHS, utilizing many of the resources that are also used to administer the PMAP. A major goal of DHS is to consolidate the State's health care programs--MA, General Assistance Medical Care (GAMC) and MinnesotaCare--into one health care program. DHS is utilizing the experience gained through PMAP implementation to purchase services for MinnesotaCare enrollees through managed care.

♦ **Rural health programs to improve access to services in rural communities**

The MinnesotaCare Act's health care reform provisions include strategies to strengthen the rural health care system. One principle that guided health care reform in Minnesota is that health care is delivered locally. The MinnesotaCare Act permits the development of Community-based Integrated Service Networks (CISNs), similar to Health Maintenance Organizations, to assure delivery systems that are responsive to the local community.

In 1985, PMAP was developed to include a rural model of managed care delivery in Itasca County. Itasca Medical Care (IMC) now provides one example of how rural providers can satisfactorily participate in a managed care delivery system. CISN and HMO expansions in rural Minnesota will provide increased access for MA, GAMC, and MinnesotaCare enrollees through health plan networks. DHS' planned statewide expansion of managed care for MA and other public program recipients should facilitate increased access to providers in rural communities and will move forward as the marketplace allows over the next few years.

♦ **Public health programs**

The public health system has long played an important role in Minnesota. The mission of public health is to protect and promote health and prevent disease and injury among the population. The public health system is responsible to assure that medical and support services are available and provided to targeted populations. Under the goals of health care reform, private health plans and public health agencies will become more interdependent as health plans take on the responsibility of serving the medical needs of high-risk and special needs populations. Currently, certain disabled populations are not required to enroll in PMAP health plans. DHS plans to test managed care models for these excluded populations over the next several years. Stakeholder groups are meeting to assure a smooth transition. An intense coordination effort may be needed, initially, as the systems move forward.

State law requires that health plan contractors identify and contract with public health clinics and agencies to serve PMAP enrollees. Despite this requirement, there are sometimes differences in service delivery between health plans and public health agencies. These differences stem from the different missions of the organizations. These issues are discussed in a subsequent section of this study and lead to the conclusion that other efforts to promote coordination and encourage the partnerships necessary to advance the goals of public health and system reform are needed.

♦ **Market reform**

Market reform is necessary to enable small employers and individuals to purchase health coverage at rates comparable to those paid by large purchasers. One concern with the existing market is that costs are shifted from large purchasers who can negotiate price based on volume to small purchasers who lack bargaining power. The Legislature has created health care purchasing pools for public and small private employers to address this concern. In addition, private sector purchasing pools have emerged as forces of market reform. The Legislature has enacted statutory changes to facilitate the continued creation of voluntary private purchasing pools.

DHS and the Department of Employee Relations are working together to develop a plan to jointly purchase health care services and to integrate administrative functions where feasible. This joint purchasing strategy should increase the purchasing power for PMAP and other DHS managed care programs.

♦ **Strategies to address non-financial barriers to access to services and coverage**

Among the health care reform strategies to address non-financial barriers to access to health services and coverage are insurance reform initiatives. One initiative for the small group insurance market requires health plan companies to issue coverage to small employers who meet participation and contribution requirements without regard to the current health status of individuals within the group, including preexisting health conditions. Another initiative requires portability of coverage, that is, enabling individuals to change jobs without losing their coverage.

Other non-financial barriers to access include a lack of health care providers within a reasonable distance, lack of transportation to primary care clinics, and cultural barriers. PMAP addresses these non-financial barriers through program participation requirements. Each health plan must have a provider network that guarantees 30 minute or 30 mile access to a primary care clinic for all enrollees. Further, the PMAP transportation program assures that enrollees are able to get to primary care clinics to keep appointments with their providers. In addition, PMAP health plans provide various incentive programs to encourage access to preventive care. For example, one PMAP health plan gives women gift certificates if they keep prenatal care appointments. Another PMAP health plan provides restricted use cellular phones to enrollees without phones who could benefit from being able to quickly contact service providers. Finally, health plans must provide interpreter services to non-English speaking enrollees. These program requirements help to reduce barriers and improve access to health care for PMAP enrollees.

AFFORDABLE HEALTH CARE

♦ **Growth limits to control the rate of increase of health care costs**

The Commissioner of Health is responsible for enforcing annual limits on the rate of increase of health care spending in Minnesota. While the overall cost containment plan emphasizes competition to moderate prices, the Legislature required this regulation to assure that goals are met. The purpose of growth limits is to reduce the rate of growth in statewide overall health spending by at least ten percent during each of five years beginning in 1994. The Commissioner of Health will monitor payers, hospitals and other providers for compliance.

The Commissioners of Health and Commerce will monitor health plan company reserves and net worth to ensure that savings from expenditure limits are passed on to consumers in the form of lower premium rates. Lower premiums will benefit both consumers and large purchasers such as DHS. A marketplace with lower spending growth should create a more receptive environment for a competitive bidding approach for PMAP. Competitive bidding is viewed as a method of integrating PMAP purchasing into the broader marketplace.

♦ **Integrated Service Network system**

Integrated Service Networks (ISNs) and Community Integrated Service Networks (CISNs) are similar to Health Maintenance Organizations (HMOs) but are new types of health plans that will be accountable for the quality and cost of health care services provided to their enrollees. ISNs/CISNs will have incentives to prevent illness, improve quality, and control costs. Competition between ISNs/CISNs will be encouraged.

PMAP will benefit from the creation of ISNs and CISNs. As PMAP is able to contract with ISNs and CISNs to provide health services, PMAP enrollees will benefit from the continuing emphasis on illness prevention and high quality services.

♦ **Uniform billing forms and procedures**

Because the existing health care market uses hundreds of different billing and payment forms, the 1994 MinnesotaCare Act required the Commissioner of Health to develop uniform billing forms, electronic billing and other billing procedures. The need for uniformity is prompted by the need to accurately compare health plans and providers through the health care reform data initiatives. An Administrative Uniformity Committee (AUC), comprised of private and public sector members, was formed and has recommended that three forms become the standard billing forms by July 1997. The AUC also recommended that uniform patient and provider identifiers be developed, including a standard patient identification card. The UAC recommendations were based upon national recommendations by the Workgroup on Electronic Data Interchange (WEDI). The Legislature enacted these recommendations in the 1994 MinnesotaCare Act. The main objectives of uniform billing forms and procedures are reduced cost and increased efficiencies in health plan and provider administrative functions which should allow providers more time to concentrate on patient care.

In January 1995, PMAP health plans began submitting encounter data in the claims formats designated as standard by the 1994 MinnesotaCare Act: UB92 for hospital claims, HCFA 1500 for outpatient claims and ADA for dental claims. The effect of uniform billing forms and procedures on PMAP will be to reduce administrative costs and improve DHS' ability to accurately compare health plans as well as compare health plan data with fee-for-service data in a way that was formerly impossible.

♦ **Prevention activities**

Prevention of illness is one strategy to help contain health care costs. The Minnesota Health Care Commission has recommended a number of prevention strategies to the Legislature.

One strategy recommended by the Minnesota Health Care Commission was for programs to improve birth outcomes. MA, including PMAP, is engaged in a program that attempts to identify women at risk of poor birth outcomes and provides a package of enhanced prenatal care services to those identified as being at risk. DHS acknowledges the need to closely coordinate with other state and federal programs to improve birth outcomes.

PMAP, as a managed care model, provides a delivery system which encourages the use of preventive services by making the health plan accountable for the quality of care delivered. For example, all PMAP health plans are conducting Quality Improvement studies on childhood immunizations and prenatal care through the QARI project. Such accountability for quality is not possible in a fee-for-service system.

II. HAS THE CURRENT IMPLEMENTATION OF PREPAID MEDICAL ASSISTANCE RESULTED IN COST SAVINGS, COST INCREASES OR COST SHIFTING?

COST SHIFTING

This report will discuss potential cost shifting from health plan contractors to counties. This cost shifting is defined by counties as "expenditures of property tax revenue for services the county now provides to PMAP enrollees that were previously covered under the fee-for-service medical assistance program." It is important to note that DHS does not intend PMAP to cause cost shifting of any kind. DHS and MDH have formulated action steps, which follow this discussion, to detect, measure and correct any cost shifting to counties.

Cost shifting to counties can potentially occur in the areas of public health, social services, hospital care, and administrative costs. Hennepin County cites care provided to PMAP enrollees who present at the county hospital's emergency room for treatment. The hospital must treat them, but the health plan need not pay if no bona fide emergency exists. Increased administrative costs, such as the cost of obtaining prior authorization, are also viewed by counties as a cost shift. Finally, public health costs for which more detailed information is presented below, were cited by the counties. It should be noted that most county participants believe that PMAP is working well for most MA enrollees.

Unreimbursed county payment or provision of services to PMAP enrollees can be considered cost shifting if a county can demonstrate that it provided a service to a PMAP enrollee and attempted to obtain reimbursement from the health plan. These costs require close scrutiny due to health plan's obligation to provide medically necessary covered services, enrollee grievance procedures where disputes arise and different perceptions of medical necessity.

♦ Social Services

County social service agencies provide a number of services that may be billed to MA under fee-for-service (FFS) if provided to an eligible recipient. Anecdotal evidence suggests that PMAP implementation has resulted in costs for some services being shifted to county property tax revenue. Hennepin County cites 11 adolescent PMAP enrollees court-ordered into treatment over a six month period, as an example of cost shifting to the social service system. This figure must be evaluated in the context of the total number of court-ordered treatments provided by each plan. Currently, chemical dependency data collected by DHS does not include information on whether the treatment was court-ordered. Thus, the total number of chemical dependency treatment admissions is unavailable for comparison. Pursuant to Minnesota Statutes section 256B.19, subdivision 1 (1994), court-ordered chemical dependency and mental health treatment need not be covered by a PMAP health plan if the health plan deems the court-ordered services not medically necessary or if the

health plan was not included in the treatment decision. Because a health plan may not be responsible to cover the cost of chemical dependency treatment, case by case review of the facts is necessary to determine whether a cost shift exists.

Another example of a possible cost shift is when a mental health professional recommends 14 outpatient sessions for an individual but the PMAP health plan authorizes only 8 sessions. If the county pays the mental health professional for the remaining 6 sessions, a cost shift could be occurring. This would be the case only if the additional sessions were medically necessary. The fact that counties are required by the mental health act to make comprehensive mental health services available explains in part why counties perceive they have no choice but to pay for sessions not covered by a health plan.

♦ **Public Health**

Discussions between county, MDH, and DHS representatives centered on how the counties could document the cost shifting they believe exists. Public health departments maintain recorded data that seemed a reliable source the counties could use to document cost shifting. Public health departments agreed to provide data to demonstrate what they believe are cost shifts to property tax revenue and other funding sources as a result of PMAP health plan action. This information is discussed below. However, because the data were inconclusive, this study also contains proposed plans for future data collection and department action.

To fully understand cost shifting to counties it is necessary to understand the mission of counties with respect to core public health functions. Public health departments throughout the state provide services, known as core public health functions, based on the public health needs of the community at large. These functions include assessment, policy development and assurance of service. Core public health functions differ from the traditional medical model in that core public health functions are based on prevention rather than being remedial in nature. Goals are predetermined and core services are provided to those in need. Financial support for these activities comes from various grants and county subsidies. When possible, third party payers are billed for public health nurse (PHN) services. For example, Ramsey County PHNs provide skilled nursing and health promotion visits. Health promotion encompasses advocacy, outreach and prevention, all services that Ramsey County PHNs consider core functions; outreach for children and prevention could be billed to MA fee-for-service and Child and Teen Checkup (C&TC), formerly known as Early Periodic Screening, Diagnosis and Testing (EPSDT)) administration. After PMAP implementation, Ramsey County believed that some of these services were not being provided. The County continued to provide services at county expense because they were viewed as essential services in line with the county's public health mission.

Public health departments bill essentially two types of services to the MA program: services provided as home-based "skilled nursing" and "health promotion" visits. Skilled nursing visits are focused on medical problems and are generally provided to the elderly, medically fragile or to post-hospitalization patients. Health promotion visits are educational in nature

and are provided to high risk families with multiple problems to address a wide array of health, parenting and child development issues. These visits are based on referral from multiple sources, including clinics, hospitals, schools, county public health or county social services, county corrections, or community social service agencies. Thus, public health departments learn of PMAP enrollees in need of PHN services through sources other that the PMAP health plan's primary care physician.

PMAP health plans contract with PHN agencies in each of the three counties that provided data for this report. PMAP health plans also contract with other home care agencies to provide services to PMAP enrollees and one health plan provides PHN services through in-house staff. Thus, PMAP has resulted in increased competition among home care providers, including PHN agencies. With competition for health plan business, it is expected that PHN skilled nursing visits may decrease in volume over time until the market stabilizes.

Health plans are obligated to manage care and provide all medically necessary MA services to their MA enrollees. The focal point of decision making regarding the medical necessity of any service is the health plan under contract, and not the individual subcontracted providers. For instance, even if a health plan's primary care physician orders PHN visits, the PHN must first obtain prior authorization from the health plan. Further, each MA enrollee has an extensive advocacy and appeal process available to them any time they believe that they need more of a medical service than the health plan finds medically necessary. However, neither the county nor the PHNs have assisted enrollees to appeal even though appeals would clarify whether the health plans should cover the service and bring the issue to the attention of the state ombudsman. It should be noted, however, that an enrollee's motivation to appeal denial of a preventive service may not be the same as the motivation to appeal, for example, denial of a surgical procedure the enrollee believed was necessary.

Most PMAP health plans require prior authorization for the first and all subsequent PHN visits, even if the health plan's primary care physician orders the visits. However, the degree of difficulty in obtaining prior authorization varies significantly between the PMAP health plans. In particular, PMAP health plans require that the PHN place the call requesting prior authorization, which takes time away from patient care. PHNs now face an administrative burden as a result of PMAP and their prior authorization requests are often denied or approval is delayed. Counties view this as a new cost to PHNs for which there is no new reimbursement.

PHNs have continued to provide services to PMAP enrollees even when their prior authorization requests have been denied because they believe the services are necessary and would have been covered under MA FFS. PHN's also provide services to PMAP enrollees prior to receiving prior authorization when they must wait up to two weeks for a response from some health plans. For example, Hennepin County Public Health contracts with the Minnesota Visiting Nurses Association (MVNA) for PHN services. Hennepin County pays MVNA based on MVNA's professional protocol. If a PMAP enrollee's condition required 7 skilled nursing visits according to MVNA protocol, and a PMAP health plan authorized and

covered 5 visits, Hennepin County would cover the remaining two visits. It is difficult to classify this situation as a cost shift because the real issue is a differing view of how many visits are actually medically necessary. Clearly, county PHN agencies view the above situation as a cost shift.

Dakota, Hennepin, and Ramsey Counties provided sample data for this study consisting of PHN records of MA services provided to PMAP enrollees. Each county's data is somewhat different. The data indicate that PHNs provided services to PMAP enrollees that were not reimbursed by the health plans. Counties stated that health plan authorization was denied in all cases before services were provided and that these visits would have been covered under the MA FFS system. Ramsey County's data shows that the county provided 9,312 visits valued at $470,628 to PMAP enrollees in 1994 for which reimbursement was not authorized by health plans. In 1993, Dakota County PHNs provided 2,170 visits to PMAP enrollees that were uncompensated by health plans. In Hennepin County, the MVNA reported a decrease in MA FFS visits and an increase in visits reimbursed by health plans.

Because not all PHN visits were prior authorized by PMAP health plans, the question of whether PHN services provided were deemed medically necessary by PMAP health plans needs to be examined. The standard used by PHNs to determine when to provide a visit is whether the PHN agency believes the visit is essential. This standard does not consider whether the PHN will be reimbursed. There is obviously a discrepancy between the public health and health plan definitions of medical necessity.

PHNs also noted differences in performance with respect to health plans' authorizing health promotion services. They reported that some health plans almost always authorized the recommended number of visits while others consistently denied authorization. DHS is concerned about these reported discrepancies in health plan performance and is investigating the situation further.

Overall, because the data provided were inconclusive, an ongoing analysis of cost shifting will be undertaken. Proposed action steps are outlined in the following section. Once again, DHS does not intend to shift costs to property tax revenue through PMAP implementation.

COST SHIFTING: ACTION STEPS

1. Health Plan/ County Relationship

Information provided by PHNs indicates variability in the way health plans coordinate with public health agencies in authorizing necessary PHN services to PMAP enrollees. Further, problems surrounding court-ordered treatment require further evaluation.

DHS and MDH will take the following action steps:

- **DHS contract managers and MDH regulators will continue to review health plan performance with respect to PHN subcontractors. Anecdotal cases of alleged health plan failure to adequately cover PHN services will be investigated. If deficiencies are found, corrective action will be proposed for those cases and a larger special examination will be undertaken to determine the extent of the potential problem.**

- **DHS and MDH will hold a meeting with Hennepin and Ramsey County health plans and county administrators on the issue of court-ordered chemical dependency treatment. The goal of the meeting will be to better define and communicate health plan coverage of chemical dependency services.**

- **DHS will provide training to PMAP counties regarding Child and Teen Check-up administration contract options as an appropriate approach for funding outreach services that are outside the responsibility of the health plan contractors.**

2. Information Analysis

As the above discussion indicates, the ability to determine the extent of cost shifting on a retrospective basis is extremely limited. The data provided is not comparable among counties. This limited review of available data necessitates the conclusion that a uniform analysis must be undertaken to determine the extent and types of cost shifting resulting from PMAP implementation.

DHS and MDH will take the following actions:

A prospective analysis of cost shifting will be undertaken to test collection and analysis of uniform data which will demonstrate the nature and extent of cost shifting. The analysis will include:

- **identification of PHN services by procedure codes;**

- **systematic collection of data on service provision to PMAP enrollees in a uniform manner by all PMAP counties, including counties that will participate in PMAP in the future;**

- **examination of PHN services previously covered through MA FFS provided within each PMAP health plan to identify the extent of services delivered by providers other than county public health agencies;**

- **collection and analysis of social services data, particularly court-ordered mental health and chemical dependency treatment; and**

- **data collection for at least a one year period for each PMAP county. A review and analysis of available data will be completed at the end of calendar year 1995 for Dakota, Hennepin, and Ramsey Counties. Review and analysis of data for other counties will occur at the end of each calendar year in which a complete year's data is available.**

COST SAVINGS/COST INCREASES

Because cost savings and cost increases can be demonstrated through the same analysis, both will be discussed in a single section. Due to the complexity of preparing this portion of the study, results will be submitted as an addendum to this study by April 1, 1995.