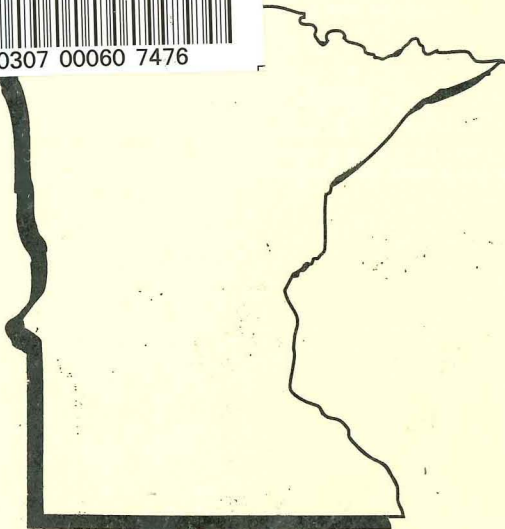


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Prepaid Medical Assistance Cost Study Addendum

Prepared Jointly by:



minnesota department of health
717 s.e. delaware street
minneapolis 55440



Department of Human Services
444 Lafayette Road
St. Paul 55155

April 11, 1995

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COST OF PREPARING THIS REPORT

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

TOTAL COST: \$3500

PREPAID MEDICAL ASSISTANCE COST STUDY: ADDENDUM

Authority

The Departments of Health and Human Services are required by the 1994 MinnesotaCare Act, Chapter 625, Article 5, section 11, to study the impact of the Prepaid Medical Assistance Program (PMAP). The report submitted to the Legislature on February 15, 1995, discussed the coordination between health care reform and PMAP as well as whether cost shifting has resulted from PMAP implementation. This addendum to the cost study analyzes whether cost savings or cost increases have resulted from PMAP implementation.

The Commissioner of Human Services is authorized to establish the prepaid medical assistance program by Minnesota Statutes section 256B.69, subdivision 1, which states in part:

The commissioner of human services shall establish a medical assistance 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 fashion while containing costs.

The Commissioner of Human Services is also authorized by Minnesota Statutes section 256B.69, subdivision 5 to

establish the method and amount of payments for services. The commissioner shall annually contract with demonstration providers to provide services consistent with these established methods and amounts for payment. * * * For payments made during calendar year 1990 and later years, the commissioner shall contract with an independent actuary to establish prepayment rates.

Prepaid Medical Assistance Program

Medical Assistance (MA) provides health care coverage to eligible recipients through two payment methodologies. Under traditional fee-for-service (FFS), an eligible recipient receives services and the health care provider is paid for each unit of service provided. Under PMAP, a prepaid health plan receives a per member per month capitation payment in advance to provide all health care services needed by a recipient. Base capitation rates for individual MA recipients are determined by program eligibility, age, gender and other factors. There are different rates for three geographic areas of the state: Hennepin County, Twin Cities metropolitan area (metro) and Greater Minnesota (non metro). Rates are adjusted to include new MA covered services, known as "add-ons," not reflected in the FFS base year data. Other additional services provided only to PMAP enrollees are not included in FFS experience, but are costs attributed to PMAP. FFS costs during a previous time period are trended forward to expected levels of growth and then discounted to create capitation payments that should result in cost savings to the state. To determine whether cost savings or cost increases have resulted from PMAP implementation, it is necessary to retrospectively compare FFS payment data with capitation payment data for the same eligibility groups over the same time period. See Appendix I for details of capitation rate development.

Previous Cost Studies

Two previous studies of PMAP have determined that PMAP implementation has resulted in cost savings to the State compared to fee-for-service (FFS). The methodology used in these studies compared capitation payments made to cover individuals enrolled in PMAP programs with FFS costs to cover a comparison group of MA recipients. The results of the studies are as follows:
Costs = spending more or (less) than FFS

<u>Costs (in millions)</u>	<u>Hennepin</u>	<u>Metro</u>	<u>Non metro</u>	<u>Total PMAP Expenditures</u>
CY 1987 \$(7.1)	(5.0)	(1.5)	(0.6)	29.2
CY 1988 (7.7)	(6.4)	(0.9)	(0.4)	29.5
CY 1889 (2.7)	(1.8)	(0.5)	(0.4)	36.5
FY 1990 (3.7)	(3.1)	(0.6)	0	33.3
FY 1991 (5.6)	(4.3)	(1.3)	0	65.4
TOTAL (26.8)				193.9

Methodology of Current Study

This study is a retrospective rate review. It does not measure the cost effectiveness of managed care. The study measures whether or not the rate setting methodology was accurate for the years examined. The methodology was reviewed by the actuarial firm of Deloitte & Touche and their suggestions were incorporated to the extent that data were available.

This section describes the methods used to address the following policy question: **In areas where PMAP is currently operating, how do the rates of health spending under PMAP compare with what the rates of spending would have been under the FFS reimbursement system?**

Because PMAP was only recently implemented in Ramsey, Anoka, Washington, Scott and Carver Counties, this study examined the PMAP cost experience for Hennepin, Dakota, and Itasca Counties only.

It is important to emphasize the fact that such policy questions necessarily involve a comparison between what actually occurred (PMAP) and something that did *not* occur (continued FFS in PMAP areas). That is, to answer such a question one must *infer* what *might have occurred but did not*--in this case the rate of health care spending under the FFS system that was in fact displaced by PMAP. Clearly, this latter level of spending must be *estimated* using appropriate analytic models and with relevant data.

For Hennepin County it is possible to use the fact that in FY 1990 65% of eligibles were still in FFS and were in fact a random sample of total eligibles. Thus, 1990 FFS costs can be safely used as the 'base' year for Hennepin County.

Because it was not possible to determine the level of costs for Dakota and Itasca for the last year of their FFS reimbursement, a different methodology was used for Dakota and Itasca Counties. Dakota is included in the "metro" geographic capitation rate grouping, while Itasca is included

in the "non-metro" grouping. A FFS trend is estimated from a set of counties that both remained on FFS reimbursement and closely resemble the counties that converted to PMAP. This methodology answers the following question:

If, from FY 1990 to FY 1993, the PMAP capitated rates had increased *at the same rate of growth by which FFS costs per person* increased in comparable counties, what level would the PMAP rates have risen to by FY 1993?

Knowing what PMAP capitation rates would be in FY 1993 *if they had increased at the FFS growth rate* does not tell what FFS costs *would have been* in FY 1993. Specifically, this question and its answer constitute an *on-going, retrospective evaluation* of how well the PMAP rates were set in comparison to the *now* known FFS costs trend. It must be emphasized that *absolute* savings or additional costs on the part of PMAP relative to what FFS would have cost cannot be determined from this methodology. This methodology does determine whether over a three year period PMAP rates were increasing, decreasing, or remaining constant relative to FFS costs. This difference, or *Index Dollars* of savings or additional costs, stands in counterdistinction to the difference in estimated FFS and capitation costs per member per month that it was possible to determine for Hennepin County.

Case Mix Adjustment

The methodology used in this study expresses both the comparison counties' FFS growth trends and the PMAP counties costs over time in terms of a *fixed* set of enrollees with regard to age and gender. For example, for Hennepin County's AFDC, the PMAP costs from FY 1990 to FY 1993 measure the PMAP rates of providing capitated services to the *FY 1993 AFDC enrollee mix* in Hennepin County. This same *FY 1993 AFDC enrollee mix* was applied to the FFS trend from the comparison counties. This 'case-mix' adjustment allows the appropriate comparisons to be drawn between the actual PMAP AFDC per member per month PMPM costs and what it would have cost to provide *this same group of enrollees* services under the FFS system.

Findings 1992-1993

Applying the methodology described above to available FFS and capitation rate data, a mixed picture of PMAP performance emerges. While capitation rates for certain eligibility groups were higher than the FFS trend, notably AFDC rates in Hennepin County in 1992 and 1993, other capitation rates were lower than the FFS trend. An example of the latter is the aged rates, particularly in Hennepin County and the metro area. 1995 rates have been adjusted and are near or approaching the FFS trend. Further downward adjustments will be made as necessary.

Non metro

AFDC Capitation rates rose in 1991 at the same rate as the FFS PMPM, and in 1992 they rose slightly less than the FFS PMPM. In 1993, however, capitation rates rose significantly faster than the FFS PMPM trend so that by FY 1993 capitation rates were above the FFS PMPM. Thus, by FY 1993 capitation rates *exceeded* the FFS PMPM trend, resulting in *additional costs in terms of Index Dollars*. That is, the actual capitation rate was higher than the capitation rate would have been in 1993 had the 1990 capitation rate grown only at the FFS PMPM trend rate.

Needy Children In 1991 and 1992 capitation rates rose only moderately faster than the FFS PMPM trend; in 1993, however, the capitation rates rose significantly faster. Thus, by FY 1993 the capitation rates were significantly higher than the ending FFS PMPM trend, resulting in *additional costs in terms of Index Dollars*.

Aged The FFS PMPM trend rose steadily over the period from 1990 to 1993. Capitation rates, on the other hand, decreased slightly in 1991 and rose only moderately in 1992. In 1993 capitation rates rose significantly faster than the FFS PMPM trend. By 1993, however, the capitation rates were still below the FFS PMPM trend; thus, overall capitation rates rose less than the FFS PMPM trend resulting in *cost savings in terms of Index Dollars*.

Metro

AFDC From 1990 to 1991 capitation rates rose significantly faster than the FFS PMPM, but in 1992 and 1993 capitation rates rose only moderately faster. Thus, by 1993 the capitation rates were significantly above the FFS PMPM trend, resulting in *additional costs in terms of Index Dollars*.

Needy Children The capitation rates for Needy Children also increased substantially faster between 1990 and 1991 than the FFS PMPM trend. In 1992 the growth rate of the capitation rate equaled that of the FFS PMPM, but in 1993 the growth in capitation rates substantially exceeded the FFS PMPM trend. Thus, by 1993 the capitation rates were significantly above the FFS PMPM trend, yielding *additional costs in terms of Index Dollars*.

Aged Capitation rates for the aged declined significantly between 1990 and 1991 while the FFS PMPM trend increased. Capitation rates increased moderately in 1992 and 1993, but by less than the FFS PMPM trend. Thus, by 1993 the capitation rates were well below the 1993 end point of FFS PMPM, yielding substantial *cost savings in terms of Index Dollars*.

Hennepin County

AFDC In 1990, the base year actual FFS PMPM for AFDC in Hennepin County was slightly below the capitation rate. From this starting position, however, the capitation rates increased at, or slightly below, the FFS PMPM trend in both 1991 and 1992. In 1993 the capitation rate rose sharply relative to the FFS PMPM trend, however. Thus, by 1993 the capitation rate was significantly higher than the estimate of what FFS costs would have become in 1993 had they grown at the FFS trend of the comparison counties. This difference between the actual 1993 capitation rates and what the estimated FFS PMPM would have been is an estimate of *true additional costs*.

Needy Children In 1990, the base year actual FFS PMPM for Needy Children in Hennepin County was significantly higher than the capitation rates, indicating that capitation rates were at a discount from FFS costs. While capitation rates increased significantly relative to the FFS PMPM trend in 1991, it declined in 1992. In 1993, however, capitation rates rose very sharply relative to the FFS PMPM trend. By 1993, the actual capitation rates were significantly higher

than the estimate of what the FFS costs would have become in 1993 had they grown at the FFS trend of the comparison counties. This difference between the actual 1993 capitation rates and what we estimate the FFS PMPM would have been is an estimate of *true additional costs*.

Aged In 1990 the capitation rates for the aged were significantly below the base year actual FFS rates in 1990, entailing once again a true discount from the FFS costs. In 1992 the capitation rate declined and rose only moderately between 1992 and 1993. Thus by 1993 the capitation rate for the elderly was significantly below the estimate of what the FFS costs would have become in 1993 had they grown at the FFS trend of the comparison counties. This difference between the actual 1993 capitation rates and what we estimate the FFS PMPM would have been is an estimate of *true costs savings*.

Total 1992-1993 Net Base Capitation Costs more or (less) than FFS growth trend=

	<u>Non metro</u>	<u>Metro</u>	<u>Hennepin</u>	<u>Total</u>
FY 1992	(\$136,240)	\$ 981,241	(\$ 3,848,415)	(\$3,003,414)
FY 1993	\$491,661	\$1,985,127	\$16,482,424	\$18,959,212
TOTAL				\$15,955,798

Additional Services

Over the period from FY 1990 to FY 1993 additional services were added to those being provided by prepaid health plans. Because these additional services were not included in base year FFS spending at the time the rates were developed, increases were made to the capitation rates.

Costs Added to Base Capitation Rate (add-ons) (Estimated Dollars)

	<u>FY 1992</u>	<u>FY 1993</u>
Immunizations	\$ 225,013	\$ 337,868
Pregnancy risk assessments	NA	615,393
FQHC	NA	46,317
CD babies	6,293,337	NA
TOTALS	6,518,350	999,578

1992-1993 Base Rate Exclusions: \$7,517,928

PMAP COSTS 1987-1993

Costs= spending more or (less) than FFS
(in millions)

	<u>Total Capitation Payments</u>
NET PMAP COSTS 1987-1991: (\$26.8)	1987-1991: \$193.9
NET PMAP COSTS 1992-1993: \$23.5	1992-1993: \$258.8
TOTAL PMAP COSTS 1987-1993: (\$3.3)	1987-1993: \$452.7

Stop-loss

In FY 1990 the State assumed the risk for catastrophic cases by paying the plans for individual catastrophic cases. By FY 1993, the PMAP rates had been increased specifically to reflect the fact that most of the prepaid health plans were fully at risk for catastrophic costs. Estimating the differential in stop-loss expenditures under PMAP compared to what they might have been under continued FFS is complicated by several factors. Unlike the analysis for 'regular' services, for stop-loss any differences across the PMAP and FFS populations in the mix of enrollees could not be controlled for, nor could separate estimates of stop-loss expenditures be derived by major eligibility program. That is, the analysis could only use a stop-loss cost PMPM aggregated across all MA program eligibility groups and without accounting for any differences in case-mix. It should be emphasized further that by its very nature, stop-loss expenditures can be expected to have very high variance, especially for a small population base. Thus, a base year estimate might vary substantially from year to year. All these concerns should be kept in mind in interpreting these stop-loss estimates.

ESTIMATED STOP-LOSS DIFFERENTIAL SPENDING

FY 1992	FY 1993
\$898,014	\$6,073,288

Services Provided Only to PMAP Enrollees

Services available to PMAP enrollees that are not available to MA recipients on FFS include interpreter services, services to pregnant individuals experiencing substance abuse and outreach services. The cost of these services for 1992-1993 is \$597,469.

Corrections in the 1995 Capitation Rates

The study compares capitation to FFS for 1992 and 1993 because FFS data is available for those years. However, capitation rates are set through 1995. The trends are thus known and can be discussed in light of the 1992-1993 findings.

Whatever flaws existed in either the trend factors or the data that were available for the FY 1993-94 rate setting process, were apparently largely corrected in the 1995 rate setting process. Non metro and metro Needy Child capitation rates, while still increasing in 1994, decreased in 1995 by 21% to 37%. Non metro and metro AFDC rates did not decrease in 1994 and 1995, but increased at a lower rate than previous years. Aged rates in each area increased between 21% and 25% in 1994 and 1995, resulting in a projected cost savings which is more realistic. The Hennepin AFDC rates continued to increase steadily both in 1994 and 1995. Hennepin Needy Children rates increased in 1994, but declined an equal amount in 1995.

Conclusions/Analysis

This study presents some important details of the financial experience of PMAP. As noted, the methodology compares actual capitation payment trends with **estimated** FFS trends for the same case-mix of enrollees. Although the methodology has some limitations, it provides the **best measure** of whether PMAP saved money or cost money. As noted, results are mixed, with some populations costing more under PMAP for FY 1993 and the Aged consistently showing cost savings. **This study does not measure the cost effectiveness of managed care. It is a retrospective rate review.** It tells whether or not the rate setting methodology was accurate for the years examined. Accuracy for the purposes of this study is measured only by comparison with an estimate of what the FFS trend would have been had FFS continued. This analysis is limited to cost comparisons, not of prepaid health plan *utilization* against some standard, since only FFS cost data were readily available.

The study demonstrates that a sound rate setting methodology with built-in discounts may not always yield the desired results. Rate setting is not an exact science. Many factors go into rate development. As Appendix I on rate development demonstrates, future predictions of cost and utilization patterns may well be actuarially sound at the time, yet be proven wrong in hindsight. The question of whether or not PMAP saved or cost the state money is an important one from a state budgetary standpoint. The financial experience of PMAP for 1987 through 1991 shows an estimated accumulated savings of \$26.8 million. The fact that PMAP saved Medicaid dollars consistently for five years, 1987-1991, demonstrates the potential for continued savings in managed care. Possible explanations for some of the study's findings follow.

Why did the capitation rates increase sharply for the AFDC and Needy Child populations in FY 1993 and 1994?

Several factors that caused the rates to increase in 1993 have been identified. One factor was a legislatively mandated 25% rate increase to MA FFS practitioner payment rates. This increase was also applied to the capitation rates. As the study demonstrates, even with a 25% increase in practitioner payments, apparent decreases in FFS utilization offset the price increase, resulting in only a modest increase in actual FFS expenditures. While FFS utilization apparently decreased, the capitation rate trend factors projected that utilization would increase between 10 and 22%. Because this study compares the actual growth of trends in capitation to FFS cost trends, a potential capitation overpayment occurs when projected FFS utilization growth does not occur. Unfortunately, this determination can only be made after the fact.

Other changes which may have affected the Needy Child rates were a change in the number of rate cells and a change in eligibility for this population. Prior to FY 1993 there were only two Needy Child rate cells, one for males and one for females. Beginning in FY 1993, the number of rate cells increased from two to six, adding age breakouts, in addition to the gender breakout. This change may have affected the array of expenditures for this group, resulting in increases in the overall expenditures for this population. In addition, because the income eligibility standard was raised to 275% of poverty, the number of member months of experience for the Needy Child population increased from 356,862 member months in FY 1990 to 537,819 member months in FY 1992. It is likely that, as eligibility for the MA program was expanded, individuals with lower real costs were added to the Needy Child category, because there was a decrease in

the average FFS PMPM cost. The capitation rates for FY 1993 and 1994 were already fixed, based on the prior population of higher cost members. In fact, average costs for this population decreased. Since the FY 1995 rates are based on the FY 1992 experience, FY 1995 rates for Needy Children did decrease by 11-37%.

Although the aforementioned facts partially explain the increases in the 1993 and 1994 capitation rates, it is likely that a major factor was an apparent data problem. FY 1993 and 1994 capitation rates were based on the FY 1990 FFS claims experience compiled in 1992. A comparison between the FY 1990 data utilized to set the FY 1993-94 rates and a recent FY 1990 data run displays a discrepancy. The old FY 1990 data run shows a PMPM cost of between 9.5 and 32.5% higher than the new data run. Thus, it is possible that the base costs for FY 1990 were overstated, resulting in capitation payments exceeding the actual FFS expenditures.

While the Hennepin County rates declined somewhat in FY 1995, why did AFDC and Needy Child rates continue to be significantly higher than projected FFS costs?

FY 1995 rates include a "Hennepin County Factor". FY 1995 rates are based on FY 1992 fee-for-service experience. Since there was no longer any Hennepin County FFS experience in FY 1992 in PMAP populations, the Hennepin rates were based on the metro FFS experience (Ramsey, Carver, Scott, Washington and Anoka counties). Because historically per capita costs are higher in Hennepin than in the rest of the metro area, a Hennepin County factor was calculated. The relationship of Hennepin to metro for FY 1990 (the last year in which FFS data was available for Hennepin) was calculated and applied as a factor by which the metro FFS experience was adjusted to account for historical differences in the Hennepin County cost experience. The factors applied were 1.26 for AFDC and Needy Children, and 1.10 for Aged. Hennepin County rates are overall 26% higher than the metro capitation rates.

While AFDC and Needy Child rates came closer to the projected FFS trends for metro and non metro, reflecting changes between the 1990 and 1992 base years, the Hennepin rates continue to project a relationship that existed in FY 1990, possibly explaining the larger gap between the capitation and projected FFS trend in the Hennepin capitation rates.

Why did the estimated savings on the Aged capitation payments exceed the 5% discount taken?

Savings on the Aged capitation rates were up to 55%, exceeding the expected 5% savings. In light of the experience with the AFDC and Needy Child rates, it is difficult to plausibly explain the demonstrated experience on the Aged rates. As noted, both sets of rates were based on the actual FFS experience. The most likely explanation lies in the difference in trend factors. The trend factors applied to the FY 1993 capitation rates were lower than the actual trends experienced in FFS. It is also possible that the data problem discussed above could have affected the Aged rates. This cannot be determined, however, because the old and new FY 1990 data sets are not comparable for the Aged rates, due to the fact that the rate cell configurations comprising the data sets were not identical. The Aged program also has some individually volatile cells because of a low number of members and very high costs. It is notable, however, that the aged rates significantly rose in FY 1995, with increases between 21 and 27%.

Implications of the Study

As noted, this study points to the drawbacks inherent in utilizing FFS data as a basis for setting capitation payments. Because it is necessary to use two to three year old data, projected trends may prove to be inaccurate in retrospect. Data problems may cause the rates to be over or understated, and using a single year base will accentuate anomalies. If the FFS base is off for any of the above reasons, even discounting the rates does not assure savings. The study, however, provides valuable information for future managed care ratesetting.

Future Rate Development/Purchasing Strategies

Capitation rate development for 1997 and beyond is likely to change. As the number of MA recipients enrolled in managed care health plans increases, a corresponding decrease in the number of recipients receiving health care through FFS occurs. The decrease in FFS experience results in a demographic base that is too small to reliably calculate capitation payments on. This process, known as "erosion," has occurred in the metro area and will require development of new rate setting methodologies or purchasing strategies. Several options are under consideration.

One strategy under consideration for fiscal year 1996 rates is to trend fiscal year (FY) 1995 rates forward for PMAP. The actuary would be required to consider the findings of this study to determine whether the FY 1995 rates are a viable base. Another strategy under consideration is competitive bidding. DHS is working with the Department of Employee Relations to explore this strategy for FY 1997 and beyond.

Profit sharing is also under consideration. Health plans currently submit encounter data, similar to a FFS bill, to DHS to document services provided to PMAP enrollees. Under profit sharing, encounter data would be processed to determine actual utilization experience. Encounter claims would be assigned a cost using a model fee schedule that replicates rates of the average payer. The results of the comparison would be reconciled with the total capitation paid to the health plan. Any surpluses would be shared by DHS and the health plan on a proportional basis.

Recommended Action Steps

- Hennepin County capitation rates should be examined, as they may be too high for the AFDC and Needy Child populations and too low for the Aged.
- When FFS data are used to set capitation rates, multiple years should be used to ensure trend stability.
- The cost and utilization experience of contracted health plans should be examined on an ongoing basis to better determine the accuracy of the rates.
- Retrospective reviews of the rates should be undertaken on an annual basis.
- If FY 1995 capitation rates are used as base rates for calculating the FY 1996 capitation rates, they should be adjusted, based on the findings of this study.
- The methodology for calculating the dollar value of stop-loss reinsurance should be evaluated if the option of maintaining full risk continues to be offered to health plan contractors.
- The state should explore the feasibility of implementing a competitive bidding approach to rate setting, as an alternative to utilizing FFS data.
- The state should explore the feasibility of implementing a profit sharing model purchasing strategy.
- The state should develop methodologies to estimate the effect that price or eligibility changes will have on the FFS base and capitation rates.

Appendix I

CAPITATION RATE DEVELOPMENT

Prepaid capitation rates are paid to each health plan contracting with DHS to serve DHS enrolled populations. A capitation payment is paid for each enrolled recipient for each month of enrollment. Payments are made at the beginning of the month for health services to be provided for that month. The capitation rate paid on behalf of an individual is determined by certain demographic and eligibility factors which assign that individual to a rate cell. Rate cells are based on the following factors: the county of residence; the major program the individual is eligible for (AFDC, Needy Children or Aged); subdivisions within major programs; gender; age; whether the individual has Medicare coverage; and whether the individual resides in a nursing home. These factors were determined by an initial actuarial analysis which was conducted prior to project implementation in 1985. The historical per member per month (PMPM) costs for various groups were examined. The rate cells were selected based on factors which were predictive of future cost and use of services.

Capitation rates are based on the historical per capita cost experience for the MA FFS population. The claims experience of the most current available base year is used. The rates are trended forward to the contract year in which they will be implemented. Capitation rates are also discounted by 5 percent for Aged and up to 10 percent for AFDC and Needy Children to provide for savings through PMAP. Thus, the rates are set at 90-95 percent of the projected FFS cost to provide comprehensive medical services to a comparable population.

Trend factors applied to the base year costs include both price and utilization factors. Price factors are calculated based on legislatively mandated price changes. For example, if a new state law provides for a price increase for home health services, since this price increase is not yet reflected in the historical base year data, it is included in the price trend factor. Utilization factors are based on the utilization trends evident in the FFS experience for the most current fiscal years. In addition, there can be an adjustment for some services when access is expected to increase. For example, for dental services for fiscal year (FY) 1995, a higher utilization factor was applied to account for reported lack of access to dental services in the FFS system. Separate trend factors are calculated for ten service categories, for eligibility groupings (AFDC, Needy Children and Aged) and for metro and non metro areas. The ten major service categories include: inpatient hospital; outpatient hospital; physician; dental; pharmacy; medical supplies; home care; transportation; public health clinic; and other practitioners.

PMAP capitation rates are based upon three geographic groupings: the Twin Cities metropolitan area (metro), Greater Minnesota (non metro) and Hennepin County. Metro rates are paid for enrollees in Ramsey, Dakota, Anoka, Scott, Carver and Washington counties. Non metro rates are utilized for Itasca and Lake counties. These geographic groupings were selected based on historical costs differences in these areas. Historically, per capita costs in the MA program have been highest in Hennepin County and lowest in the non metro area, while costs for other metro counties have been somewhere in between. These cost differences are most likely due to higher hospital costs and higher utilization of services in general in the metro area.

Base capitation rates do not vary by health plan. Hennepin County rates, however, are health

plan specific due to hospital adjustments which are added to the base rates. These adjustments accommodate differences in use of teaching hospitals and hospitals that qualify for disproportionate population adjustment (DPA) payments. Teaching hospitals qualify for an adjustment for the cost of medical education (ME), while hospitals that serve a disproportionate number of low-income patients qualify for DPA. The estimated value of ME and DPA payments are taken out of the base rates and put back in on a health plan specific basis based on each health plan's projected use of ME and DPA hospitals. In addition, for rate year fiscal 1995, Ramsey County rates are also health plan specific, due to adjustments made for "core hospital" increases. These were legislatively mandated increases to selected metro area hospitals.