HEALTH CARE COST CONTAINMENT

ISSUE TEAM

MINNESOTA STATE PLANNING AGENCY
HEALTH PLANNING UNIT

OCTOBER 1984

I. EXECUTIVE SUMMARY

Issue Title: State Role in Health Care Cost Containment

Team Leader: John Dilley, State Planning Agency

Governor's Subcabinet: Human Services Subcabinet
Len Levine, Chair

SUMMARY OF RECOMMENDATIONS:

The recommendations presented in this report primarily concern the Medical Assistance program because that program constitutes such a large proportion of the state's spending for health care. Many of the recommendations also concern General Assistance Medical Care, the state's program for medically indigent people who do not qualify for Medical Assistance. These recommendations are consistent with those being presented by the Department of Health in a separate report to the legislature on acute care cost containment.

A. Hospital Reimbursement

1. Base reimbursement on diagnostic groupings using the categories of Blue Cross/Blue Shield's Aware program. This change can be accomplished through promulgation of a permanent rule by DHS. The proposal for establishing the rates should receive a thorough review by appropriate state agencies in the hearings process.

2. Authorize DHS to study selective contracting for inpatient hospital reimbursement. A system of negotiated contracts is too complex to implement without substantial analysis and preparation, but DHS should study options for selective contracting to determine which, if any, could be used in Minnesota to reduce expenditures for inpatient hospital services.

B. Medicare Certification of Skilled Nursing Facilities

3. Require nursing homes to be Medicare-certified as a condition of participation in the Medicaid program.

4. Obtain a federal waiver to allow the state Medicaid program to treat Medicare as a third party payor.

C. Prepayment in the Twin Cities

5. Seek federal waivers to require prepayment to providers in the Twin Cities area.

6. Study the potential use of federal waivers to remove fee-for-service and implement a primary care/case management system in areas of the state not covered under the first recommendation.

D. Competitive Bidding

7. Employ competitive bidding contracts for pharmaceuticals, laboratory services, and non-emergency transportation.

E. Relative Responsibility

8. State legislation should be changed to establish MA relative contribution schedules which treat parents of children in out-of-home care and elderly spouses equitably, taking into account family size, special needs, and the costs of raising non-disabled children at home.

9. Once changed fee schedules are implemented, the Department of Human Services should develop ways to increase actual payment compliance. The possibility of giving counties financial or other incentives to obtain payments from responsible relatives should be examined.

F. Reimbursement of Other Providers

10. Continue to use the current standards (50th percentile of 1978 and 1979) as the base rates, but change statutory language so the current standards are established as fixed rates without reference to percentiles of any particular years.

11. Update the schedule on "as needed" basis, with need defined as the need to ensure access to care. Require the Department of Human Services to monitor access to care for MA and GAMC clients on a regular basis. The Department should report to the legislature any evidence of access problems which arise from reduced levels of provider participation.

12. Remove rateable reductions for GAMC providers.

G. Copayments for Recipients

13. Do not impose copayments on clients in the Medical Assistance and GAMC programs. Implement cost containment measures that control utilization through providers rather than clients/consumers.

H. Moratoria

14. The state should continue the moratoriums on MA certification of beds in nursing homes and intermediate care facilities for the mentally retarded.

The underlying principle for these recommendations is that the state should act as a prudent purchaser of health care services. The state should not pay more than is necessary to maintain an adequate supply of services of good quality.

All of the recommendations should reduce state expenditures on health care except for the twelfth (removal of rateable reductions in GAMC).

II. BACKGROUND

A. Issue background

Health care spending in the United States more than tripled between 1972 and 1982, and since then has continued to rise at a rate much greater than that of inflation. Nationally, health care expenditures were 10.5% of the GNP in 1983. For state and local governments, health expenditures were between 8 and 9% of their total expenditures from 1950 to 1970; by 1982, state and local health expenditures were 13.5% of total expenditures. States' spending for Medicaid alone increased more than 400 percent from 1973 to 1983.

The rapidly rising costs of government-financed health care programs have made health care cost containment a high priority issue for both the states and the federal government. Federal health policies in recent years have sought to shift health care costs to states and private payers, a trend which is expected to continue with the implementation of the Medicare DRG system. For their part, states have implemented cost containment measures in Medicaid, other state health care programs for low income people, and state employee health insurance programs with varying degrees of success.

In Minnesota, overall Medical Assistance expenditures rose 38.8% between FY 1981 and FY 1984. By category of service, community intermediate care facilities for mentally retarded people had the largest percentage increase in Medical Assistance expenditures--95% from $50,748,000 in FY 1981 to $98,938,000 in FY 1984. State hospital services for the mentally retarded population increased 49% from $63,022,000 in FY 1981 to $93,825,000 in FY 1984. Hospital (inpatient and outpatient) expenditures increased 41% from $104,895,000 in FY 1981 to $148,085,000 in FY 1984. Nursing homes (including skilled nursing facilities, and intermediate care facilities--levels 1 and 2) rose 33.5% (from $315,969,000 in FY 1981 to $421,904,000 in FY 1984).

During the 1983 and 1984 legislative sessions, the state took several actions to contain health care costs. Moratoriums were placed on Medicaid certification of nursing home beds and ICF-MR beds; changes were made in the reimbursement rules for nursing homes and ICF-MRs; and a moratorium was placed on the construction of additional hospital bed capacity.

The projected rate of increase in Medical Assistance expenditures in the next biennium is less than the rate of increase in the current biennium. The total expenditures if FYs 1986-87 are expected to be 22.7% higher than in FYs 1984-85. The expenditures in FYs 1984-85 are 25.2% higher than in FYs 1982-83. Although the difference appears small when expressed in percentage terms, the dollar amount is $49 million.

B. Issue charge as approved by subcabinet

Evaluate the effectiveness of existing regulatory and market mechanisms in containing health care costs, including Medicaid costs; examine means of increasing the state's ability to control health care costs through changes in market, regulatory, and alternative care mechanisms; assess the short term effects and long term consequences of the 1983 long term care cost containment legislation; develop state strategy for long-term control.

C. Analysis method

1. Issue Team

John Dilley, State Planning Agency, Team Leader
David Doth, Department of Human Services
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Tom Gaylord, Department of Human Services
Maria Gomez, Department of Human Services
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2. Approach

The issue team met several times during the period from February to October 1984. Initial meetings were devoted to discussion of the general topic of health care cost containment and of the issue analysis process. Team members shared knowledge of ongoing and future cost containment activities in Minnesota, in other states, and on the federal level.

Health planning staff reviewed the literature on past patterns and future trends in health care expenditures as well as descriptions and evaluations of various cost containment efforts.

The team discussed at some length the Health Department's study of the Certificate of Need program and the Department of Human Services/ State Planning study of the effects of the Chapter 199 Nursing Home Reimbursement legislation. Team members also reviewed health-related legislation which was passed during the 1983 session, including the moratorium on hospital construction and the Health Department's mandate to develop methods of controlling acute care costs.

Team members recognized that the team charge was very broad, and that some selection and prioritization of specific sub-issues was necessary. Since the Health Department study was also addressing cost containment issues, a concerted effort was made to prevent duplication of work, and it was decided that the major focus of the issue team would be on the Medical Assistance program.

The team examined trends in Medical Assistance expenditures over the past three years in order to determine which categories had the most potential for cost containment. The team examined a number of specific MA cost containment proposals from the Department of Human Services.

The issue team also discussed at length a list of cost containment options developed by the Finance Department. The major categories of options examined included reducing the costs for all payors; reducing the state's costs for state programs; paying for fewer services per person; sharing or limiting the risk to the state; limiting the dollars spent per unit of service; limiting overall expenditures; substituting cheaper services for more expensive ones; and improving collections.

Based on these discussions and research, the issue team selected several issues which could feasibly be addressed in the timeframe, and developed the options and recommendations which appear in this report.

Minnesota State Planning Agency

Health Cost Containment Issue Team

Medical Assistance Expenditure by Category of Service
(in thousands of dollars)

Category of Service	FY 1981	FY 1982	FY 1983	FY1984	Proj. FY1985	Proj. FY1986	Proj. FY1987
Inpatient hospital	$ 90,211	$ 108,351	$ 129,936	$ 135,956	$ 151,475	$ 169,870	$ 190,290
Outpatient hospital	14,684	16,988	20,793	12,129	13,375	14,670	15,790
SNF	198,781	232,215	256,868	290,233	311,867	345,821	385,341
ICF-1	106,941	114,792	115,795	120,811	126,295	136,399	141,750
ICF-2	10,247	10,988	10,946	10,860	11,373	12,283	13,339
PT, OT, ST, Audiology in nursing homes	10,812	11,897	13,581	16,477	N.A.	N.A.	N.A.
ICF/MR	50,748	68,745	83,776	98,938	106,559	113,462	119,589
State Hospital-MR	63,022	70,787	86,341	93,825	101,342	103,679	102,078
State Hospital-MI, CD	9,676	9,475	8,821	10,283	N.A.	N.A.	N.A.
Physicians/Osteopaths	39,530	40,401	41,617	46,843	51,475	56,070	60,190
Drugs, prescribed	26,307	28,912	29,684	34,286	38,400	42,700	46,000
Dental	13,964	12,881	11,978	12,503	13,375	14,670	15,790
Other Services	27,118	30,170	36,653	32,876	N.A.	N.A.	N.A.
Recipient Recovery	(4,226)	(7,012)	(7,414)	(11,303)	(27,000)	(30,000)	(33,000)
* TOTAL	$ 657,815	$ 749,591	$ 839,378	$ 922,511	$1,038,616	$1,148,425	$1,257,948

* Includes administrative costs in addition to expenditures to providers.

Medical Assistance Expenditure Increases for Selected Services

Category of Service	Percentage increase over previous year			
	FY 1983	FY 1984	FY 1985	FY 1986
Inpatient hospital	19.9	4.6	11.4	12.1
Skilled Nursing Facilities	10.6	13.0	7.5	10.9
ICF/MR	21.9	18.1	7.7	6.5
State Hospitals/MR	22.0	8.7	8.0	2.3
Physicians	3.0	12.6	9.9	8.9
TOTAL	12.0	9.9	12.6	10.6

III. HOSPITAL REIMBURSEMENT UNDER MEDICAL ASSISTANCE PROGRAM

A. Background.

In response to legislation placing a limit of five percent on prices charged the MA by providers, DHS changed its hospital reimbursement from a cost-based policy to a hospital-specific flat amount for an admission for any diagnosis. The amount is the hospital's average for all patients in the base year, and it is increased by no more than five percent each year. Under this system, a hospital receives the same payment for a quadruple heart bypass operation as it does for its simplest operation. The base amount is recalculated every three years to adjust for changes in the composition of the hospital's admissions.

B. Statement of the Problem.

The flat-amount payment system introduces perverse incentives for hospitals, and the system does not respond efficiently to changes in the hospitals' case mixture. One result can be early discharge for patients--whether appropriate or not. Another result can be the avoidance of relatively expensive diagnoses by hospitals through referrals to other institutions. The public hospitals, which are obligated to provide service to referred patients, may experience an increase in the diagnostic severity of their patient load without a corresponding increase in their reimbursement. Early discharge of inpatient chemically dependent patients may be contributing to an increase in the caseload at Anoka State Hospital, which would reduce the proportion of care financed with federal funds through MA. The extent of these possible responses to the incentives, however, is unknown, and many hospitals may in fact not be responding to these incentives.

C. Policy Options.

1. Return to the previous cost-based reimbursement system. While this option would eliminate the adverse consequences of the recent changes, it would restore the reimbursement system previously felt unacceptable for implementation of the percentage cap.

2. Base reimbursement on diagnostic groupings using the categories in Blue Cross/Blue Shield's Aware program. This will reimburse hospitals on the basis of their case mixture, much as Medicare reimburses. Once rates are established for diagnostic groups, the increases can be capped or indexed. The initial prices established for diagnostic groups must be set very carefully to ensure equity between hospitals and the state and among hospitals.

3. Base reimbursement on a fully developed system of diagnostically related groups, using Medicare's categories as the starting point. This would result in approximately 500 categories. The large number would create a closer relationship between costs and medical conditions than either of the first two options, but the system's complexity would place a heavier administrative burden on the state.

4. Negotiate contracts with selected hospitals for MA patients. The state of California has implemented selective contracting in its Medi-Cal program and achieved substantial savings. Most of the essential factors contributing to the success of the proposal in California appear to exist in Minnesota, but Minnesota also has hospitals that are more experienced negotiators--particularly in the Twin Cities--than was the case in California.

D. Recommendations.

1. Base reimbursement on diagnostic groupings using the categories of Blue Cross/Blue Shield's Aware program. This change can be accomplished through promulgation of a permanent rule by DHS. The proposal for establishing the rates should receive a thorough review by appropriate state agencies in the hearings process.

2. Authorize DHS to study selective contracting for inpatient hospital reimbursement. A system of negotiated contracts is too complex to implement without substantial analysis and preparation, but DHS should study options for selective contracting to determine which, if any, could be used in Minnesota to reduce expenditures for inpatient hospital services.

IV. MEDICARE CERTIFICATION FOR SKILLED NURSING FACILITIES

A. Background.

As an alternative to extended hospital stays, the Medicare program provides elderly and disabled beneficiaries with a maximum of 100 days of intensive nursing or rehabilitation care in Medicare-certified skilled nursing facilities. Medicare does not cover custodial care; the nursing home stay must follow at least 3 days of hospitalization.

Currently, nursing home participation in the Medicare program is on a voluntary basis in Minnesota and several other states. The availability of Medicare-certified beds varies considerably from state to state and from county to county within Minnesota. From the nursing home's perspective, there are both advantages and disadvantages to Medicare participation.

According to a 1982 Urban Institute study, the primary advantages for the nursing home are attraction of patients who shift to private-pay after their Medicare coverage ends, and the higher reimbursements that Medicare provides in many states compared to Medicaid coverage. On the disadvantage side, nursing homes have three major problems with the Medicare reimbursement system: the detailed accounting it requires, its retroactive application, and the actual rates. The Medicare system requires that nursing homes keep track of their expenses on a departmental or cost-center basis, a method which differs from the way many homes currently keep accounts. Many nursing homes regard Medicare retroactive disallowances, especially unpredictable disallowances, as a substantial disincentive for participation. Finally, for most services, Medicare pays a daily rate calculated as the nursing home's average costs per day for all its patients. To the extent that Medicare patients are more costly than the average patient due to more intensive care, a home can stand to lose money treating Medicare patients. The amount of loss would depend on the similarity between the Medicare requirements and the home's practices for its non-Medicare patients.

State interest in Medicare maximization policies has grown with the implementation of the Medicare DRG hospital reimbursement system. The DRG system is expected to increase the number of Medicare eligible nursing home admissions.

B. Statement of the Problem.

In Minnesota, 16.7% of Medicaid-certified skilled nursing beds are Medicare-certified. This figure is very low when compared to the national average of 67.1%; only five states have a lower percentage than Minnesota (1981 HCFA data).

Minnesota Department of Health data indicate that only about 30% of the skilled nursing facilities in the state have any Medicare-certified beds. Forty-six counties, with one-fourth of the state's population, have no Medicare-certified beds. While some patients do receive nursing home care outside their county of residence, there are whole sections of the state without Medicare-certified homes.

Because of the lack of Medicare-certified beds, expenses for nursing home patients that would be Medicare-eligible are reimbursed instead by private-pay and by the Medicaid program. Since Medicare is totally federally funded while the state of Minnesota pays 45% of Medicaid costs, expenditures for Medicare-eligible persons which are picked up by Medicaid represent an added burden to the state's Medicaid budget.

C. Policy Options.

1. Continue present policy of voluntary nursing home participation in the Medicare program.

2. Require nursing homes to bill Medicare for all potentially covered patients before billing Medicaid. Some states require nursing homes to present Medicare denials when submitting Medicaid claims.

   This type of policy is pursued both by states with mandatory Medicare participation and those with voluntary participation. The rationale behind this type of policy is that Medicare participation by itself may not affect admission or billing practices -that is, certification of homes does not necessarily lead to increased Medicare-covered days.

3. Require nursing homes to be Medicare-certified as a condition of participation in the Medicaid program.

4. Obtain a federal waiver to allow the state Medicaid program to treat Medicare as a third party payor. Under this option, the state would pay the nursing homes up front for care under the Medical Assistance program and then pursue Medicare reimbursement from the federal government. This option would provide nursing homes with an incentive to participate in Medicare since they would be guaranteed payment and the state would assume some of their paperwork burden.

D. Recommendations.

1. Require nursing homes to be Medicare-certified as a condition of participation in the Medicaid program.

2. Obtain a federal waiver to allow the state Medicaid program to treat Medicare as a third party payor.

   Nursing home patients in several areas of the state lack access to Medicare-certified beds within reasonable distance from their homes. Requiring Medicare participation if nursing homes want to participate in Medicaid would result in Medicare certification of more homes.

   The state should also pursue federal approval for treatment of Medicare as a third party payor under Medicaid. This approach would minimize nursing homes' disincentives for serving Medicare patients.

E. Budget Implications and Timetable

Implementation of these recommendations would clearly reduce the state's Medicaid nursing home costs. Since the Medicare DRG hospital reimbursement system is expected to increase the number of Medicare-eligible nursing home admissions, savings to the state Medicaid budget could be considerable and increase over time.

Estimates of the amount of potential savings are not currently available. Current information on Medicare rates and nursing home days has been requested from Blue Cross/Blue Shield, the state's fiscal intermediary for Medicare, for further analysis of this issue.

F. References

Feder, J. & Scanlon, W. The underused benefit: Medicare's coverage of nursing home care. Milbank Memorial Fund Quarterly/ Health and Society, 60(4), 1982, 604-632.

Giel, D. Memo to Senator Linda Berglin re: Medicare Certification for Skilled Nursing Facilities. Senate Research, State of Minnesota, January 10, 1984.

V. REQUIRE PREPAYMENT FINANCING IN METROPOLITAN AREA

A. Background:

In 1981 Congress gave states expanded authority to enroll Medicaid recipients in prepaid health plans and permitted states to guarantee recipients up to six months of eligibility as an incentive to enroll. In 1982 the legislature enacted the guarantee and set the maximum monthly payment rate to participating HMOs at 85% of the average monthly expenditure for AFDC recipients in a given county. As an incentive for county effort, the state cut in half the county's share of non-federal MA expenditures for enrolled recipients. In 1984 the legislture raised the maximum payment to 90%.

Prior to the 1982 changes, DHS had contracts with two HMOs in the Twin Cities, and only 513 AFDC recipients were enrolled. By early 1984 DHS had contracts with all six HMOs in the Twin Cities, and enrollment was about 5,000. Clearly the HMOs found the payment rates attractive, and recipients responded to the six month guarantee of MA eligibility.

Congress also permits states to seek waivers of freedom of choice under Section 1915(b) of the Social Security Act to remove fee-for-service and mandate enrollments in prepaid health plans if a sufficient number of plans are available, accessible, and equipped to handle the enrollments.

Although Congress specifically prohibited state "lock ins" of recipients to particular prepaid health plans in 1982, they removed this prohibition in 1984 but required quality assurance and grievance mechanisms of states who obtain waivers. The maximum "lock in" period is six months. (Minnesota received freedom-of-choice and "lock in" waivers for its Medicaid Prepaid Demonstration Project in 1982, prior to the prohibition.)

Congress also gave states authority to seek waivers to replace the fee-for-service system with a primary care system, in which a primary care physician would serve as the case manager for recipients in return for a fee. Michigan has implemented this system.

B. Statement of the Problem:

The issue for the state is how to obtain economic and efficient health care while assuring access to quality care. The current state policy is to encourage AFDC recipients to enroll in HMOs, but to permit recipients to remain in fee-for-service in the metropolitan area if they desire. This policy has produced selection factors that have worked against the goal of the policy.

In 1984, DHS studied the cost-effectiveness of its HMO contracts and concluded that selection factors were present. They presented these findings:

1. For the time period of the study, the average monthly payment for new AFDC recipients in fee-for-service was $73.45.

2. The average monthly payment to HMOs for AFDC enrollees was $61.30.

3. The group of new recipients who enrolled in HMOs and then moved to fee-for-service had an average monthly cost of $138.51.

4. AFDC recipients with prior fee-for-service experience who first enrolled in HMOs and then returned to fee-for-service had an average monthly cost of $94.23.

Comparison of the first two findings confirms the expected--the HMO environment is less expensive for comparable populations. While there may have been some self-selection of the healthy population into the HMOs, the hospitalization rates for the HMO enrollees were about one-third the rates for the recipients in fee-for-service, a finding consistent with numerous national studies (including the recent Rand Corporation study that controlled for selection through random assignment).

Comparison of the second finding with the third and fourth suggests that a new type of selection factor exists: a trend of the higher-cost recipients disenrolling from HMOs and moving into fee-for-service. This behavior may reflect a desire by these recipients to avoid the utilization controls of the HMOs. Whatever the cause, in the words of DHS's report this trend "points up the broader issue of maintaining the fee-for-service system as an available option to the recipients."

If the state required the fee-for-service system in order to ensure adequate access to medical services, the economic inefficiency of the fee-for-service system would be the necessary price for gaining that access. But because the overwhelming majority of the physicians in the Twin Cities area are affiliated with an HMO, the price purchases very little increase in access to services. The cost of the policy, however, is high: the state essentially forfeits its ability to pay for services in the most efficient manner.

C. Options:

1. Seek federal waivers to require the use of prepayment to providers in the metropolitan area. Initially the prepayment would be required only for providers serving the AFDC recipient population, but DHS should study expanding the program to cover the elderly. Initially the six metro HMOs would constitute the available providers, but DHS should explore expanding the program to include other organizational structures. This could include new organizations (e.g., PPOs) as well as existing ones (e.g., community health centers).

2. Implement a "lock in" for up to six months (the federal maximum) of AFDC recipients who enroll in HMOs. This option would deter some recipients from enrolling, but it would control utilization for those who do.

3. Study the possibility of obtaining federal waivers to remove freedom of choice in order to implement a primary care/case management system in other areas of the state.

The first option would place all medical care for AFDC recipients on a prepaid basis and prevent the movement of high-cost recipients back into the fee-for-service system. Given the high physician participation rate in HMOs, there should not be any significant limitation on access. Recipients would be free to disenroll from a particular HMO in order to switch to another.

The second option also would prevent the movement of high-cost recipients back into the fee-for-service system, but only for a few months. Because it involves a much tighter restriction on recipients, however, this option might not be well received by recipients.

The third option would not constrain costs as much as the first because the case managers would not face strong financial incentives to reduce utilization of services. It is also a very complex undertaking from an administrative perspective. This option would not be particularly useful for the metropolitan area (option one would do much more for much less), but it might work well in other areas of the state where HMOs do not exist.

D. Recommendations:

1. Seek federal waivers to require prepayment to providers in the Twin Cities area. The program should include the following features:

   a. Initially, the waivers should cover only the AFDC recipient population, but DHS should consider including the elderly on Medicare as soon as feasible in a way consistent with the Medicare and Medicaid demonstration projects currently in operation or planning.

   b. Recipients should be permitted to change their selected HMO provider just as they currently can withdraw from a particular HMO (i.e., no "lock in" to a particular HMO).

   c. Elimination of the guarantee of elibility for six months because it will be unnecessary.

   d. Because the current basis for determining the HMO payment rates would be eliminated once the program is implemented, DHS should recommend to the legislature an appropriate methodology. The experience gained by DHS in the past three years should provide a solid basis for their recommendation.

e. Counties participating in the Medicaid Prepaid Demonstration Project should be exempt from this program for the duration of their participation.

2. Study the potential use of federal waivers to remove fee-for-service and implement a primary care/case management system in areas of the state not covered under the first recommendation. The program should include the following features:

   a. Because recipients would be free to designate their case managers, no phase-in period would be necessary.

   b. Recipients should be permitted to change their designated case manager (i.e., no "lock in").

   c. Counties participating in the Medicaid Prepaid Demonstration Project should be exempt from this program for the duration of their participation.

VI. COMPETITIVE BIDDING FOR PHARMACEUTICALS, LABORATORY SERVICES, AND TRANSPORTATION

A. Background.

In 1981, Congress authorized states to employ competitive bidding for purchasing laboratory services, medical supplies, and other items. The Governor's Task Force on Health Care recommended that the MA program incorporate competitive bidding for bulk purchases. DHS now purchases on a volume basis three types of items: prescription glasses, wheelchairs, and hearing aids. DHS estimates that the annualized savings for the three items currently purchased on a volume basis are: prescription glasses $382,000 on 43,000 jobs; wheelchairs, $552,000; and hearing aids, $48,000.

In FY 1984, DHS spent about $40 million on pharmaceuticals, with $24 million of that amount being spent for the drugs. DHS expects that its changes in pharmacy reimbursement on October 15, 1984, should save 10% of the Average Wholesale Price. DHS estimates that the state can save an additional 5% to 10% of the Average Wholesale Price on pharmaceuticals through competitive bidding. (Savings: $220,000 per year, of which $92,000 would be state dollars.)

DHS spends about $4 million per year on laboratory services. DHS estimates that a competitively bid contract can save one-fourth this amount, or $1 million per year. (Savings: $1,000,000 per year, of which $420,000 would be state dollars.)

DHS spent $4.9 million in FY 1984 on medical transportation; DHS estimates that one-half this amount was for non-emergency transportation. The department calculates that it can save 10% of the non-emergency costs through competitive bidding contracts. (Savings: $245,000, of which $103,000 would be state dollars.)

The total annual estimated savings on these three items is $1,465,000, of which $615,000 would be state dollars. DHS indicates a need of 2 positions to operate these program changes, with an increase in costs of $59,100 for FY 1986 and $69,100 for FY 1987.

B. Policy Options.

1. Maintain the status quo.

2. Employ competitive bidding contracts for pharmaceuticals, laboratory services, and non-emergency transportation.

C. Recommendation.

Employ competitive bidding contracts for pharmaceuticals, laboratory services, and non-emergency transportation.

VII. RELATIVE RESPONSIBILITY FOR MEDICAID RECIPIENTS

A. Background.

Medicaid regulations allow states to require relative contributions toward the costs of caring for Medicaid recipients from relatives, including parents of children in out-of-home care and spouses of elderly receiving nursing home care.

Under Federal regulations, Medical Assistance recipients can not be refused services because of a failure of responsible relatives to contribute to the costs of their care. In Minnesota, counties may waive relative contributions if they feel that such contributions will create undue hardship.

The current implementation of relative contributions in Minnesota for children in out-of-home care and elderly spouses in nursing homes is described below.

1. Parental fees for children in out-of-home care

Parental fees for children placed in 24 hour out-of-home care were revised by Laws of Minnesota 1984, Chapter 530 to eliminate inequities in fees among counties and among types of residential placements. Authority for establishment of a fee schedule was transfered from the county boards to the Department of Human Services.

The population covered by this program includes children in 24 hour out-of-home care (including respite care) who meet one of the following conditions: have mental retardation, epilepsy, or a physical or emotional handicap; are receiving MA based on their own eligibility; or are in state hospitals.

The situations covered include those in which 1) MA pays for a child's medical care and residential facility costs, and 2) MA pays for a child's medical care but room and board is paid by other sources (such as foster care, etc.) Fees can not be charged to parents whose children are receiving services under a federal MA waiver while living in their natural home until a rule is promulgated that will grant that authority.

Parents do not have to pay fees if they are on MA or if their annual gross income is less than $11,000. Above $11,000, the fees are based on income and household size according to the revised Rule 27 fee schedule (see enclosed chart). In no case may the fees be greater than 5% of the parents' annual income as defined in the Property Tax Refund Act. Only income may be considered in determining fees; resources may not be considered. The fee to be paid by the parents is limited to the amount for only one child if they have more than one child in out-of-home care.

For children receiving MA, the amount of the parental fee is to be the lesser of 1) the rate on the revised Rule 27 fee schedule; or 2) the rate corresponding to 5% of the parental annual income as defined in the Property Tax Refund Act.

For children not receiving MA, the fee is to be the lesser of 1) the 5% fee; or 2) the fee under the county's current social services fee schedule.

For children in state hospitals, the fee is to be the lesser of 1) the Rule 27 fee; 2) the 5% of annual income fee; or 3) 10% of the state hospital per capita rate. (There are three different per capita rates for the three different disability groups in state hospitals; the maximum daily contribution for CD is $7.71; for MI is $10.86; for MR is $13.59.)

2. Spouses' contribution for elderly in nursing homes

The initial determination of Medicaid eligibility for an elderly individual receiving nursing home care is based on the income and resources of the family unit, including both the individual and his/her spouse. Income and resource limits are established by Minnesota law within guidelines established by the federal government. Current income limits are shown below.

MEDICAL ASSISTANCE INCOME LIMITS

Family Size	Annual Income	Monthly Income
1	$3,936	$328
2	4,944	412
3	6,000	500
4	6,996	583
5	7,860	655
Each additional person	936	78

Individuals whose income exceeds these limits may still qualify for Medical Assistance through the spend down provisions. There are two types of spend down: 1) six month spend down in which the applicant's medical expenses in the application month and/or the three preceeding months total more than one half of his/her annual excess income; and 2) continuing spend down in which the applicant has continuing medical expenses which exceed the amount of his/her excess income each month.

Medical Assistance recipients are also limited in the value of the resources they may possess. The value of a homestead and one car is excluded from the limit; the value of other resources, including cash, savings, trusts, etc., can not exceed $3000 for a single individual or $6000 for a two person household.

In cases where the Medicaid eligible person in a nursing home has a spouse at home who is not receiving MA, that spouse must contribute their income and resources above the MA limits to help pay the medical expenses of the institutionalized spouse.

The fee schedule for spousal contributions was updated during the 1984 legislative session to reflect Social Security increases in the cost of living. The current fee schedule is as follows:

UPDATED SPOUSE TO SPOUSE CONTRIBUTION SCHEDULE

FOR MEDICAL ASSISTANCE

Net Monthly Income of Non-Institutionalized Spouse	Non-institutionalized Spouse's Contribution per month
$0 - 600	$0
$601 - 700	30% of the amount over $600
$701 - 900	$30 plus 40% of the amount over $700
$901 - 1050	$110 plus 50% of the amount over $900
Over $1050	$185 plus 100% of the amount over $1050

Net monthly income is determined in the same way as it is for MA clients, except that no income disregards are allowed.

B. Statement of the Problem.

A preliminary examination of the current fee schedules for two groups of responsible relatives under the Medical Assistance program reveals clear inequities in the income and resource contributions required from each group. Elderly spouses of MA receipients in nursing homes have resource limits while parents of children in out-of-home care have no resource limits. There is no cap on the spousal income contribution while the income contributions of parents are limited to 5% of adjusted gross income.

The issue of equity in relative contributions goes beyond the amount of relative contributions to problems of equity in the determination of MA eligibility. As a result of the categorical eligibility criteria for Medicaid which are established by federal regulations, many children from "working poor" families are not eligible for MA while many children in out-of-home care are automatically MA eligible, regardless of their parents' income level.

The equity issue also extends to parents who have disabled or non-disabled children living at home. Many of these parents pay more for day care alone than the maximium parental fee under the current MA fee schedule. Parents of children in out-of-home care should contribute the amount it would cost to raise a non-disabled child at home. MA should pay only for the additional costs associated with the child's disability.

C. Recommendations.

1. State legislation should be changed to establish MA relative contribution schedules which treat parents of children in out-of-home care and elderly spouses equitably, taking into account family size, special needs, and the costs of raising non-disabled children at home.

2. Once changed fee schedules are implemented, the Department of Human Services should develop ways to increase actual payment compliance. The possibility of giving counties financial or other incentives to obtain payments from responsible relatives should be examined.

VIII. PROVIDER REIMBURSEMENT UNDER THE MEDICAL ASSISTANCE (MA) AND GENERAL ASSISTANCE MEDICAL CARE (GAMC) PROGRAMS

A. Background.

Since 1981, MA and GAMC fees for physicians, dentists, and other non-institutional health care providers have been frozen at the 50th percentile (median) of their charges for earlier years (1979 for MA; 1978 for GAMC). In addition, the Commissioner of Human Services has had the authority to reduce payments for health care services for GAMC clients ("rateable reductions") if necessary to keep expenditures within appropriations. The maximum allowable rateable reduction for non-institutional fee-for-service providers was 25% until July 1, 1984, when it became 10%.

The rateable reduction authority and the 1978 fee freeze for GAMC are scheduled to sunset on June 30, 1985. There is no sunset provision for the freeze on MA rates.

B. Statement of the Problem.

Lobbyists for dentists, physicians, pharmacists, and other providers have announced that they plan a coordinated effort to pass legislation in the 1985 session which will increase the the base reimbursement rates for their services and provide for regular rate increases.

Providers maintain that they have to charge other clients more ("shift costs") because government programs and large insurors pay less than provider-set fees. However, the state, as a prudent purchaser, should pay providers only enough to induce them to provide the service. Minnesota's rates for common procedures appear to fall about the middle of the range for upper Midwestern states.

There is currently no evidence that MA or GAMC clients are having any significant difficulty in obtaining services. A recent Department of Human Services study revealed that more physicians, pharmacists, and outpatient hospitals submitted GAMC billing claims in 1984 than during a similar period in 1981. The number of dentists submitting claims was 17% less than in 1984, but they served 1545 more recipients. DHS has been able to find services for the few clients on whose behalf it has been requested to do so. These data do not prove conclusively that there are no access problems, but they do suggest strongly that any problems that currently exist are not serious enough to require major increases in provider reimbursement.

C. Policy Options.

There are three variables to consider in analyzing provider reimbursement options: (1) base rates; (2) future updates of rates; and (3) rateable reductions.

Options can be selected independently for each of these variables; there are numerous possible variations of options.

Base Rates: Options

1. Maintain current standards; base FY 1986 rates on the 50th percentile of 1978 (GAMC) and 1979 (MA).

2. Use cost data from a more recent year (1982 or 1983) to set base rate; base FY 1986 rates on the 50th percentile of 1982 or 1983.

Future Updates of Rates: Options

1. Establish the base rate as a fixed fee schedule with updating on an "as needed" basis rather than on a predetermined basis.

2. Move the base rate up one year annually; for example, base FY 1987 rates on the 50th percentile of 1984 if FY 1986 rates are based on 1983 rates.

3. Update the base rate anually by the previous year's inflation rate capped at 5%.

Rateable Reductions: Options

1. Remove GAMC rateable reductions.

2. Retain GAMC rateable reductions.

D. RECOMMENDATIONS

1. Base Rates

Continue to use the current standards (50th percentile of 1978 and 1979) as the base rates, but change statutory language so the current standards are established as fixed rates without reference to percentiles of any particular years.

2. Future Updates

Update the schedule on "as needed" basis, with need defined as the need to ensure access to care. Require the Department of Human Services to monitor access to care for MA and GAMC clients on a regular basis. The Department should report to the legislature any evidence of access problems which arise from reduced levels of provider participation.

3. Rateable Reductions

Remove rateable reductions for GAMC providers.

E. BUDGET IMPLICATIONS

1. RECOMMENDED OPTIONS: Use current standards; update as needed; remove GAMC rateable reductions

STATE MA AND GAMC COSTS (millions)

	FY 1985	FY 1986	FY 1987	BIENNUM
MA	450.8	488.8	537.3	1026.1
GAMC	59.8	79.7	90.7	170.4
TOTAL	510.6	568.5	628.0	1196.5
CHANGE FROM 1985		57.9	117.4	175.3

STATE COSTS FOR PROVIDERS ONLY (millions)

	FY 1985	FY 1986	FY 1987	BIENNUM
MA + GAMC	87.8	91.9	99.6	191.5
CHANGE FROM 1985		4.1	11.8	15.9

2. OTHER OPTIONS:

a. Use current standards; update annually using 5% inflation cap.

STATE COSTS FOR PROVIDERS ONLY (millions)

	FY 1985	FY 1986	FY 1987	BIENNUM
MA + GAMC	87.8	96.5	109.8	206.3
CHANGE FROM 1985		8.7	22.0	30.7
DIFFERENCE FROM RECOMMENDED OPTIONS		4.6	10.2	14.8

b. Set new standard for FY 1986 at 50th percentile of 1982; update annually using 5% inflation cap.

STATE COSTS FOR PROVIDERS ONLY (millions)

	FY 1985	FY 1986	FY 1987	BIENNUM
DENTISTS	8.9	12.4	13.5	25.9
ALL OTHERS*	78.9	97.1	111.2	208.3
MA + GAMC	87.8	109.5	124.6	234.1
CHANGE FROM 1985		21.7	36.8	58.5
DIFFERENCE FROM RECOMMENDED OPTIONS		17.6	25.0	42.6

* Increase for physicians used to project all others except dentists.

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c. Set new standard for FY 1986 at 50th percentile of 1983; update annually using 5% inflation cap.

STATE COSTS FOR PROVIDERS ONLY (millions)

	FY 1985	FY 1986	FY 1987	BIENNUM
MA + GAMC	87.8	118.7	123.5	242.2
CHANGE FROM 1985		30.9	35.7	66.6
DIFFERENCE FROM RECOMMENDED OPTIONS		26.8	23.9	50.7

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d. Set new standard for FY 1986 at 50th percentile of 1983; change standard annually, so that 1987 rates are based on 50th percentile of 1984. (Providers are expected to request legislation similar to this option.)

STATE COSTS FOR PROVIDERS ONLY (millions)

	FY 1985	FY 1986	FY 1987	BIENNUM
DENTISTS	8.9	12.8	14.2	26.9
ALL OTHERS*	78.9	106.0	123.5	229.4
MA + GAMC	87.8	118.7	137.6	256.4
CHANGE FROM 1985		30.9	49.8	80.8
DIFFERENCE FROM RECOMMENDED OPTIONS		26.8	38.0	64.9

* Increase for physicians used to project all others except dentists.

Note: Option 2d. estimates the increase from 1983 to 1984 billings for providers by dividing the percentage increase in physicians' fees from 1979 to 1983 by four. If the increase in physicians' fees from 1982 to 1983 were projected instead, the costs for 1987 would have been 138.7 million, or 2.6 million higher.

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e. Use current standards; retain GAMC rateable reductions.

STATE COSTS FOR PROVIDERS ONLY (millions)

	FY 1985	FY 1986	FY 1987	BIENNUM
MA + GAMC	87.8	89.4	96.9	186.3
CHANGE FROM 1985		1.6	9.1	10.7
DIFFERENCE FROM RECOMMENDED OPTIONS		(2.5)	(2.7)	(5.2)

IX. COPAYMENTS IN THE MEDICAL ASSISTANCE AND GENERAL ASSISTANCE MEDICAL CARE PROGRAMS

A. Background.

Cost-sharing by consumers has been proposed as a means of reducing health care costs in both government health care programs and private health plans. Under certain circumstances which are defined by Federal regulations, states may include three types of cost-sharing (enrollment fees, deductibles, and copayments) in their Medicaid program. Copayments are the most widely used type, and are also a feature of many private health plans.

Under federal Medicaid regulations, the state may impose copayments on services furnished to categorically or medically needy recipients, except for the following: (1) children under 18 years old; (2) pregnant women, if the services are related to the pregnancy or to a condition that would affect the pregnancy; (3) institutionalized patients who must spend all of their income except for a personal needs allowance on medical care; (4) emergency services or family planning services to any client; and (5) HMO-furnished services to categorically needy enrollees. All cost-sharing charges must be "nominal" which is defined relative to the state's reimbursement amounts. Providers must accept the copayment plus the state's payment as payment in full, and may not refuse service because of a client's inability to pay the copayment.

Minnesota law does not currently provide for copayments in MA or GAMC. The GAMC statute explicitly prohibits the imposition of any charge beyond the state's reimbursement.

B. Statement of the Problem.

The primary reasons given for using copayments in health care programs are (1) to make the consumer more cost-conscious and presumably more careful in the use of services, and (2) to reduce the primary payor's costs. The major reasons against using copayments are concerns related to underutilization of necessary medical services, especially preventive care.

This analysis was done in order to determine the potential impacts of copayments on the MA and GAMC budgets and on the health status of recipients.

C. Policy Options.

1. Do not institute copayments in the MA and GAMC programs.

2. Pass state legislation to impose copayments on all services allowed under federal regulations.

D. Recommendation

1. Do not impose copayments on clients in the Medical Assistance and GAMC programs. Implement cost containment measures that control utilization through providers rather than clients/consumers.

   Current regulations would allow copayments for services that account for about 29% at most of the MA and GAMC services that were delivered in FY 1983. While the imposition of copayments on these services would result in short-term savings to the state MA and GAMC budgets, the long-term savings are questionable. More importantly, it is possible that the imposition of copayments may have a negative impact on the health status of MA and GAMC recipients. Since the MA and GAMC populations are, on the whole, less healthy than the general population, this is not a risk the state should take.

   There is no doubt that even "nominal" copayment amounts are seldom nominal to a person on a welfare budget, and will result in postponement or avoidance of some necessary services. It is impossible to predict whether the lack of these services will increase costs and worsen health status by increasing the incidence of illness that might have been prevented or treated more inexpensively at an earlier date.

E. Budget Implications

1. No copayments

STATE MA AND GAMC COSTS (millions)

	FY 1985	FY 1986	FY 1987	BIENNUM
MA + GAMC	510.6	561.8	628.0	1196.5
CHANGE FROM 1985		57.9	117.4	175.3

2. Copayments on all federally allowed services

STATE MA AND GAMC COSTS (millions)

	FY 1985	FY 1986	FY 1987	BIENNUM
MA + GAMC	510.6	561.8	619.5	1181.3
CHANGE FROM 1985		51.2	108.9	670.7
DIFFERENCES FROM RECOMMENDED OPTION		(6.7)	(8.5)	(15.2)

The long-term budgetary implications of instituting copayments are unclear. Some states which have imposed copayments have experienced a pattern of decreasing utilization in the first year or two followed by utilization rising as fast or faster than caseload increases. This pattern may result from provider control of demand for services, especially when providers have an incentive to offset losses from unpaid copayments with the delivery of more services.

X. MORATORIUMS: NURSING HOME AND ICF/MR BEDS

A. Background:

In 1983, the legislature enacted a moratorium on the certification of nursing home beds under the MA program. Under the moratorium, any new nursing home beds are not be eligible for MA reimbursement except in certain limited situations. The moratorium also prohibits the recertification of nursing home beds from less expensive to more expensive levels of care. For several years prior to the moratorium, there had been growth within the industry and shifts to the most expensive level of care--neither of which was justified by the growth in the elderly population. The moratorium ended the expansion in the nursing home industry.

In 1983 the legislature also enacted a moratorium on the certification of beds in intermediate care facilities for the mentally retarded (group homes and state hospitals). Under this moratorium, the supply of state hospital and group home beds is restricted to 7,500, and the limit is to drop to 7,000 in a few years.

B. Statement of the Issue:

Should the state lift either moratorium, or should the state continue them? Each moratorium was enacted to contain costs in programs with generous MA reimbursement, which had led to rapid expansion in the supply of facilities. Both reimbursement systems have been changed, but there are still good reasons to retain the moratoriums. In the nursing home industry, the state expects to implement case-mix reimbursement and incorporate a rental concept in the reimbursement for property-related costs. In the ICF/MR industry, the state is implementing a broad waivered-services program to encourage non-institutional residential settings for the mentally retarded population. Until these changes are fully implemented and evaluated, it is prudent to restrict the supply of certified beds to see how these changes work in a steady-state environment.

C. Recommendation:

The state should continue the moratoriums on MA certification of beds in nursing homes and intermediate care facilities for the mentally retarded.